Benefits Information Guide

Lam Research Corporation Group Welfare Benefit Plan – Summary Plan Description

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Your Lam Research Corporation Benefits Program

About the Program

One of the great things about working for Lam Research Corporation (**Lam Research** or the **Company**) is our benefits package. Lam Research offers health care, financial protection and retirement savings benefits that are competitive in our industry and relevant to our employees' needs.

Our diverse employee population is one of our greatest strengths. We have designed our benefits package to offer a variety of choices to meet the different needs of individual employees. This flexibility gives you the power to choose and custom-tailor your benefits to fit your situation.

Lam Research is pleased to provide its eligible employees with the following health and welfare plan coverages:

- Medical
- Dental
- Vision
- Basic Life, Supplemental Life, Basic Accidental & Dismemberment (AD&D) and Supplemental AD&D
- Voluntary Disability Insurance (VDI) and Short Term Disability (STD)
- Long Term Disability (LTD)
- Employee Assistance Program (EAP)
- Group Legal Services

These benefits are provided through a plan that is officially known as the "Lam Research Corporation Group Welfare Benefit Plan" (the **Plan**).

Also, under the Lam Research Corporation Cafeteria Plan, eligible employees may also elect to contribute to the Health Care Flexible Spending Account (**Health Care FSA**) and the Dependent Care Flexible Spending Account (**Dependent Care FSA**), together referred to as the "**FSAs.**" All of these benefits collectively make up the Lam Research Corporation Benefits Program (the **Program**).

About This Document

To make informed choices that work to your best advantage, you need to understand your benefits and your coverage options. This Benefits Information Guide (**Guide**) contains important information about the Program. It describes the Program in effect as of January 1, 2020.

This Guide is a wrap-around summary plan description (**wrap-around SPD**) for the Plan. Together, this Guide and the coverage summaries described below make up the summary plan description for your benefit coverages as required by law.

- This Guide provides a brief summary of your benefits and detailed information about participation, enrollment, when coverage begins and ends, and Plan operation under the Plan.
- The coverage summaries include schedules of benefits for the self-insured programs and the certificates of insurance for the fully-insured programs. The coverage summaries provide detailed information about an individual benefit offered under the Plan—for example, the applicable copayments (copays), coinsurance, deductibles, and benefits covered, payment amounts, offsets, and exclusions; the coverage summaries can be accessed on this website: **www.LamBenefits.com.**

This Guide, together with the coverage summaries, replaces previous SPDs and is intended to comply with Section 102 of the Employee Retirement Income Security Act of 1974, as amended, and its regulations (**ERISA**). The complete terms of the Plan are set forth in the official Plan documents, insurance contracts, and the Lam Research Corporation Cafeteria Plan established under Section 125 of the Internal Revenue Code, as amended, and its regulations (**IRC**). In the event of any difference between this Guide or a coverage summary and the official Plan documents and insurance contracts relating to the relevant type of coverage under the Plan, the official Plan documents and insurance contracts will govern.

Generally, references to “you” or “your” in this Guide refer to the enrolled employee and enrolled dependents. However, with respect to enrollment provisions in this Guide, references to “you” or “your” refer to the enrolled employee only.

If You Need More Information

If you have questions or need additional information, call the Benefits Help Desk at 1-877-291-9494 or e-mail benefits@lamresearch.com.

How the Lam Research Benefits Program Works

The Program gives you many choices and puts you in control of your benefits. Like most purchasing decisions, there is more to making a choice than just knowing what options are available.

Pre-Tax and After-Tax Payments

Most of your benefits, except those listed below, are purchased with pre-tax dollars, which means you pay for benefits before your federal, Social Security (FICA) and in most states, state and local income taxes are calculated. As a result, when your taxes are calculated, they are based on a lower level of income. In most cases, the net effect is that you pay less in taxes.

Not all benefits can be paid on a pre-tax basis. Benefit costs paid on an after-tax basis are deducted from your pay after your taxes have been calculated. The following benefits are purchased with after-tax dollars:

- Employee Supplemental Life Insurance
- Dependent Life Insurance and Dependent Supplemental Accidental Death and Dismemberment (AD&D) Insurance
- Employee Supplemental Accidental Death and Dismemberment (AD&D) Insurance
- Voluntary Disability Insurance (VDI) and Short Term Disability (STD)
- Coverage for same-sex and opposite-sex domestic partners and their children
- Group Legal Services

In addition, the value of Basic Life Insurance coverage over $50,000 and the premium amount Lam Research pays for Long Term Disability coverage is imputed income to you. This is explained in greater detail in the “Employee Life and Accidental Death and Dismemberment (AD&D) Insurance” and “Long Term Disability (LTD)” sections. You have the option of electing a cap of $50,000 for your Employee Life Insurance benefit, so that you will not have any imputed income.

Benefit Choices

You have a wide range of benefit choices. When you enroll, you can choose from the following benefits:

Medical

- Anthem Blue Cross Life and Health (Anthem) Consumer Directed Health Plan (CDHP) with Health Savings Account (HSA) option
- Anthem Base Preferred Provider Organization (PPO) Plan option
- Kaiser Traditional Health Maintenance Organization (HMO) plan—offered in California and parts of Oregon and Washington only
- Kaiser Consumer Directed Health Plan (CDHP) with Health Savings Account (HSA)—offered in California and parts of Oregon and Washington only

Dental

- Preventive Plan option
- Enhanced Plan option
- Premium Plan option

Vision

- Base Plan option
- Enhanced Plan option

Employee Assistance Program (EAP)

- EAP (employer-provided; you and your eligible dependents are automatically enrolled)

Employee Life and Accidental Death & Dismemberment (AD&D) Insurance

- Employee Basic Life Insurance (employer-provided; you are automatically enrolled)
- Employee Supplemental Life Insurance
- Basic Accidental Death and Dismemberment (AD&D) Insurance (employer-provided; you are automatically enrolled)
- Employee Supplemental AD&D Insurance

Dependent Life and Accidental Death & Dismemberment (AD&D) Insurance

- Spouse Dependent Life and AD&D Insurance
- Child(ren) Dependent Life and AD&D Insurance

Flexible Spending Accounts (FSAs)

- Health Care FSA
- Dependent Care FSA

Disability

- Voluntary Disability Insurance (VDI) Plan for California employees (you are automatically enrolled)
- Short Term Disability (STD) Plan for non-California employees (you are automatically enrolled but you have the option to decline this coverage)
- Long Term Disability (LTD) Plan (employer-provided; you are automatically enrolled)

Group Legal Services

- ARAG's UltimateAdvisor Legal Expense Insurance

Coverage Level Choices

In addition to having many plans to choose among, you also need to decide whom to cover.

Medical, Dental, and Vision Coverage Levels

For medical, dental, and vision coverage, you may choose coverage for:

- You only;
- You and your spouse/domestic partner;
- You and your child(ren); or
- You and your family (your spouse/domestic partner and your children and/or your domestic partner's children).

Since each plan requires separate enrollment decisions, you can choose different coverage levels for each. For example, you may elect medical coverage for you only and dental coverage for you and your family.

Declining Medical Coverage

Lam Research strongly encourages you to maintain medical coverage for yourself and, if applicable, your family members—either under a Lam Research-sponsored Medical Plan or under your spouse's/domestic partner's medical plan.

You may, however, decline medical coverage. If you decline Lam Research-sponsored medical coverage, Lam Research will not have any obligation, nor assume any responsibility for the payment or reimbursement of any medical expenses, bills, or claims you or a family member may incur (unless you happen to be covered under the plan of a spouse/domestic partner who also works for Lam Research).

Employee Supplemental Life and Supplemental AD&D Insurance

You may enroll yourself in Employee Supplemental Life and Supplemental AD&D Insurance, which is in addition your Employee Basic Life and Basic AD&D Insurance.

Dependent Life and AD&D Insurance

As long as you enroll yourself in Employee Supplemental Life and Supplemental AD&D Insurance, you may also enroll your spouse/domestic partner and/or eligible children in Dependent Life and AD&D Insurance.

Eligibility

The Program's eligibility requirements for employees and their dependents are defined below. If the eligibility rules described in the coverage summaries of the Program's component plans differ from the eligibility requirements described in this Guide, the Guide's eligibility requirements will govern.

Employee Eligibility

You may enroll in the Program if you are classified as a regular employee or intern of Lam Research in the Company's U.S. payroll records for employment tax purposes and you work at least 20 hours per week. (Lam Research uses the Monthly Measurement Method to determine full-time employee status for purposes of the Affordable Care Act.)

You are not eligible to enroll in the Program if you work fewer than 20 hours per week or are classified by Lam Research as a temporary employee who is not in the Company's U.S. payroll records or an independent contractor, even if a court or administrative agency subsequently determines that any such individual should be retroactively reclassified as a common law employee of Lam Research. International employees are also excluded, except as otherwise specifically designated by Lam Research.

Intern Employees

If you are classified as an intern, your eligibility is limited to medical, dental, vision, and EAP coverage only. Note, Interns are not subject to a minimum hours work week.

Rehired Employees

If your employment ends while you are enrolled in the Program, and you are rehired after 13 consecutive weeks, you will be treated as a new employee. If you are rehired during the same plan year (January 1 through December 31) and within 13 consecutive weeks after your previous period of employment ended, your previous election of benefits will be reinstated subject to any applicable insurance company requirements.

In addition, if you terminate your employment, and are rehired by the Company during the same plan year and within 30 days of your prior termination of employment, you will continue to be eligible for the same pre-tax benefits in which you participated prior to your termination of employment. If you are rehired more than 30 days after your prior termination of employment or during a subsequent plan year, you must enroll again in the Program to participate in pre-tax benefits.

Dependent Eligibility

If you are eligible and enroll yourself for coverage, you may also enroll your eligible dependents in Medical, Dental, Vision, and Dependent Life and Dependent Supplemental AD&D Insurance coverage. You and your eligible dependents are automatically enrolled in the Employee Assistance Program (EAP).

Eligible dependents include:

- Your legal spouse.
- Your eligible children.
- Your duly qualified domestic partner (same-sex/opposite-sex).
- Your qualified domestic partner's eligible children.

Spouse Eligibility

A person is your “spouse” under the Program if, and only if, such person and you became married to each other under the law of any jurisdiction and the marriage has not been legally terminated or you and your spouse are not legally separated.

Child Eligibility

Child means:

- A child who is under 26 years of age who is:
  - Your, your spouse’s, or your domestic partner’s natural child, stepchild, legally adopted child (or one in the process of being adopted), or foster child, regardless of his or her marital, student, residency, or financial dependency status. (See also “Dependent Children of Domestic Partners” below).
  - A child for whom you, your spouse, or your domestic partner has been appointed legal guardian by a court of law.
  - A child for whom you, your spouse, or your domestic partner is required to provide coverage under a Qualified Medical Child Support Order (QMCSO). (**Note**: You may obtain a free copy of the Program’s procedures governing QMCSOs from the Benefits Help Desk.)
- An unmarried child of any age if he or she is dependent on you, your spouse, or your domestic partner for support due to a physical or mental disability which began prior to age 26 and while enrolled in the Program. The Plan Administrator has the right to require proof of continuing disability.

You must enroll in Employee Supplemental AD&D Insurance before you can enroll your dependents in the Dependent Supplemental AD&D Insurance. You may enroll your legal spouse and/or your children from their live birth through age 26. Your spouse or children cannot be full-time member(s) of the armed forces of any country. Your child cannot be enrolled by more than one employee.

Administrative guidelines for dependents may vary by plan. Refer to your coverage summaries for details.

Domestic Partner Eligibility

The following criteria must be met in order for your same-sex or opposite-sex domestic partner to qualify for coverage (all must be true and correct):

- You cohabit and reside together in the same residence and intend to do so indefinitely. You have resided in the same household for at least 12 months.
- You are engaged in an intimate committed relationship of mutual caring and support and are jointly responsible for your common welfare and living expenses. Your intimate relationship distinguishes you from being simply roommates, friends, or a live-in service provider (such as a nanny), all of whom are not eligible for domestic partner coverage.
- You are each other’s sole domestic partner, and you intend to remain so indefinitely.
- Neither of you is married to or legally separated without dissolution of marriage from anyone else nor have you had another domestic partner within the prior 12 months.

- You are both at least 18 years of age and mentally competent to consent to a contract.
- You are not related by blood to a degree of closeness that would prohibit legal marriage in the state in which you reside.
- You are not in this relationship or applying for domestic partner coverage solely for the purpose of obtaining health care coverage from Lam Research.

Dependent Children of Domestic Partners

Besides meeting the "Child Eligibility" requirements above, the children of the domestic partner must also meet each of the requirements listed below.

- The domestic partner's home is the child's primary place of residence for more than 50% of the year.
- The child's principal financial support is provided by the domestic partner(s).
- The child is eligible to be claimed as a "dependent" on either your or your domestic partner's federal income tax return.
- You or your domestic partner has legal guardianship of the child.

Domestic Partnership Acknowledgments

When enrolling in coverage, you acknowledge the following:

- You understand that your enrollment may have legal implications relating, for example, to your ownership of property or to taxability of coverage provided, and that before enrolling in coverage you should seek competent legal advice concerning such matters.
- You understand that Lam Research will treat the receipt of coverage by the domestic partner who is not an employee of Lam Research and by that partner's children as taxable income to the employee. That additional income will be reported on the employee's paychecks, subject to normal withholding requirements, and to the Internal Revenue Service (IRS) at the end of the year. Furthermore, you understand that payments withheld from the employee's pay for such benefits will be subject to imputed income.
- You understand that a civil action may be brought against one or both of you for any losses (as well as attorney's fees and cost) due to any false statement or for failure to notify Lam Research of changed circumstances as required by the "Notification Upon Change in Domestic Partnership Status" section below. You further understand that falsification of information or failure to notify Lam Research of changed circumstances pursuant to the "Notification Upon Change in Domestic Partner Status" may lead to disciplinary action against the employee, including discharge from employment.
- You understand and agree that Lam Research is not legally required to extend any coverage. You understand that the information attested to by enrolling in coverage will be treated as confidential by Lam Research, but will be subject to disclosure:
  - Upon the express written authorization of the employee;
  - Upon request of the insurance company or Plan Administrator; or
  - If otherwise required by law.

Notification Upon Change in Domestic Partnership Status

- You acknowledge that you have an obligation to notify Lam Research if there is any change in your domestic partnership status (for example, the death of a partner, a change in residence of one partner, termination of the relationship, etc.) as attested to by enrolling in coverage that would terminate such status. You will notify Lam Research within 30 days of such change.
- You understand that any coverage obtained as a result your domestic partnership will terminate on the last day of the month of the date that the relationship ends, whether Lam Research is notified or not. You agree that both of you will be liable to repay Lam Research for any benefits received after the relationship ends and that Lam Research may collect the entire amount due from either one of you.

Dependent Eligibility Audits

You are responsible for determining if someone qualifies as your spouse/domestic partner or dependent child for purposes of the Plan's dependent eligibility rules, subject to the Plan Administrator's final approval.

The Plan Administrator may require you to provide proof that an individual satisfies the Plan's eligibility requirements. In addition, if at any time during a plan year, your spouse/ domestic partner or child becomes ineligible for coverage, you are responsible for notifying the Plan Administrator of that change in eligibility within 30 days of such change.

From time to time, the Plan Administrator may decide to conduct an eligibility audit. If the Plan Administrator finds that you have enrolled an individual for coverage in the Plan who did not meet the dependent eligibility criteria, the coverage for that individual will be discontinued on a prospective basis.

If it is determined that you acted fraudulently or intentionally misrepresented in a material way the status of the individual as your dependent, coverage may retroactively be denied, and you may be required to repay any benefit claims paid to or on behalf of such individual. Other employment action may be taken against you in cases involving intentional misconduct on your part.

Special Rules Regarding Domestic Partners

Contributions for Coverage

Federal tax rules do not allow your domestic partner's health coverage under the Plan to receive the same tax-favored treatment that applies to a spouse's coverage, unless your domestic partner is your IRS tax dependent. That is also true for coverage provided to a domestic partner's dependent children. Lam Research assumes all dependents are IRS tax dependents, except domestic partners and their children. As a result, any contributions that Lam Research makes toward the cost of your domestic partner's (and the children of your domestic partner's) coverage are treated as taxable imputed income to you. Furthermore, your own contributions for your domestic partner's (and the children of your domestic partner's) coverage must be made on an after-tax basis, rather than through pre-tax contributions. In this case, the amount of taxable imputed income is the difference between your after-tax contributions for that coverage and its fair market value.

Health Care FSA

You cannot be reimbursed from your Health Care FSA for claims submitted for otherwise qualified health care expenses incurred on behalf of your domestic partner or his or her children, unless such individuals are your IRS tax dependents.

Health Savings Account

You cannot use distributions from your Health Savings Account (HSA) to pay for the otherwise qualified medical expenses of your domestic partner or his or her children, unless such individual qualifies as a "qualifying child" or "qualifying relative" under the definition of an IRS tax dependent.

HSA funds can generally be used for the qualified medical expenses of you, your spouse, and your IRS tax dependents claimed on your federal tax return.

Please consult a tax advisor for information regarding whether or not your domestic partner and his or her children are your IRS tax dependents and for information about state income tax treatment of domestic partner coverage.

Definition of an IRS Tax Dependent

An IRS tax dependent for health care, including medical, prescription drug, dental, vision and Health Care FSA plan purposes is defined under federal law. While Lam Research always recommends that you consult with a tax advisor, the definition provided here is a summary of these complex rules for **federal** tax purposes.

Definition of an IRS Tax Dependent—General Rule

Definition of Spouse

Your spouse, as defined by federal law, is a federal tax dependent. A person is your "spouse" under the Plan if, and only if, such person and you became married to each other under the law of any jurisdiction and the marriage has not been legally terminated.

You may be subject to federal income tax on the group health plan coverage provided by Lam Research to a same-sex or opposite-sex domestic partner.

Definition of Child

Your child who has not reached age 27 as of the end of the taxable year is eligible for medical coverage and health FSA reimbursements (under Code Section 105). But an adult child (generally from age 19 (or age 24 in the case of a student) to age 26) is not a tax dependent under Code Section 152.

To meet this general IRS tax dependent rule, the child must be your (the employee's) son, daughter, stepson, or stepdaughter. A son or daughter includes your eligible foster child and your legally adopted child or a child who is lawfully placed with you for adoption.

An individual who is a child (that is, a son, daughter, stepson, stepdaughter, eligible foster child, and legally adopted child or a child who is lawfully placed for adoption) of an eligible Lam Research employee does not have to meet the requirements of the **Other Categories** below to be exempt from taxation for employer-sponsored medical, prescription drug, dental, and vision coverage purposes.

This exclusion does **not** apply to the child of your domestic partner. However, see **Other Categories** below to determine the federal tax impact, if any, of covering your domestic partner or his or her child.

Other Categories
If you are covering an individual who is not a federal tax dependent under the general rule, he or she may still be a federal tax dependent for group health plan purposes if he or she is a U.S. citizen or resident who is a "qualifying child" or a "qualifying relative." A "qualifying child" generally is a person who meets **all** of these requirements: • Is younger than the employee covering the child; • Is unmarried (that is, has not filed a joint tax return during the calendar year at issue); • Is under age 19 (or age 24 in the case of a student) or is permanently and totally disabled; • Is your child, grandchild, brother, sister, stepbrother or stepsister, or niece or nephew; • Does not provide over one-half of his or her own support for the calendar year; and • Lives with you for more than one-half of the calendar year. If a person does not meet the definition of "qualifying child," he or she might be a federal tax dependent by satisfying the "qualifying relative" requirements. A "qualifying relative" generally is a person who meets **all** of these requirements: • Is not your qualifying child or any other taxpayer's qualifying child during the calendar year; • Receives over one-half of his or her support from you for the calendar year; and • Is "related to you" or "lives with you for the entire calendar year as a member of your household."
Examples
Your domestic partner might be your IRS tax dependent if he or she is a U.S. citizen or resident, receives over one-half of his or her support from you, and lives with you for the entire calendar year as a member of your household. Even though a domestic partner is not a "relative" in the traditional sense, he or she may meet the definition of a "qualifying relative." Your domestic partner's child typically will not be your IRS tax dependent, unless the domestic partner also is your IRS tax dependent.

Rescission of Coverage

When a loss of eligibility is not reported timely as required by the Program and applicable law prevents the Program from retroactively terminating coverage, the Program has the discretion to determine the prospective date of termination. The Program also has the discretion to determine the date of termination for rescissions.

The Plan has the right to rescind your, your spouse's/domestic partner's and/or your dependent children's coverage in the case of fraud or intentional misrepresentation of material fact in applying for or obtaining coverage or obtaining coverage under the Program. The Program will provide at least 30 calendar days' advance notice before your coverage is rescinded. Upon providing such notice, the Program may:

- Void your, your spouse's/domestic partner's and/or your dependent children's coverage for the period of time coverage was in effect;
- Terminate coverage as of a date to be determined at the Program's discretion; or
- Immediately terminate coverage.

If your coverage is or will be rescinded, you have the right to file an appeal as described in the coverage summary provided by your Medical Plan option.

Enrolling for Coverage

The Program gives you the power to select your own coverage. This opportunity also gives you responsibility for learning about your coverage and making your own choices.

Enrollment

New Hire Enrollment

As a new employee, you must enroll in the Program within 30 days of your date of hire. The coverage you select goes into effect on your date of hire and remains in effect until the end of the plan year.

Note: If you elect a CDHP Medical Plan option with coverage starting in a month other than January and want to make the maximum annual contribution to the HSA, you must be enrolled in the CDHP Medical Plan option during December of the same plan year and remain enrolled through the end of the following plan year.

Open Enrollment

Each year, Open Enrollment is an opportunity for current employees to review the Program and current coverage elections. During Open Enrollment, which usually occurs in the last quarter of the year, you select your coverage for the next plan year. You can change your coverage elections, increase or decrease coverage levels, and add or drop coverage as you see fit. With Lam Research's flexible coverage, you select what's right for you.

During Open Enrollment, you enroll by using the applicable convenient and easy-to-use web enrollment system, PlanSource (Lam Research's administrator). Before you enroll, visit **www.LamBenefits.com** (the Lam Research Benefits Information website) and carefully review the Lam Research Medical, Dental, Vision, Life, Accidental Death and Dismemberment (AD&D), Legal plans, the Flexible Spending Accounts (FSAs) and the Health Savings Account (HSA). Carefully consider what benefits best meet your needs because the benefits you select during Open Enrollment will remain in effect for the entire following plan year—from January 1 through December 31.

Health Care FSA Considerations When Enrolling in a CDHP

If you are considering enrolling in a CDHP Medical Plan option, due to IRS regulations, the following applies regarding Health Care FSA participation:

If you enroll in a CDHP and also elect the Health Care FSA, there are restrictions on your Health Care FSA reimbursements. The Health Care FSA can only be used to pay for eligible dental and vision expenses until the IRS High Deductible Health Plan annual deductible is met. This is called a "limited purpose" Health Care FSA.

Family Members Working for the Company

It is not uncommon for spouses, parents and their children to be eligible employees of the Company. In this situation, special rules apply to what Program coverage is available to each eligible employee. The following chart summarizes how eligible working family members may enroll for coverage under the program.

	Working Spouse 1	Working Spouse 2	Working Child
Medical	May enroll as an employee or as a dependent of the other spouse, but not both	May enroll as an employee or as a dependent of the other spouse, but not both	May enroll as an employee or as a dependent of one parent, but not both
Dental and/or Vision	May enroll as an employee and as a dependent of the other spouse	May enroll as an employee and as a dependent of the other spouse	May enroll as an employee and as a dependent of a parent
Health Care FSA	May decline coverage or each of you may enroll up to the annual maximum	May decline coverage or each of you may enroll up to the annual maximum	May decline coverage or enroll up to the annual maximum
Dependent Care FSA	May decline coverage or enroll up to the annual maximum (or spousal maximum if both participate in the Dependent Care FSA)	May decline coverage or enroll up to the annual maximum (or spousal maximum if both participate in the Dependent Care FSA)	May decline coverage or enroll up to the annual maximum
Basic Life and AD&D Insurance	Receives Company-provided Basic Life and Basic AD&D Insurance coverage	Receives Company-provided Basic Life and Basic AD&D Insurance coverage	Receives Company-provided Basic Life and Basic AD&D Insurance coverage
Employee Supplemental Life Insurance	May enroll yourself only	May enroll yourself only	May enroll yourself only
Employee Supplemental AD&D Insurance	May enroll yourself only	May enroll yourself only	May enroll yourself only
Spouse/Domestic Partner Life Insurance	You may not enroll in supplemental life insurance for your spouse/domestic partner	You may not enroll in supplemental life insurance for your spouse/domestic partner	You may enroll your spouse/domestic partner not working for the Company
Spouse/Domestic Partner Supplemental AD&D Insurance	You may not enroll in supplemental AD&D insurance for your spouse/domestic partner	You may not enroll in supplemental AD&D insurance for your spouse/domestic partner	You may enroll your spouse/domestic partner not working for the Company

	Working Spouse 1	Working Spouse 2	Working Child
Dependent Life Insurance	If you and your spouse enroll in Employee Supplemental Life Insurance, both of you may enroll eligible child(ren) not working for the Company in an eligible position, up to the benefit maximum combined between employee and spouse	If you and your spouse enroll in Employee Supplemental Life Insurance, both of you may enroll eligible child(ren) not working for the Company in an eligible position, up to the benefit maximum combined between employee and spouse	If you are enrolled in Employee Supplemental Life Insurance, you may enroll eligible child(ren) not working for the Company in an eligible position, up to the benefit maximum
Dependent Supplemental AD&D Insurance	If you and your spouse enroll in Employee Supplemental AD&D Insurance, both of you may enroll eligible child(ren) not working for the Company in an eligible position, up to the benefit maximum combined between employee and spouse	If you and your spouse enroll in Employee Supplemental AD&D Insurance, both of you may enroll eligible child(ren) not working for the Company in an eligible position, up to the benefit maximum combined between employee and spouse	If you are enrolled in Employee Supplemental AD&D Insurance, you may enroll eligible child(ren) not working for the Company in an eligible position, up to the benefit maximum
Short Term Disability (STD)	Automatically enrolled but can be declined	Automatically enrolled but can be declined	Automatically enrolled but can be declined
Voluntary Disability Insurance (VDI)[1]	Automatically enrolled	Automatically enrolled	Automatically enrolled
Long Term Disability (LTD)	Receives Company-provided LTD coverage	Receives Company-provided LTD coverage	Receives Company-provided LTD coverage
Employee Assistance Program EAP	Receives Company-provided EAP coverage	Receives Company-provided EAP coverage	Receives Company-provided EAP coverage
Group Legal Services	May enroll	May enroll	May enroll

[1] Available only to employees in California.

Making Enrollment Decisions

With the Program, **you** decide what is right for you. To enroll successfully, there are a few simple steps you need to take to ensure that you enroll in the coverage that best meets your needs:

- Review all of the information found on the Lam Research Benefits Information website at **www.LamBenefits.com** before accessing the PlanSource enrollment website, which you can link to through the Lam Research Benefits Information website. Full benefits information, including coverage summaries, is available on this website.

> **Lam Research Benefits Enrollment Website:**
> Plan Source:
> **https://benefits.plansource.com**

1. When you are ready to enroll, follow the instructions found on the Lam Research Benefits Information website under the Enroll tab.

2. You will need to enroll each dependent in each plan you want them covered under. For example, if you want your spouse/domestic partner covered under the Medical, Dental, and Vision Plans, you must enroll him or her for coverage separately under each plan.

3. Medicare Secondary Payer and Affordable Care Act (ACA) rules require the Plan Administrator to report Social Security Numbers for employees and their dependents. As a result, Social Security numbers are required for enrollment. If you are enrolling an eligible dependent who does not have a Social Security number, such as a newborn, you will need to contact the Benefits Help Desk at **1-877-291-9494** for further assistance.

4. **You must enroll within 30 days.** If you do not enroll within 30 days of your date of hire or during the Open Enrollment period, you may not enroll until the next Open Enrollment period for coverage effective January 1 of the following year—unless you experience a qualifying life event during the year.

During the year, you will continue to use the PlanSource website to:

- Review your coverage information;
- Change or update your beneficiaries;
- Make changes to your coverage within 30 days due to a qualifying life event (for example, adding coverage due to marriage).

The PlanSource website requires an ID and password; be sure to maintain that information for future use.

Important Steps to Remember
• Complete your enrollment by the deadline, which is 30 days from your date of hire or by the end of the Open Enrollment period. • To change your beneficiary designations for Employee Life Insurance or AD&D Insurance, go to **https://benefits.plansource.com**, click on Update My Beneficiaries and make the appropriate changes.

- To change your 401(k) Plan beneficiary, you must visit the Fidelity Investments website at **www.netbenefits.com**.

Once you have enrolled, you will be able to print a confirmation statement. Review this statement carefully to verify that your coverage elections are presented correctly. If there are any errors and the Open Enrollment period has not yet ended, you can go back into PlanSource's enrollment site at **https://benefits.plansource.com** to correct the error. If there is an error at a time other than Open Enrollment, contact the Benefits Help Desk for further instructions. The confirmation statement is proof of your enrollment—be sure to keep a copy for your records.

If you have any questions about enrollment or about the Program, call the Benefits Help Desk for assistance at **1-510-572-2892** or toll-free at **1-877-291-9494** or email **benefits@lamresearch.com**.

Enrolling a Child Under a Qualified Medical Child Support Order (QMCSO)

Medical, dental, and/or vision coverage for a child may be provided under the terms of a Qualified Medical Child Support Order (QMCSO). A QMCSO is a judgment from a state court or an order issued through an administrative process under state law that requires you to provide medical, dental, and/or vision coverage for a dependent child under the Program.

This coverage applies when:

- You do not have legal custody of the child; and
- The child is not dependent on you for support.

You do not have to wait for the Open Enrollment period to enroll the child. However, the child must otherwise meet the terms of an eligible dependent and be enrolled within 60 days of date the QMCSO is deemed "qualified" by the Plan Administrator.

When the Company receives a valid QMCSO, the custodial parent or state agency can enroll the affected child if you do not. If you need assistance or have any questions about QMCSOs, call the Benefits Help Desk for assistance at **1-510-572-2892** or toll-free at **1-877-291-9494** or email **benefits@lamresearch.com**.

To be considered a qualified medical child support order, the order must meet the requirements of section 609 of ERISA, including clearly specifying all of the following:

- Your (the participant's) name and last known mailing address and the name and mailing address of each alternate recipient (dependent child subject to the order);
- A description of the coverage type to be provided by the Program to each alternate recipient (for example, medical (including prescription drug), dental, and/or vision, etc.);
- The period to which the order applies; and
- Each plan to which the order applies.

You and each child will be notified by Lam Research of the Plan's procedures for determining whether such an order meets the administrative procedures and requirements of a QMCSO. The Program or a plan within the Program will not provide any type or form of coverage or option not otherwise provided by the Program. You may

obtain a copy of the QMCSO administrative procedures, free of charge, from the Benefits Help Desk.

State Eligibility Laws and the Employee Retirement Income Security Act of 1974 (ERISA)

States sometimes pass laws that require benefit plans to provide coverage or benefits to individuals who otherwise are not eligible. For example:

- A state law may mandate health care coverage for an ex-spouse, a domestic partner, or a child who exceeds the Plan's age requirements and is not otherwise eligible for coverage under the Plan; or
- A particular state insurance law may mandate coverage for a particular condition or medication that is not ordinarily covered by the Company's Medical Plan.

While an insurance company or HMO (for example, Kaiser) may be required to comply with such state laws, the Company, generally, is not. Therefore, if you are enrolled in one of the Company's self-insured benefit options, you should know that this type of state mandate does not apply to the Company's self-insured benefit options as a result of the federal law known as ERISA. ERISA preempts state laws that "relate to an employee benefit plan." However, ERISA does not preempt state insurance laws. So, if you are enrolled in one of the Company's fully-insured benefit options or HMOs, the insurance company for that option or HMO may be required to comply with a state insurance law mandating coverage and/or benefits for insurance policies or HMOs offered, or covering individuals, in that state.

Changing Your Coverage

At Annual Open Enrollment

You can change your coverage each year during the Open Enrollment period. If you do not make an election during Open Enrollment, many of your current plan year's elections (except for any FSA or HSA elections) carry over to the next plan year. IRS regulations require you to re-elect to participate in the Health Care and/or Dependent Care FSA and HSA if you wish to contribute to these accounts.

During the Plan Year

Once you enroll in or decline health and welfare coverage or participation in the FSAs[2], your election generally stays in effect for the plan year. However, you can make certain changes during the plan year if you have a qualified change in status, a special enrollment right, or other change in circumstance. These mid-plan year changes are collectively referred to as "qualifying life events." To make enrollment changes during the plan year, you must enroll on the PlanSource's enrollment site at **https://benefits.plansource.com** within the timeframes specified below.

Qualified Changes in Status

Note: Changes must be made **within 30 days** of the event unless otherwise noted and are retroactive to the date of the qualified change in status.

A qualified change in status is a specific change in circumstance that affects eligibility for coverage under the Program or a plan within the Program. Changes to your elections must be due to and consistent with the qualified change in status, as determined by the Lam Research Benefits Department. Qualified changes in status include:

- You have a baby, adopt, or have a child placed in your care for adoption. (Note, changes must be made within 60 days of this event.)
- You get married, divorced, legally separated, or your marriage is annulled.
- You gain a domestic partner or lose one through termination of the domestic partnership or death.
- Your spouse or dependent dies.
- You, your spouse, or your dependent has a change in employment status resulting in a loss or gain of eligibility for coverage. For example, one of you:
  - Takes or returns from an unpaid leave of absence;
  - Switches from full-time to part-time employment (or vice versa); or
  - Begins or ends employment. (This provision does not apply if rehired within 30 days.)
- Your dependent gains or loses eligibility for coverage (for example, he or she becomes a legal dependent or attains the limiting age).

[2] See the "Flexible Spending Accounts (FSAs)" section for details regarding how the mid-year change rules apply to the FSAs.

- You, your spouse, or your dependent moves to a new place of residence, resulting in a loss or gain of eligibility for coverage (for example, you participate in an HMO and are transferred outside of the service area).

Special Enrollment Rules

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides additional flexibility in whom you can enroll in medical benefits under the Plan due to certain events. To qualify for special enrollment, you must enroll on the PlanSource website at **https://benefits.plansource.com** no later than 30 days after the date of the event:

- **Non-enrolled employee:** If you are eligible but not enrolled, you can enroll in medical benefits as a result of marriage or if you acquire a child through birth, adoption, or placement for adoption.
- **Non-enrolled spouse:** You can enroll your spouse in medical benefits when you marry. You can also enroll your spouse if you acquire a child through birth, adoption, or placement for adoption. However, if you are not enrolled, you must also enroll.
- **Non-enrolled child(ren):** You can enroll your eligible child(ren) in medical benefits when you gain a new eligible dependent as a result of marriage, birth, adoption, or placement for adoption. However, if you are not enrolled, you also must enroll.

Under HIPAA's special enrollment rules, you can enroll in medical coverage under the Program during the plan year if you are eligible but elected "no coverage" because you had medical coverage elsewhere (for example, under a spouse's/domestic partner's plan) and that other medical coverage later ends. This special enrollment right permits you to enroll and, if you are enrolled, to enroll your spouse/domestic partner and/or children. To qualify for this special enrollment right, the following requirements must also be met:

- The coverage must end because of a loss of eligibility, such as a divorce, termination of domestic partnership, termination of employment, or the other employer stops contributing to the other plan;
- Your "other coverage" has not been lost because of something you did or did not do (for example, performing an act that constitutes fraud or making an intentional misrepresentation of material fact, or failing to make your required contributions); and
- You must enroll on the PlanSource website no later than 30 days after your or your dependents' other coverage ends or after the other employer stops contributing toward the other coverage.

If you or your dependent is eligible but not enrolled for coverage, you are eligible to enroll if you meet either of the following conditions and you enroll on the PlanSource website **no later than 60 days** after the date of the event:

- You or your dependent loses eligibility for state Medicaid or Children's Health Insurance Program (CHIP) coverage.
- You or your dependent becomes eligible for premium assistance, with respect to coverage under the Program, due to state Medicaid or CHIP coverage.

Premium Assistance

If you are eligible for coverage under the Medical Plan but you can't afford the premiums, some states have premium assistance programs that can help pay for coverage using funds from their Medicaid program and the Children's Health Insurance Program (CHIP).

Whether or not you or your dependents are already enrolled in Medicaid, if you think you or any of your dependents might be eligible for Medicaid or CHIP, contact your state Medicaid or CHIP office by calling **1-877-KIDS NOW (1-877-543-7669**) or visiting **http://www.insurekidsnow.gov/** for more information.

Other Changes in Circumstance

Certain other events also permit you to change your coverage during the plan year. The change you make must be requested no later than 30 days (or no later than 60 days in the case of enrolling in or losing eligibility for Medicare or Medicaid) after the date of the event, and the change must be consistent with the event:

- A Qualified Medical Child Support Order (QMCSO) requires you to provide health care coverage for a child.
- You, your spouse, or your child either becomes enrolled in or loses eligibility for Medicare or Medicaid coverage.
- Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) coverage from another employer for you, your spouse, or your child is exhausted.
- The coverage period (plan year) of another employer plan, for example, your spouse's, is different from the Company's plan year. For example, if your spouse is enrolled in a separate employer plan with a non-calendar plan year and your spouse drops coverage under that plan during his or her plan's annual enrollment period, this rule permits you to make a mid-plan year change to enroll your spouse in coverage under the Program, as long as Lam Research is satisfied that the enrollment is due to and consistent with this change in circumstance. This rule would prevent either you or your spouse from having either double coverage or no coverage for part of a plan year.
- You experience a significant change in cost of benefits under the Program.
- You or your dependent experiences a significant curtailment or loss of benefits, or the Program adds or improves a benefit option.
- You or your dependent loses coverage under another group health plan sponsored by a governmental or educational institution, including a state children's health insurance program (CHIP), medical care program of an Indian Tribal government, state health benefits risk pool, or a foreign government group health plan.
- You enroll in medical coverage under the Marketplace. You may prospectively revoke your election of medical coverage for yourself and your dependents (but not the Health Care FSA) in order to enroll in one of the medical coverages under the Marketplace, provided that: (a) you make your requested election change within the election change period; and (b) you certify that you and your dependents have enrolled or intend to enroll for new coverage under one of the medical plans under the

Marketplace that is effective beginning no later than the day immediately following the last day of the original medical coverage that is revoked.

- You have a change in your employment status. You may prospectively revoke your election for medical coverage for yourself and your dependents (but not the Health Care FSA) due to an employment status change; provided that: (a) you had been in an employment status with the Company under which you were reasonably expected to average at least 30 hours of service per week and there has been a change in your employment status so that you now are reasonably expected to average less than 30 hours of service per week, even though the reduction does not result in you ceasing to be eligible for medical coverage under the Plan; (b) you make your requested election change within the election change period; and (c) you certify that you and your dependents have enrolled or intend to enroll in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original medical coverage is revoked.
- You experience a change permitted under the Family and Medical Leave Act of 1993, as amended ("FMLA").

How to Make Changes During the Plan Year

If you experience a qualifying life event and want to change your Lam Research benefit elections, you must complete enrollment online through the PlanSource website within 30 days of the event (or within 60 days after the birth/adoption of a newborn or after the date you or your dependent becomes eligible for premium assistance or loses eligibility for Medicaid or CHIP or enrolls in or loses eligibility for Medicare or Medicaid). To make a change, follow these steps:

- **PlanSource:** Access the enrollment website at **https://benefits.plansource.com.** On the Home Page, click on ***Make a Change to My Benefits***.

As long as you enroll online within the required timeframe, coverage changes will take effect on the date of the event.

Depending on the date of the event, you may be directly billed for retroactive coverage. Retroactive coverage will be paid on an after-tax basis. Refunds for any excess premiums paid will only be made upon written request within 60 days of the change.

Be sure to keep copies of all required documents. (For example, if you are ending coverage for a spouse following a divorce, keep a copy of the divorce decree. If you are adding coverage for a child, keep a copy of the birth certificate or, for an adoption, keep a court order of placement.)

You may be asked to provide documentation to support your request to make changes for these events. If you do not provide the documents to support your requested change during the timeframe allowed, any changes made due to a qualifying life event will be removed and retroactive adjustments may be applied.

If you do not complete enrollment online within 30 days of the event (or within 60 days as applicable), no change will be allowed during the plan year—unless you experience another qualifying life event.

Note: Discovering or determining after your enrollment in the Medical Plan that a less expensive option may be available to you through the federal or state insurance exchange is not a qualifying life event that will allow you to drop your coverage in the

Medical Plan during the plan year. Therefore, you are encouraged to explore the options available to you in a federal or state insurance exchange before the end of your initial or Open Enrollment period.

Medical

Note: As required by the Patient Protection and Affordable Care Act (Affordable Care Act or ACA) individuals must maintain health care that provides "minimum essential coverage" or are required to pay a penalty. There are exemptions to this requirement including, but not limited to, financial hardship, religious conscience, and incarceration. Visit **www.healthcare.gov** for additional information.

Lam Research offers the following approaches to medical care:

- Consumer Directed Health Plan (CDHP) from Anthem Blue Cross (Anthem) with a Health Savings Account (HSA) provided by HSA Bank.
- Preferred Provider Organization (PPO) plan: Anthem Base PPO, also known by the Prudent Buyer network in California.
- Health Maintenance Organization (HMO) plan offered by Kaiser, available to employees living in California and parts of Oregon and Washington.
- Consumer Directed Health Plan (CDHP) from Kaiser with a Health Savings Account (HSA) provided by HSA Bank, available to employees living in California and parts of Oregon and Washington.

Directories for the various provider networks are available on each Claims Administrator's website. Anthem's website is **www.anthem.com/ca** and Kaiser's website is **www.kp.org.**

About the Medical Plan Options

Each of the Medical Plan options provides comprehensive coverage and routine care, but they differ in cost (as outlined in your enrollment materials) and how they work (as described below). All of Lam Research's Medical Plan options are presented in side-by-side comparison format in enrollment material charts and below. These charts indicate deductibles, out-of-pocket maximums, coinsurance, and copays, and employee costs under each plan. They also include information on covered services and exclusions.

Due to geographic limitations, not all Medical Plan options are available to all employees. For example, the Kaiser HMO and the Kaiser Consumer Directed Health Plan (CDHP) with Health Savings Account (HSA) are offered only in California and parts of Oregon and Washington. However, the Anthem CDHP with HSA and Base PPO medical plans are accessible to all eligible U.S. employees. The PlanSource enrollment website at **https://benefits.plansource.com** lists the Medical Plan options available in your geographic area.

High-level charts summarizing benefits payable under the Medical Plan options are included in your enrollment materials. You should review the charts carefully before making your medical enrollment decision. If you need additional details, the coverage summary for each Medical Plan option can be accessed on the Lam Research Benefits Information website at **www.LamBenefits.com**.

How Do I Know Which Medical Plan Option Is Right for Me?
Deciding which Medical Plan option is right for you should be based on your needs, the location of enrolled dependents, and the costs of each Medical Plan option. For a comparison of the Medical Plan options, review the charts provided in your enrollment materials and on the Lam Research Benefits Information site **www.LamBenefits.com**.

Health Assessment

Once enrolled in an Anthem Medical Plan option, you can access the Health Assessment. The assessment measures your health risks and provides a personalized action plan for living a healthier life. The information you provide is completely confidential and is never shared with Lam Research or other entities.

To take the assessment, go to **http://www.anthem.com/ca**. Under the "**Care"** tab click on the Health and Wellness Center link to locate the Health Assessment tool.

Preventive Care Services

As required by the Affordable Care Act, the Anthem and Kaiser Medical Plan options cover certain preventive care items and services with no cost sharing (that is, these preventive services are covered 100% with no deductibles or copays that you must pay) **when delivered by in-network providers**.

Under the ACA, the Medical Plan options generally may use reasonable medical management techniques to determine frequency, method, treatment or setting for a recommended preventive care service if not specified in a recommendation or guideline.

The preventive care items and services that must be provided under the Affordable Care Act to you with no cost-sharing if provided in-network can be found at **https://www.healthcare.gov/preventive-care-benefits/**.

Note: When preventive and non-preventive care items and services are delivered by an in-network provider during the same office visit, special rules apply regarding whether or not you will be responsible for any of the expenses. You should review your coverage summary and contact the Claims Administrator or insurance company of the Medical Plan option in which you're enrolled to confirm which in-network preventive care items and services may be covered with no cost sharing.

If you have any questions regarding whether a particular preventive care pharmaceutical drug or service will be offered with no cost sharing, contact CVS Caremark.

Consumer Directed Health Plans (CDHPs)

The Consumer Directed Health Plans (CDHPs) with Health Savings Accounts (HSAs) are Medical Plan options administered by either Anthem or Kaiser. These options offer traditional health coverage similar to the Anthem PPO or Kaiser HMO Medical Plan options. The CDHPs include coverage for physicians' office visits, hospital and

emergency services and supplies, diagnostic services such as X-rays, pregnancy and maternity care, and prescription drug coverage, but with no copays.

The CDHPs are high deductible health plans with an annual deductible that you must pay before the Medical Plan option pays any benefits (aside from certain in-network preventive care services which are covered at 100% without a deductible). You can pay for the deductible (and other eligible health care expenses) with money from your Health Savings Account (HSA) (described below). Once you meet your deductible for covered expenses for the plan year, you pay coinsurance (a percentage of the health care provider's charges) or copay (if applicable) for the remainder of that year, until you reach your out-of-pocket maximum.

For the Anthem CDHP, you can receive care from any health care provider you choose, but benefits are paid at a higher level when care is received from providers in the Anthem network. If you or your dependents receive care from a provider who is not in the network, benefits are paid at a lower level.

This Benefits Information Guide highlights only certain aspects of the Anthem CDHP. You can obtain an Anthem CDHP coverage summary, free of charge, from the Benefits Help Desk or by visiting **www.LamBenefits.com**. The Anthem CDHP coverage summary describes the applicable deductibles, coinsurance, benefits covered and exclusions. The coverage summary is part of this Guide, so keep it with this Guide for reference. In the event of any discrepancy between this Guide and your coverage summary, the coverage summary will govern.

How to Find a Network Provider

To find a participating provider near you or to request a directory of providers, free of charge, call the toll-free number on your medical ID card or go to Anthem's website at **www.anthem.com/ca**.

Kaiser CDHP

This Benefits Information Guide highlights only certain aspects of the Kaiser CDHP. You can obtain a Kaiser CDHP coverage summary, free of charge, from the Benefits Help Desk or by visiting **www.LamBenefits.com**. The Kaiser CDHP coverage summary describes the applicable deductibles, copays, benefits covered and exclusions. The coverage summary is part of this Guide, so keep it with this Guide for reference. In the event of any discrepancy between this Guide and your coverage summary, the coverage summary will govern.

When you elect the Kaiser CDHP, you are required to use the Kaiser network for all your care, except for very specific emergencies. Services are provided through specific Kaiser facilities.

The Kaiser CDHP is available only in California and parts of Oregon and Washington.

Health Savings Account (HSA)

Note: The Health Savings Account (HSA) is not part of the Medical Plan or any ERISA-covered benefit plan sponsored by the Company. The information about an HSA is provided in this Guide solely for your convenience.

If you enroll in the CDHP, an HSA administered by ConnectYourCare (CYC) is established for you. The Health Savings Account (HSA) enables you and Lam Research

Corporation to set money aside for payment of qualified health care expenses. The amount that may be contributed is:

- **Lam Research contributions.** For 2020, Lam Research will contribute up to $1,300 for single coverage and up to $2,600 for family coverage to an HSA on your behalf. This amount may change from year to year at Lam Research's sole discretion.
- **Your contributions.** You also can make pre-tax contributions, up to a calendar-year maximum, described below. Pre-tax contributions to your HSA are deducted from your paycheck before federal income taxes are taken out. State taxes may still apply.

Calendar-Year HSA Maximum
For 2020, IRS rules allow up to $3,550 to be contributed to your HSA if you have single coverage and up to $7,100 for two-person or family coverage. If you are age 55 or older, you may contribute up to an additional $1,000. These maximums include your pre-tax contributions and Company contributions.

The maximum contribution you can make during a calendar year is the difference between the Company contribution and the annual maximum that applies to you.

The contributions to your HSA, along with any interest earned on the contributions, grow tax-free. You can also invest a portion of your HSA savings in a variety of investment options.

Similar to a Health Care FSA, you can use the amounts in your HSA to pay for out-of-pocket, qualified health care expenses. However, unlike a Health Care FSA, unspent money is portable (meaning you can take it with you if you leave the Company) and also rolls over into the next year to cover expenses or to continue earning interest tax-free. For a list of qualified health care expenses, log onto **www.ConnectYourCare.com/LamResearch** or you may contact CYC Customer Service at **1-877-924-3967**.

Important Considerations

- If you are enrolling in the CDHP mid-year, the maximum annual contribution for the year will be prorated based on the number of months during the plan year you are enrolled in the CDHP. To be eligible for the maximum annual contribution to your HSA, you must be enrolled in the CDHP through December of the same plan year and remain enrolled through the end of the following plan year. However, the Company contribution will remain prorated.
- If you enroll in a CDHP, there are restrictions on your Health Care FSA. Your Health Care FSA can only be used to pay for dental and vision expenses until the IRS High Deductible Health Plan (HDHP) annual deductible is met. This is called a "limited purpose" FSA.
- Qualified health care expenses include amounts paid for medical care for you, your spouse, a qualifying child, or a qualifying relative under the definition of an IRS tax dependent. (See "Definition of a Tax Dependent" in the Eligibility section.) You may not use amounts from your HSA to pay for the medical care of your adult child, your domestic partner, or the child of your domestic partner, unless such individual

otherwise meets the requirements of a qualifying child or qualifying relative under the definition of an IRS tax dependent.

- Beginning in 2020, qualified health care expenses include amounts paid for over-the-counter medicines, drugs and menstrual products purchased without a prescription.

PPO Plan

The Base PPO is a Preferred Provider Organization (PPO) Medical Plan option administered by Anthem. This option includes a national network of physicians and hospitals that have contracted with Anthem to provide services at reduced rates.

You can choose any provider you wish, but you receive higher coverage levels if you use an Anthem PPO in-network provider. (If a PPO in-network provider is not available in your area, you will receive the in-network level of coverage.) Whether you use in-network or out-of-network providers, the PPO includes an annual out-of-pocket maximum that caps your expenses for covered services for the plan year.

How to Find a Network Provider

To find an Anthem PPO in-network provider near you, visit **www.anthem.com/ca**. You also can call the member service telephone number listed on your medical ID card for help in finding a provider.

HMO Plan

This Benefits Information Guide highlights only certain aspects of the Kaiser HMO. You can obtain a Kaiser HMO coverage summary free of charge by clicking on the hyperlink in the “Your Lam Research Corporation Benefits Program” section of this Guide. The Kaiser HMO coverage summary describes the applicable copays, coinsurance, benefits covered, and exclusions. The coverage summary is part of this Guide, so keep it with this Guide for reference. In the event of a discrepancy between this Guide and your coverage summary, the coverage summary will govern.

When you elect the Kaiser HMO, you are required to use the Kaiser network for all your care, except for very specific emergencies. Services are provided through specific Kaiser facilities. Out-of-pocket costs for HMO participants are generally low, as there are no deductibles and most covered services are paid in full after a copay.

The Kaiser HMO plan is only available in California and in parts of Oregon and Washington.

Other Facts You Should Know About Your Medical Plan Options

Your Maternity Rights (Newborns’ and Mother’s Health Protection Act)

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

The Lam Research Benefits Program does not impose penalties on, or provide incentives to, mothers or attending providers to avoid the requirements of the Newborns' and Mothers' Health Protection Act.

Your Rights Following a Mastectomy (Women's Health and Cancer Rights)

The Lam Research Benefits Program's Medical Plan options include coverage for a medically necessary mastectomy and patient-elected reconstruction after the mastectomy. Specifically, for you or your enrolled dependent who is receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications at all stages of mastectomy, including lymphedema.

Benefits will be subject to the same annual deductibles, coinsurance and copay provisions as for all other medically necessary procedures under your Medical Plan option.

If you have any questions, refer to the coverage summary for the Medical Plan option in which you are enrolled or contact the Claims Administrator for your Medical Plan option (Anthem or Kaiser). You can find the Claims Administrator's telephone number and address in the **Other Plan Information** section of this Guide or in the coverage summary.

Consumer Protections under the Affordable Care Act

The Company's medical and prescription drug plan benefits provide you with certain protections—sometimes referred to as "group market reforms" or "consumer protections" under the Affordable Care Act, including:

- Prohibition of preexisting condition exclusions
  - The Plan does not impose any preexisting condition exclusions.
- Prohibiting discrimination against participants and beneficiaries based on a health factor
  - The Plan does not discriminate against participants and beneficiaries based on a health factor.
- Prohibition on waiting periods that exceed 90 days
  - See the Eligibility section of this SPD for more details.

- Prohibition on lifetime or annual dollar limits on essential health benefits
  - The Plan does not impose any lifetime or annual dollar limit on essential health benefits.
- Prohibition on rescissions
  - The Plan will not retroactively rescind your coverage except in the case of fraud or an intentional misrepresentation of a material fact. A rescission is defined as a retroactive cancellation or discontinuance of coverage. If coverage is cancelled or discontinued prospectively, that is not considered a rescission. It is also not a rescission if you do not pay your required premium and your coverage is cancelled or discontinued back to the date that the premium was not paid. The Plan will provide you with at least 30 calendar days' advance notice before your coverage is rescinded. If your coverage is or will be rescinded, you have the right to file an appeal.
- Eligibility of Children until at least age 26
  - The Plan extends coverage to adult Children until the end of the month in which a Child attains age 26.
- Summary of benefits and coverage and uniform glossary
  - Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.
- Solely with respect to insured medical benefit options, the medical loss ratio requirements
- Accommodations in connection with coverage of preventive health services
  - The Company's medical and prescription drug plan options provide preventive care benefits in-network without cost-sharing. See the summary of your medical plan benefits for more details on what constitutes preventive care for this purpose; the list changes periodically. Preventive care generally includes items and services with a rating of "A" or "B" under the United States Preventive Services Task Force, immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the CDC; and with respect to children and women, certain preventive care and screenings based on guidelines supported by the Health Resources and Services Administration.
    - General information pertaining to other preventive services and a prescription drug list is available at https://www.healthcare.gov/preventive-care-benefits/. The list of in-network preventive care items and services with no cost sharing includes: certain screenings (e.g., blood pressure, cholesterol, diabetes and lung cancer screenings), immunizations, counseling (e.g., alcohol misuse, obesity and tobacco use counseling), colonoscopies (including many related items and services, such as bowel preparation medications, anesthesia, and polyp testing) and other items and services that are designed to detect and treat medical conditions to prevent avoidable illness and premature death.
    - For women, the medical and prescription drug options also will cover an annual well-woman visit (and additional visits in certain cases); screening for gestational diabetes; testing for the human papilloma virus; counseling for

sexually transmitted diseases; counseling and screening for human immunodeficiency virus (HIV); FDA-approved contraceptive methods and counseling as prescribed for women; breastfeeding support, supplies and counseling (including lactation counseling services); and screening and counseling for interpersonal and domestic violence. In addition, a woman who is at increased risk for breast cancer may be eligible for screening, testing and counseling and if at low risk for adverse medication effects may be eligible to receive risk-reducing medications, such as tamoxifen or raloxifene, in-network, without cost sharing. If your Physician prescribes this type of medication to reduce your risk of breast cancer, contact the Claims Administrator to ensure that you satisfy the administrative requirements necessary to receive this benefit. You may be required to meet requirements beyond just submitting the prescription. For example, you and/or your physician may need to demonstrate that you are at an increased risk for breast cancer.

NOTE: The Plan generally may use reasonable medical management techniques to determine frequency, method, treatment, age, setting and other limitations for a recommended preventive care service. When preventive and non-preventive care is provided during the same office visit, special rules apply regarding whether or not cost sharing will be imposed.

- Internal claims and appeals and external review process
  - See the Claims and Appeals Procedures section of this SPD for more information.
- Consumer patient protections (choice of health care professional and coverage of emergency services)
  - If you need "emergency services," the medical options offered by the Company will provide you with coverage regardless of whether the provider for such "emergency" services is in-network or out-of-network. Also, "emergency services" are subject to special cost-sharing rules that require non-grandfathered group health plans like the Company's to not impose a higher copayment or coinsurance, for example, for out-of-network emergency services than for in-network emergencies services, but in certain circumstances you may be "balance billed." For details on this requirement, including what constitutes an emergency service, contact the Claims Administrator.
  - The medical and prescription drug options offered to you will not discriminate against an eligible health care provider based on his or her license or certification to the extent the provider is acting within the scope of his or her license or certification under state law. This rule is subject to certain limitations and does not require the medical options to accept all types of providers into a network.
- Limitations on cost sharing (i.e., the out-of-pocket expense maximum requirements)
  - As required by the Affordable Care Act, your total in-network out-of-pocket costs will not exceed the IRS maximum, as indexed annually. The Affordable Care Act's individual out-of-pocket expense maximum applies to each covered individual, whether the individual has self-only, family, or another coverage tier. So, it's possible that this limit will result in payment for an individual before the family out-of-pocket expense maximum is hit for a high deductible health plan

("HDHP") if the HDHP has a family deductible that is less than the self-only limit under the Affordable Care Act.

  - The maximum imposed by the Affordable Care Act creates a separate, legally required limit on in-network out-of-pocket costs, which requires that additional costs count toward these limits even if they do not apply toward your medical option's out-of-pocket maximum. Costs that apply toward your total in-network out-of-pocket maximum include, for example, deductibles, copayments, coinsurance, and eligible prescription drug expenses. Out-of-pocket expenses that do not apply toward your in-network out-of-pocket maximums include, for example, premium contributions, spending for non-covered items and services, out-of-network items and services, and the additional cost if you purchase a brand-name prescription drug in a situation where a generic drug was available and medically appropriate as determined by your physician.
  - The actual out-of-pocket expense maximums under the medical and prescription drug option that you elect may be lower than the legal maximums. Please contact your medical Claims Administrator for more information. See the "Plan Contacts" section for contact information.

- Coverage for individuals participating in approved clinical trials
  - You are eligible for coverage of routine costs for items and services furnished in connection with your participation in an approved clinical trial. The clinical trial must relate to the treatment of cancer or another life-threatening disease or condition. Contact your medical Claims Administrator for more information. See the "Plan Contacts" section for contact information.

Benefit Coverage for COVID-19 Testing

As required by the Families First Coronavirus Response Act (FFCRA) as amended by the CARES Act, the Plan will provide coverage for COVID-19 diagnostic testing at no cost to you (i.e., no deductible, copayment or coinsurance). The "cost of testing" includes the cost of the health care provider office visits, urgent care center visits, and emergency room visits to the extent that the item or service relates to the furnishing or administration of the "COVID-19 test" or evaluation for purposes of determining if you need a diagnostic test.

Benefit Coverage for COVID-19 Treatment

If you are diagnosed with COVID-19, treatment for COVID-19 will be covered, to the extent medically necessary, at the same cost sharing as applicable under the terms of the Plan. Treatment for COVID-19 is subject to cost sharing, meaning it is subject to the deductibles, copays and coinsurance under the medical plan option you have selected.

If you participate in a High Deductible Health Plan ("HDHP"), coverage under your HDHP related to COVID-19 treatment can be paid before you meet your deductible. Cost sharing as specified by the HDHP Plan will continue to apply.

Prescription Drugs

CVS Caremark administers prescription drug coverage for Lam Research's Anthem Medical Plan options. CVS Caremark is unaffiliated with Anthem. A brief summary of your out-of-pocket costs associated with the Anthem Base PPO is provided below.

If you elect Kaiser CDHP or Kaiser HMO coverage, your prescription drug coverage is administered by Kaiser as part of your Medical Plan option.

About Your Prescription Drug Coverage

What the Plan Covers

As long as you meet the Program's eligibility requirements and you are enrolled in an **Anthem Base PPO** medical benefit option under the Plan, you have prescription drug coverage through CVS/Caremark. As a result, you can purchase prescription drugs for yourself and/or your covered dependents through retail pharmacies or through the mail. Cost sharing provisions are contained in the chart below.

	Short-Term Medicines CVS Caremark Retail Pharmacy Network (Up to a 30-day supply)		**Long-Term Medicines** CVS Caremark Mail Service Pharmacy or CVS Pharmacy Locations (Up to a 90-day supply)
Generic Medicines Always ask your doctor if there's a generic option available. It could save you money.	**$10** for one 30-day supply of a generic medicine	**$30** for three 30-day supplies of a generic medicine	**$20** for a generic medicine
Preferred Brand-Name Medicines If a generic is not available or appropriate, ask your doctor to prescribe from your plan's preferred drug list.	**$30** for one 30-day supply of a preferred brand-name medicine	**$90** for three 30-day supplies of a preferred brand-name medicine	**$60** for a preferred brand-name medicine
Non-Preferred Brand-Name Medicines Drugs that aren't on your plan's preferred list will cost more.	**$60** for one 30-day supply of a non-preferred brand-name medicine	**$180** for three 30-day supplies of a non-preferred brand-name medicine	**$120** for a non-preferred brand-name medicine
Maximum Out-of-Pocket	$3,000 per individual / $6,000 per family (Integrated with medical)		

Please Note: When a generic is available, but the pharmacy dispenses the brand-name medication for any reason other than doctor or other prescriber indicates "dispense as written," you will pay the difference between the brand-name medication and the generic plus the brand copayment.

Note: Pharmacy does not have an out of network benefit the same way medical does. There is no penalty for filling a script at a pharmacy that is not part of CVS Caremark network; however, the claim will not process. You would be required to submit a paper claim for CVS to reimburse 100% of the cost of the submitted drug less your copayment.

Max Allowable Benefit for Infertility: Infertility max amount is not shared with medical, it is pharmacy only and the amount is set at: $10,000.

The Plan pays benefits for eligible expenses associated with outpatient prescription drug services. The chart below briefly describes how the retail pharmacy and mail order pharmacy components operate.

Provision	Retail	Mail Order
Access	For your short-term prescriptions, you have access to a network of pharmacies, including many chain pharmacies such as CVS, Walgreens, Target, Wal-Mart, Kroger, and Rite-Aid. These pharmacies agree to charge lower rates for prescription drug services.	For your long-term maintenance prescriptions, you have access to a mail order pharmacy. You can get up to a 90-day supply of your long-term medications by mail. You may also fill a 90-day supply at your local CVS or CVS/Target Pharmacy for the same mail order copayment as defined by your plan, this is the Maintenance Choice Program.
Prescriptions When You Need Them	At the point that you fill your short-term prescription, you decide whether to go to a network pharmacy or a non-network pharmacy.	The mail order pharmacy is designed to meet your long-term or maintenance medication needs and save you time and money. The mail order program provides delivery of your prescriptions to your home in confidential, tamper-resistant, and temperature-controlled packaging.
Your Cost	In general, your cost will depend on whether your prescription is filled with a generic, preferred brand, or non-preferred brand, and if you use a network or non-network pharmacy. In most instances, your cost will be lower when you use generics and network pharmacies.	In general, your cost will depend on whether your prescription is filled with a generic, preferred brand, or non-preferred brand. In most instances, your cost will be lower when you use generics.
Finding a Pharmacy	You can select a network pharmacy from the online directory at www.caremark.com. Or, you can call CVS/Caremark directly for assistance.	Access a mail service order form through the CVS/Caremark website at www.caremark.com. You also may call Caremark's FastStart program to get started with mail service order at 1-866-772-9414. This is for participants only.

		You also may have your provider call Caremark's New Rx at 1-800-378-5697.

How Benefits Are Paid

The Plan pays benefits for eligible expenses related to covered prescription drug services based on all of the following:

- Whether you fill your prescription through:
    - A retail network pharmacy;
    - A retail non-network pharmacy; or
    - The mail order pharmacy.
- The type of prescription you receive:
    - Generic;
    - Preferred brand; or
    - Non-preferred brand.
- Whether the prescription is for maintenance medications.

Eligible Expense

An expense is considered eligible only if the following apply:

- You or your covered dependent incurs the expense while coverage is in effect;
- The covered service for which you incur the expense is recommended by a physician, dentist, or optometrist and is medically necessary for the care and treatment of an illness or injury;
- A provider usually charges its patients for the covered service; and
- The expense is not attributable to cost differentials due to:
    - Filling a brand name prescription drug when a generic/generic equivalent is available,
    - Filling prescriptions at Retail for maintenance medications

Member Services

Visit Caremark's website, www.caremark.com, to view your plan design and copayment information, search for details on prescription medications, locate a participating pharmacy near you, and manage your home delivery prescriptions. For future reference, this number is listed on the back of your CVS prescription drug ID card.

Should you need additional or replacement ID cards, contact CVS/Caremark or visit www.caremark.com.

Retail Pharmacies

The retail pharmacies that participate in the network should be your primary source for filling short-term prescriptions. If you fill your prescription at a non-network pharmacy, the claim will not process electronically. You would be required to submit a paper claim for CVS to reimburse 100% of the cost of the submitted drug less your copayment.

To fill a prescription through a retail network pharmacy:

- Go to a network pharmacy
- Present your prescription to the pharmacist

- Present your ID card to the pharmacist
- Sign for, pay and receive your prescription

If you fill a prescription at an out-of-network pharmacy, you're required to submit your claim directly to CVS/Caremark at the following address:

CVS Caremark
P.O. Box 52116
Phoenix, AZ 85072-2116

If you need to submit a claim, follow these steps:

- Complete a form. Complete a separate form for each covered person and submit completed claim forms directly to the appropriate claims administrator at the address shown in the chart above. If you don't complete the necessary form or identify yourself appropriately, you may experience delay in the processing of your claim. Member Claim Forms are available at www.caremark.com.
- Submit the appropriate information. Include all of the following:
  - Your member ID and account number (your member ID is included on your ID card, and your account number is the seven-digit policy number included on your ID card); and
  - Itemized bills (you can submit as many itemized bills as you wish with each form). If you're going to be hospitalized, you may wish to obtain a claim form prior to hospitalization (be sure to show your ID card at the time of your admission). Also, when you submit itemized bills be sure they include your provider's name and address, the patient's name, the diagnosis, and the date of service. A description of the service, diagnosis, or other statement regarding the service's purpose and service charge should also be included.
- Submit promptly. Be sure to submit your claims promptly after you receive the service.
- Who receives benefits. The claims administrator processes your request for benefits then pays benefits directly to you or your physician, hospital, other health care facility, pharmacy, or other health care provider.

Mail Order Pharmacy

You can fill your long-term maintenance medications through the mail. With the mail order pharmacy, you receive up to a 90-day supply of your medication for less than the cost of three fills at a Retail pharmacy.

To fill a prescription through the Mail Order Pharmacy:

- Ask your physician to write a prescription for a 90-day supply, plus refills, so that you can submit it directly to the mail order pharmacy with your form. Be sure to ask your physician to prescribe generic medications if available to help reduce costs.
- If you need medication immediately, ask your physician for two prescriptions, the first for an immediate supply. You can then take this to your local network pharmacy. The second is for the long-term supply. You can submit this one to the mail order pharmacy. An alternative is to use the Maintenance Choice program at a CVS retail pharmacy or CVS/Target, in which case your physician only needs to write a single prescription for a 90-day supply, plus refills.

- Complete a mail order form and send it to CVS/Caremark. Be sure to include your original prescription. A new form and pre-addressed envelope is then sent to you with each delivery. You also can print forms at www.caremark.com. Submit a mail order form for each prescription.
- Payment is due with each order.

Maintenance Choice Program

Voluntary Maintenance Choice gives members the option to fill their maintenance medications in 90-day supplies at either CVS Pharmacy or CVS Caremark Mail Service Pharmacy for the same price. There are no refill restrictions and members can move their prescriptions between CVS Pharmacy and CVS Caremark Mail Service Pharmacy as desired. Members who choose to fill in these channels benefit from lower copayments. Clients receive the benefit of mail pricing for all prescriptions filled at CVS Pharmacy and Mail service.

Formulary and Non-Formulary Medications

The Formulary is a guide for you and your doctor to refer to when filling out your prescriptions. If there is no generic medication available for your condition, there may be more than one brand name for you and your doctor to consider. Caremark provides a list of formulary brand name medications to help you and your doctor decide medications that are clinically appropriate and cost effective. If a drug you are taking is not on the formulary, you may want to discuss alternatives with your doctor or pharmacist. Using drugs on the formulary will keep costs low.

A current drug list is available online at www.caremark.com or upon request by calling CVS Caremark Customer Care. To avoid paying higher copayments associated with non-preferred drugs; take this list with you when you visit your doctor so he or she can refer to it when prescribing medications for you and your covered dependents.

Generic Substitution

You can save the most money by choosing generic drugs when available. Ask your Physician to authorize generic substitution when medically appropriate. CVS Caremark will never give you a generic instead of a brand-name drug without your Physician's permission. If a generic drug is not available, you'll pay the applicable brand-name copayment. If you or your Covered Dependent requests a brand-name drug when the Physician approves an available generic drug, you must pay the brand copayment plus the difference in cost between the prescribed brand-name drug and its generic equivalent. This is the DAW (Dispense As Written) penalty.

CVS Caremark Specialty Pharmacy Services

CVS Caremark Specialty Pharmacy Services is a full-service specialty pharmacy that provides specialty injectable and oral drugs for chronic conditions, and members can only fill these drugs at Caremark Specialty Pharmacy. CVS Caremark provides these products directly to Covered Persons along with personalized service and educational support for your specific therapy. Conditions covered include Multiple Sclerosis, Rheumatoid Arthritis, Gaucher's Disease, Allergic Asthma, Osteoporosis, Cystic Fibrosis, Hepatitis C, Crohn's Disease, Pulmonary Hypertension, Psoriasis, and others. To learn more about CVS Caremark Specialty Pharmacy Services, visit Caremark.com

or to get started with the service, call Caremark Connect at 1-800-237-2767. Note: All specialty medications are subject to Specialty Guideline Management (SGM) review. SGM is a program that helps to ensure appropriate utilization for specialty medications based on evidence-based medicine guidelines. Patient progress is continually assessed to determine whether appropriate therapeutic results are achieved. Prescribers may call 1-866-814-5506 to request an SGM review.

Quantity Limitations

CVS Caremark develops limitations to ensure safe and appropriate medication use. The list below includes those drugs subject to Quantity Limitations. Regardless of what is prescribed by your Physician, the amount dispensed will be based on the recommended limitation. For more information, call CVS Caremark Customer Care at 1-800-378-0780.

- ADHD/Narcolepsy Agents
- Anticholinergic, Combination, and Mast Cell Stabilizer Oral Inhalation (misc. asthma /COPD agents)
- Anti-Migraine
- Butorphanol Nasal Solution
- Corticosteroid Oral Inhalation (steroid inhalers)
- ED Alprostadils, PDE-5 Inhibitors Limit & ED-BPH Cialis
- Influenza
- Intranasal Steroids/Antihistamines
- Long & Short Acting Beta2-Agonists (respiratory/asthma inhalers)
- Pain (oxycodone/APAP ext-rel)
- Pain (tapentadol, tapentadol ext-rel)

Prior Authorization

Prior authorization requires a drug's prescribed use to be evaluated against a predetermined set of criteria before the prescription will be covered. In addition to the Quantity Limitations above, certain drugs or drug classes will require prior authorization for you to receive coverage for them. If you're taking one or more of the drugs listed below, you can avoid delays and interruptions in your therapy by asking your doctor to call the CVS Caremark Prior Authorization Department at 1-888-413-2723. The request will be evaluated to determine if you still qualify for Plan coverage of the prescribed therapy.

If you don't meet the criteria standards and still wish to take the medication, you'll be responsible for the entire cost of the drug. Please note that this list may be updated periodically throughout the year.

- Anabolic Steroids
- Compounded Drug Products Exceeding a $300 Threshold
- Narcolepsy (sleep disorder)
- Pain, Oral/Intranasal Fentanyl Products (oral/intranasal narcotics)
- Sublingual Immunotherapy (SLIT) Agents
- Suboxone, Subutex
- Testosterone – Topical/Buccal/Nasal (Brand and Generic)
- Testosterone – Injectable
- Vfend

Step Therapy

Generic Step Therapy requires that a cost-effective generic alternative is tried first before targeted single-source brands are covered. The list below includes those drug classes subject to Generic Step Therapies.

- COX2 inhibitors/ Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)
- Fibrates
- HMG-CoA Reductase Inhibitors
- Prostagl Analog
- Serotonin Norepinephrine Reuptake Inhibitors (SNRIs)
- Selective Serotonin Reuptake Inhibitors (SSRIs)

With Generic Step Therapy, if you choose to stay on your current, higher-cost brand-name medicine, you may have to pay the full price if you have not tried a generic option to treat your health condition. Your doctor can contact CVS Caremark to request a prior authorization if you have a unique medical situation that requires you to keep taking the higher-cost (brand-name) medicine. If you have previously taken generic medicine in the same drug class, you may not be affected by this change.

Appeals

Formal procedures are in place if you need to appeal a benefit decision relative to your prescription drug benefits. The same appeals process that applies for health care coverage decisions applies for prescription drug benefit decisions. The first request for coverage is called an initial coverage review. Your appeal should be mailed to:

CVS Caremark Prescription Claim Appeals MC 109
P.O. Box 52084
Phoenix, AZ 85072-2084

Alternatively, you can fax your appeal to 1-866-443-1172 Attn: Urgent Appeals.

This must be done within 180 days of a denial.

About Your Prescription Drug Coverage

What the Plan Covers

As long as you meet the Program's eligibility requirements and you are enrolled in an **Anthem CDHP medical coverage** option under the Plan, you have prescription drug coverage through CVS/Caremark. As a result, you can purchase prescription drugs for yourself and/or your covered dependents through retail pharmacies or through the mail. Cost sharing provisions are contained in the chart below.

	Short-Term Medicines CVS Caremark Retail Pharmacy Network (Up to a 30-day supply)	Long-Term Medicines CVS Caremark Mail Service Pharmacy or CVS Pharmacy Locations (Up to a 90-day supply)
Generic Medicines Always ask your doctor if there's a generic option available. It could save you money.	**15% (after deductible)**	**15% (after deductible)**
Brand-Name Medicines You will generally pay more for a brand-name medication.	**15% (after deductible)**	**15% (after deductible)**
Preventive Drug List	Your Health Plan comes with a Preventive Drug List. Brand and Generic drugs on this list are covered at 100%. You can access the Preventive Drug List on Caremark.com	
Annual Deductible	$2,000 per individual / $4,000 per family (Integrated with medical)	
Maximum Out-of-Pocket	$3,000 per individual / $6,000 per family (Integrated with medical)	

Please Note: When a generic is available, but the pharmacy dispenses the brand-name medication for any reason other than doctor or other prescriber indicates "dispense as written," you will pay the difference between the brand-name medication and the generic plus the brand copayment.

Note: Annual Deductible is $2,800 per individual in a family. Out of Pocket Maximum is $3,000 per individual in a family.

Note: Pharmacy does not have an out of network benefit the same way medical does. There is no penalty for filling a script at a pharmacy that is not part of CVS Caremark network; however, the claim will not process electronically. You would be required to submit a paper claim for CVS to reimburse 100% of the cost of the submitted drug less your coinsurance.

Max Allowable Benefit for Infertility: Infertility max amount is not shared with medical, it is pharmacy only and the amount is set at: $10,000.

The Plan pays benefits for eligible expenses associated with outpatient prescription drug services. The chart below briefly describes how the retail pharmacy and mail order pharmacy components operate.

Provision	Retail	Mail Order
Access	For your short-term prescriptions, you have access to a network of pharmacies, including many chain pharmacies such as CVS, Walgreens, Target, Wal-Mart, Kroger, and Rite-Aid. These pharmacies agree to charge lower rates for prescription drug services.	For your long-term maintenance prescriptions, you have access to a mail order pharmacy. You can get up to a 90-day supply of your long-term medications by mail. You may also fill a 90-day supply at your local CVS or CVS/Target Pharmacy for the same mail order coinsurance as defined by your plan, this is the

		Maintenance Choice Program.
Prescriptions When You Need Them	At the point that you fill your short-term prescription, you decide whether to go to a network pharmacy or a non-network pharmacy.	The mail order pharmacy is designed to meet your long-term or maintenance medication needs and save you time and money. The mail order program provides delivery of your prescriptions to your home in confidential, tamper-resistant, and temperature-controlled packaging.
Your Cost	In general, your cost will depend on whether your prescription is filled with a generic, preferred brand, or non-preferred brand, and if you use a network or non-network pharmacy. In most instances, your cost will be lower when you use generics and network pharmacies.	In general, your cost will depend on whether your prescription is filled with a generic, preferred brand, or non-preferred brand. In most instances, your cost will be lower when you use generics.
Finding a Pharmacy	You can select a network pharmacy from the online directory at www.caremark.com. Or, you can call CVS/Caremark directly for assistance.	Access a mail service order form through the CVS/Caremark website at www.caremark.com. You also may call Caremark's FastStart program to get started with mail service order at 1-866-772-9414. This is for participants only. You also may have your provider call Caremark's New Rx at 1-800-378-5697.

How Benefits Are Paid

The Plan pays benefits for eligible expenses related to covered prescription drug services based on all of the following:

- Whether you fill your prescription through:
  - A retail network pharmacy;
  - A retail non-network pharmacy; or
  - The mail order pharmacy.
- The type of prescription you receive:
  - Generic;
  - Preferred brand; or
  - Non-preferred brand.
- Whether the prescription is for maintenance medications.
- Whether the prescription is covered under the Preventive Drug List

For the Preventive Drug List, your plan pays benefits that allow you to bypass your deductible if your maintenance drug is on the list. To find out if your medication is on the preventative drug list, go to www.caremark.com or www.LamBenefits.com.

Eligible Expense

An expense is considered eligible only if the following apply:

- You or your covered dependent incurs the expense while coverage is in effect;
- The covered service for which you incur the expense is recommended by a physician, dentist, or optometrist and is medically necessary for the care and treatment of an illness or injury;
- A provider usually charges its patients for the covered service; and
- The expense is not attributable to cost differentials due to:
  - Filling a brand name prescription drug when a generic/generic equivalent is available,
  - Filling prescriptions at Retail for maintenance medications

Member Services

Visit Caremark's website, www.caremark.com, to view your plan design and coinsurance information, search for details on prescription medications, locate a participating pharmacy near you, and manage your home delivery prescriptions. For future reference, this number is listed on the back of your CVS prescription drug ID card.

Should you need additional or replacement ID cards, contact CVS/Caremark or visit www.caremark.com.

Retail Pharmacies

The retail pharmacies that participate in the network should be your primary source for filling short-term prescriptions. If you fill your prescription at a non-network pharmacy, the claim will not process electronically. You would be required to submit a paper claim for CVS to reimburse 100% of the cost of the submitted drug less your coinsurance.

To fill a prescription through a retail network pharmacy:

- Go to a network pharmacy
- Present your prescription to the pharmacist
- Present your ID card to the pharmacist
- Sign for, pay and receive your prescription

If you fill a prescription at an out-of-network pharmacy, you're required to submit your claim directly to CVS/Caremark at the following address:

CVS Caremark
P.O. Box 52116
Phoenix, AZ 85072-2116

If you need to submit a claim, follow these steps:

- Complete a form. Complete a separate form for each covered person and submit completed claim forms directly to the appropriate claims administrator at the

address shown in the chart above. If you don't complete the necessary form or identify yourself appropriately, you may experience delay in the processing of your claim. Member Claim Forms are available at www.caremark.com.

- Submit the appropriate information. Include all of the following:
    - Your member ID and account number (your member ID is included on your ID card, and your account number is the seven-digit policy number included on your ID card); and
    - Itemized bills (you can submit as many itemized bills as you wish with each form). If you're going to be hospitalized, you may wish to obtain a claim form prior to hospitalization (be sure to show your ID card at the time of your admission). Also, when you submit itemized bills be sure they include your provider's name and address, the patient's name, the diagnosis, and the date of service. A description of the service, diagnosis, or other statement regarding the service's purpose and service charge should also be included.
- Submit promptly. Be sure to submit your claims promptly after you receive the service.
- Who receives benefits. The claims administrator processes your request for benefits then pays benefits directly to you or your physician, hospital, other health care facility, pharmacy, or other health care provider.

Mail Order Pharmacy

You can fill your long-term maintenance medications through the mail. With the mail order pharmacy, you receive up to a 90-day supply of your medication for less than the cost of three fills at a Retail pharmacy.

To fill a prescription through the Mail Order Pharmacy:

- Ask your physician to write a prescription for a 90-day supply, plus refills, so that you can submit it directly to the mail order pharmacy with your form. Be sure to ask your physician to prescribe generic medications if available to help reduce costs.
- If you need medication immediately, ask your physician for two prescriptions, the first for an immediate supply. You can then take this to your local network pharmacy. The second is for the long-term supply. You can submit this one to the mail order pharmacy. An alternative is to use the Maintenance Choice program at a CVS retail pharmacy or CVS/Target pharmacy, in which case your physician only needs to write a single prescription for a 90-day supply, plus refills.
- Complete a mail order form and send it to CVS/Caremark. Be sure to include your original prescription. A new form and pre-addressed envelope is then sent to you with each delivery. You also can print forms at www.caremark.com. Submit a mail order form for each prescription.
- Payment is due with each order.

Maintenance Choice Program

Voluntary Maintenance Choice gives members the option to fill their maintenance medications in 90-day supplies at either CVS Pharmacy or CVS Caremark Mail Service Pharmacy for the same price. There are no refill restrictions and members can move their prescriptions between CVS Pharmacy and CVS Caremark Mail Service Pharmacy as desired. Members who choose to fill in these channels benefit from lower

coinsurance. Clients receive the benefit of mail pricing for all prescriptions filled at CVS Pharmacy and Mail service.

Formulary and Non-Formulary Medications

The Formulary is a guide for you and your doctor to refer to when filling out your prescriptions. If there is no generic medication available for your condition, there may be more than one brand name for you and your doctor to consider. Caremark provides a list of formulary brand name medications to help you and your doctor decide medications that are clinically appropriate and cost effective. If a drug you are taking is not on the formulary, you may want to discuss alternatives with your doctor or pharmacist. Using drugs on the formulary will keep costs low.

A current drug list is available online www.caremark.com or upon request by calling CVS Caremark Customer Care. To avoid paying higher coinsurance associated with non-preferred drugs; take this list with you when you visit your doctor so he or she can refer to it when prescribing medications for you and your covered dependents.

Generic Substitution

You can save the most money by choosing generic drugs when available. Ask your Physician to authorize generic substitution when medically appropriate. CVS Caremark will never give you a generic instead of a brand-name drug without your Physician's permission. If a generic drug is not available, you'll pay the applicable brand-name coinsurance. If you or your covered dependent requests a brand-name drug when the Physician approves an available generic drug, you must pay the brand coinsurance plus the difference in cost between the prescribed brand-name drug and its generic equivalent. This is the DAW (Dispense As Written) penalty.

CVS Caremark Specialty Pharmacy Services

CVS Caremark Specialty Pharmacy Services is a full-service specialty pharmacy that provides specialty injectable and oral drugs for chronic conditions, and members can only fill these drugs at Caremark Specialty Pharmacy. CVS Caremark provides these products directly to Covered Persons along with personalized service and educational support for your specific therapy. Conditions covered include Multiple Sclerosis, Rheumatoid Arthritis, Gaucher's Disease, Allergic Asthma, Osteoporosis, Cystic Fibrosis, Hepatitis C, Crohn's Disease, Pulmonary Hypertension, Psoriasis, and others. To learn more about CVS Caremark Specialty Pharmacy Services, visit Caremark.com or to get started with the service, call Caremark Connect at 1-800-237-2767. Note: All specialty medications are subject to Specialty Guideline Management (SGM) review. SGM is a program that helps to ensure appropriate utilization for specialty medications based on evidence-based medicine guidelines. Patient progress is continually assessed to determine whether appropriate therapeutic results are achieved. Prescribers may call 1-866-814-5506 to request an SGM review.

Quantity Limitations

CVS Caremark develops limitations to ensure safe and appropriate medication use. The list below includes those drugs subject to Quantity Limitations. Regardless of what is prescribed by your Physician, the amount dispensed will be based on the recommended limitation. For more information, call CVS Caremark Customer Care at 1-800-378-0780.

- ADHD/Narcolepsy Agents
- Anticholinergic, Combination, and Mast Cell Stabilizer Oral Inhalation (misc. asthma /COPD agents)
- Anti-Migraine
- Butorphanol Nasal Solution
- Corticosteroid Oral Inhalation (steroid inhalers)
- ED Alprostadils, PDE-5 Inhibitors Limit & ED-BPH Cialis
- Influenza
- Intranasal Steroids/Antihistamines
- Long & Short Acting Beta2-Agonists (respiratory/asthma inhalers)
- Pain (oxycodone/APAP ext-rel)
- Pain (tapentadol, tapentadol ext-rel)

Prior Authorization

Prior authorization requires a drug's prescribed use to be evaluated against a predetermined set of criteria before the prescription will be covered. In addition to the Quantity Limitations above, certain drugs or drug classes will require prior authorization for you to receive coverage for them. If you're taking one or more of the drugs listed below, you can avoid delays and interruptions in your therapy by asking your doctor to call the CVS Caremark Prior Authorization Department at 1-888-413-2723. The request will be evaluated to determine if you still qualify for Plan coverage of the prescribed therapy.

If you don't meet the criteria standards and still wish to take the medication, you'll be responsible for the entire cost of the drug. Please note that this list may be updated periodically throughout the year.

- Anabolic Steroids
- Compounded Drug Products Exceeding a $300 Threshold
- Narcolepsy (sleep disorder)
- Pain, Oral/Intranasal Fentanyl Products (oral/intranasal narcotics)
- Sublingual Immunotherapy (SLIT) Agents
- Suboxone, Subutex
- Testosterone – Topical/Buccal/Nasal (Brand and Generic)
- Testosterone – Injectable
- Vfend

Step Therapy

Generic Step Therapy requires that a cost-effective generic alternative is tried first before targeted single-source brands are covered. The list below includes those drug classes subject to Generic Step Therapies.

- COX2 inhibitors/ Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)
- Fibrates
- HMG-CoA Reductase Inhibitors
- Prostagl Analog
- Serotonin Norepinephrine Reuptake Inhibitors (SNRIs)
- Selective Serotonin Reuptake Inhibitors (SSRIs)

With Generic Step Therapy, if you choose to stay on your current, higher-cost brand-name medicine,
you may have to pay the full price if you have not tried a generic option to treat your health condition. Your doctor can contact CVS Caremark to request a prior authorization if you have a unique medical situation that requires you to keep taking the higher-cost (brand-name) medicine. If you have previously taken generic medicine in the same drug class, you may not be affected by this change.

Appeals

Formal procedures are in place if you need to appeal a benefit decision relative to your prescription drug benefits. The same appeals process that applies for health care coverage decisions applies for prescription drug benefit decisions. The first request for coverage is called an initial coverage review. Your appeal should be mailed to:

CVS Caremark Prescription Claim Appeals MC 109
P.O. Box 52084
Phoenix, AZ 85072-2084

Alternatively, you can fax your appeal to 1-866-443-1172 Attn: Urgent Appeals.

This must be done within 180 days of a denial.

See your Medical Plan option's coverage summary for details about your prescription drug coverage. You can obtain your Medical Plan option's coverage summary, free of charge, by contacting the Benefits Help Desk for assistance at 1-510-572-2892 or toll-free at 1-877-291-9494 or email: **benefits@lamresearch.com**.

Anthem's Base PPO Medical Plan Option

Prescription Drug Type	Anthem's Base PPO You Pay Per Fill…
Retail (Up to a 30-Day Supply)	
• Generics	$10
• Preferred	$30
• Non-Preferred	$60
Mail Order (Up to a 90-Day Supply)	
• Generics	$20
• Preferred	$60
• Non-Preferred	$120

Retail (Up to a 30-Day Supply)

Your copays do not count toward your annual deductible, but they do count toward your out-of-pocket maximum. **Note**: If a generic drug is available and you receive a preferred brand drug, you also pay the difference in cost between the generic drug and the preferred brand drug—unless your physician writes the prescription as "dispense as written."

For prescription drugs received from a non-participating retail pharmacy, you pay 50% of the cost of prescription drugs in addition to the copays.

Mail Order (Up to a 90-Day Supply)

Mail order is only covered in-network.

Anthem's CDHP Medical Plan Option

Retail (Up to a 30-Day Supply)

After you meet the Anthem CDHP's annual deductible, you pay 15% for prescription drugs received from a participating retail pharmacy. **Note**: If a generic drug is available and you receive a preferred brand drug, you also pay the difference in cost between the generic drug and the preferred brand drug—unless your physician writes the prescription as "dispense as written."

For prescription drugs received from a non-participating retail pharmacy, you pay 30% of the cost of prescription drugs in addition to the annual deductible, plus any amount exceeding the limited fee schedule amount.

Mail Order (Up to a 90-Day Supply)

After you meet the Anthem CDHP's annual deductible, you pay 15% for prescription drugs received through mail order.

Preventive Care Prescription Drugs

If you are enrolled in a CDHP Medical Plan option, certain preventive care prescription drugs are covered at 100%.

If you have any questions regarding whether a particular preventive care item or service will be offered with no cost sharing, contact CVS Caremark.

How to Contact CVS Caremark

For more information about prescription drug coverage available to participants in the Anthem Medical Plan options, go to **www.caremark.com**. The following are the CVS Caremark phone numbers to call depending on your information needs:

Retail Prescription Drug Program Customer Service:	**1-800-378-0780**
Mail Order Delivery Fast Start:	**1-866-772-9414**
Mail Order Customer Service:	**1-800-378-0780**

Written requests and claims should be sent to:
CVS Caremark
P.O. Box 52116
Phoenix, AZ 85072-2116

Dental

This Benefits Information Guide highlights only the important aspects of the Dental Plan. You can obtain a Dental Plan coverage summary, free of charge, from the Benefits Help Desk. The Dental Plan coverage summary describes the applicable coinsurance, deductibles, benefits covered, and exclusions. The coverage summary is part of this Guide, so keep it with this Guide for reference. In the event of a discrepancy between this Guide and your coverage summary, the coverage summary will govern.

Lam Research offers you three Dental Plan options:

- Preventive Plan;
- Enhanced Plan; and
- Premium Plan.

You can elect dental coverage for you only or for you and your eligible dependents, or you may decline coverage.

The Lam Research Benefits Information website lists the Dental Plan options available, as well as the cost of each option and coverage level.

The Preventive, Enhanced, and Premium Plans, administered by Delta Dental, provide traditional indemnity dental care. In many areas, the Dental Plan options also feature a preferred provider network. When you use a dentist in the Delta Dental network, your claims are handled automatically. Network dentists will not bill you for charges over the Dental Plan option's limits.

The Preventive Plan covers only preventive services (that is, exams and cleanings), plus periodic X-rays. The Enhanced Plan covers preventive, basic, major restorative care for children and adults, and orthodontia for covered children. The Premium Plan covers preventive, basic, major restorative care, and orthodontia for both covered children and adults.

Vision

This Benefits Information Guide highlights certain important aspects of the Vision Plan. You can obtain a Vision Plan coverage summary, free of charge, from the Benefits Help Desk. The Vision Plan coverage summary describes the applicable coinsurance, benefits covered, and exclusions. The coverage summary is part of this Guide, so keep it with this Guide for reference. In the event of a discrepancy between this Guide and your coverage summary, the coverage summary will govern.

Lam Research offers two Vision Plan options provided through Vision Service Plan (VSP):

- Base Plan; and
- Enhanced Plan.

You can elect vision coverage for you only or for you and your eligible dependents, or you may decline coverage.

The Lam Research Benefits Information website lists the Vision Plan options available, as well as the cost of each option and coverage level.

Under both options, you may obtain vision services through VSP's extensive network of providers or through a non-VSP provider. You will receive higher benefits if you use a VSP provider.

Using a VSP Provider

In most cases, you will receive the maximum benefit if you stay within the VSP network. When you use a VSP provider, depending on the service, you may pay a copay to the VSP provider at the time of service. After you pay the copay, the Vision Plan, in most cases, pays the full cost of:

- Eye exams Frequency limitations may apply.
- Lenses (within allowable limits) Frequency limitations may apply.
- Frames (within allowable limits) Frequency limitations may apply.
- Contact lenses (if medically necessary and within allowable limits) Frequency limitations may apply.

VSP also offers the following services and supplies subject to copays and allowable limits. In addition, VSP discounts may apply. These services and supplies are available **in-network only**.

- Retinal screening;
- Computer vision coverage (available only to employees, not dependents);
- Sun care benefit (nonprescription sunglasses);
- Laser VisionCare™ Program; and
- Diabetic eye care.

Flexible Spending Accounts (FSAs)

Lam Research's Benefits Program features two Flexible Spending Accounts (FSAs) that can reduce your taxes and help you budget:

- The Health Care Flexible Spending Account (Health Care FSA); and
- The Dependent Care Flexible Spending Account (Dependent Care FSA).

The Health Care FSA qualifies as a "self-insured medical reimbursement plan" under IRC Section 105, and eligible expenses reimbursed from the Healthcare FSA are excluded from your gross income under IRC Section 105(b).

The Dependent Care FSA qualifies as a "dependent care assistance plan" under IRC Section 129, and eligible expenses reimbursed from the Dependent Care FSA are excluded from your gross income under IRC Section 129(a).

Both of these accounts are optional. You may enroll in one or both, or you may decline participation. If you want to participate in an FSA, you must enroll during Open Enrollment (or within 30 days of hire if a new employee).

How FSAs Work

FSAs let you pay for eligible health care and/or dependent day care expenses on a tax-free basis. When you enroll in an FSA, you tell Lam Research to direct part of your pay into your FSA(s). Lam Research takes your FSA contribution from your pay before federal, Social Security (FICA) and, in most states, before state and local income taxes are withheld. This lowers the amount of your taxable pay which, in turn, lowers the income taxes you pay. In addition, Lam Research matches 15% of your contribution to the Dependent Care FSA.

When you have an eligible expense, you file a claim to be reimbursed from your FSA. Since the reimbursement payment is not taxed, your money isn't taxed when it goes into your FSA or when it comes out.

Eligible Expenses

IRS regulations determine the types of expenses that are eligible for reimbursement through FSAs. You can find a complete list on the IRS website at **www.irs.gov** (look for Publications 502 for health care information and 503 for dependent care information). In general, eligible expenses are the same as expenses that could otherwise be deducted from your income taxes.

Other Facts You Should Know

Before you decide whether to participate in an FSA, it's important that you plan your FSA contributions carefully. Here's why:

- Your contribution amount(s) may be used for expenses you incur during the plan year, which is January 1 through December 31 (or from date of hire through December 31, if you're a new hire). You have until March 31 of the following year to file claims for reimbursement for eligible expenses incurred during the previous plan year. If, at the end of the plan year on December 31, you have a remaining balance in your Health Care FSA that you do not request reimbursement for by March 31 of the following year, up to $550 of the remaining balance will automatically be carried over to your

following plan year Health Care FSA. However, if you are enrolling in the CDHP Medical Plan option for the next plan year, your carryover balance (up to $550) will be converted into a “limited purpose” Health Care FSA to be used for dental and vision expenses only.

- Once you enroll in an FSA, you cannot change your election or contribution amount for the rest of the plan year, unless you have a qualifying life event (as defined earlier in this Guide or for example, you experience a significant cost increase or decrease for day care services) and elect to change your contribution amount within 30 days through the PlanSource enrollment website at https://benefits.plansource.com. Before you enroll, it is important to carefully estimate your eligible expenses and decide upon amounts you want to set aside in each FSA. Although up to $550 of remaining contributions in your Health Care FSA after December 31 for which you do not file a claim for reimbursement by March 31 of the following plan year will automatically carry over to the following year’s Health Care FSA, because of the tax advantage of the FSAs, the IRS requires that any money over $550 remaining in your Health Care FSA at the end of the plan year be forfeited. Under the Dependent Care Account, all remaining money in your account at the end of the plan year will be forfeited.
- You cannot transfer money between FSAs, and you cannot use Dependent Care FSA money to pay for Health Care FSA expenses (or vice versa). If you want to be reimbursed for eligible health care and dependent care expenses, you must enroll in both FSAs.
- Under the Health Care FSA, you will be reimbursed for eligible expenses up to the amount of your total annual election, regardless of how much you have actually contributed when the claim is submitted. However, under the Dependent Care FSA, you will be reimbursed only up to the amount of your contributions to date. For example, if you elect to contribute $2,000 to each FSA for the plan year and, on June 30, you submit claims for eligible expenses to each FSA for the full $2,000, you will receive a $2,000 reimbursement (minus any amount previously reimbursed for the plan year) from your Health Care FSA and only the lesser of a $1,000 reimbursement or the balance as of June 30 from your Dependent Care FSA (disregarding any contributions by Lam Research to your Dependent Care FSA). You can claim the remaining contributions to your Dependent Care FSA as soon as they are deposited into your account.

- You cannot claim a tax credit or deduction for any expenses reimbursed through an FSA. However, you may claim a tax credit for any unreimbursed expenses, subject to IRS rules. Participation in an FSA lowers your Social Security taxes, which may affect the Social Security benefits you receive after you retire. However, for most people, the tax advantages of an FSA usually outweigh the reduced Social Security benefits. If you have any questions, contact a tax advisor.
- Participation in an FSA can lower your taxable income, but it does not lower base pay for purposes of determining coverage for pay-based benefits such as Employee Life Insurance, Disability Insurance, and Workers' Compensation.
- If you are on an extended leave of absence (LOA) for (more than one month), you may elect to continue group health coverage, including Health Care FSA coverage, by paying your employee contribution via check to Basic Pacific, the LOA premium services administrator for Lam Research.
- Your coverage under the Health Care FSA (except to the extent provided under COBRA) and/or the Dependent Care FSA will terminate on the earliest of:
  - The last day of the plan year;
  - The day before the effective date of your election to revoke coverage;
  - The date the FSA is terminated;
  - The day before the date on which you cease to be an eligible employee; or
  - The date on which your employment terminates for any reason.

Health Care FSA

For the 2020 plan year, you may contribute from $50 to $2,750 to the Health Care FSA. For subsequent plan years, the Health Care FSA salary reduction contribution limit will be adjusted for inflation according to IRC Section 125(i)(2).

You can use your account to pay for eligible health care expenses you or your eligible dependents incur and which are not covered (or fully covered) by your health care plans. For a list of qualified health care expenses, log onto **www.ConnectYourCare.com** or contact ConnectYourCare Customer Service at **1-877-924-3967**. You can find a complete list of health care expenses on the IRS website at **www.irs.gov** (look for Publication 502).

Your Eligible Dependents

The qualified health care expenses of your spouse/domestic partner and your dependent children and your domestic partner's children are eligible for reimbursement under your Health Care FSA.

Note: Qualifying expenses for your domestic partner may be eligible for reimbursement only if your domestic partner qualifies as an IRS tax dependent. In general, a domestic partner's child will not be eligible to be reimbursed under a Health Care FSA unless your domestic partner qualifies as a dependent. (See "Definition of a Tax Dependent" in the **Eligibility** section.)

You also can use your Health Care FSA for reimbursement for your dependent child's qualified health care expenses even if you are divorced or separated and have agreed to let your ex-spouse claim the child as a dependent for tax purposes.

Note: For purposes of the Health Care FSA, qualified health care expenses for children are eligible for reimbursement as long as the children will not reach age 27 by the end of the calendar year of the year of your Health Care FSA participation.

Beginning in 2020, you can use the Health Care FSA to purchase over-the-counter medications, drugs and menstrual products without a prescription.

Expenses Not Eligible for Reimbursement

The following is a partial list of expenses for which you **cannot** be reimbursed under the Health Care FSA:

- Premiums you pay for any health care coverage, including those for health plans maintained by the employer of your spouse or other dependent.
- Elective cosmetic surgery.
- Dancing and swimming lessons, even if prescribed as physical therapy.
- Household help.
- Maternity clothes.
- Health club dues.

Using the Health Care FSA vs. the Tax Deduction

When you receive reimbursement from the Health Care FSA for your eligible expenses, you cannot take a tax deduction on your federal income tax return for the same expenses. You have to choose whether you want to take the tax deduction or receive reimbursement through the Health Care FSA. Whether you would benefit more from participating in the Health Care FSA or using the IRS tax deduction for health care expenses depends on your situation. Lam Research cannot provide tax advice; you should consult a qualified tax advisor for that. However, Lam Research can provide you with some general guidelines.

Using a Health Care FSA is usually more tax advantageous than claiming health care expenses as income tax deductions. In general, you may only deduct health care expenses from your income taxes if your eligible expenses in a given year are more than 10% of your adjusted gross income, you itemize your income tax deductions, and you and your spouse are under age 65. If you or your spouse is age 65 or over, you can deduct eligible health care expenses that exceed 7.5% of your adjusted gross income.

Dependent Care FSA

The Dependent Care FSA can only be used to reimburse expenses to care for your eligible dependents so that you and your spouse can work or you can work and your spouse can seek employment.

To participate in a Dependent Care FSA, you must be working and be one of the following:

- Married and:
  - You and your spouse both work (or your spouse is looking for work), or
  - Your spouse is either a full-time student at least five months of the year or is mentally or physically disabled and unable to care for himself/herself;

- A single parent; or
- Divorced or legally separated and have primary custody of your child (even if your former spouse claims the child for income tax purposes).

You may use the money in your Dependent Care FSA to pay for eligible dependent care expenses, such as:

- Care provided in your home, in someone else's home, or in a day care center. (If the day care center provides care for more than six children, it must comply with all local and state laws governing day care centers.)
- Care provided by a relative, as long as the relative is not your own child under age 19 or someone you claim as a dependent on your income tax return.
- Education expenses for someone not yet in kindergarten, such as nursery school expenses, if the amount you pay for schooling is incidental to and cannot be separated from the cost of care.

Your Eligible Dependents

To be eligible for reimbursement, the expenses incurred must be on behalf of a:

- Dependent child under age 13; or
- Physically or mentally disabled dependent of any age, including an elderly parent, who is unable to care for himself or herself.

Contributions to the Dependent Care FSA

There is a $5,000 maximum annual contribution limit to your Dependent Care FSA, subject to IRS limits based on your marital and tax-filing status, as outlined in the table below.

Lam Research matches 15% of your contribution to the Dependent Care FSA, and the $5,000 maximum annual contribution limit includes your contributions and Lam Research's matching 15% contribution. Be sure to take this into consideration when estimating your contributions.

Dependent Care Flexible Spending Account (FSA)	
If You Are…	**Your Dependent Care FSA Contribution Limit Is…***
Single, or Married and file a joint tax return, and your spouse does not have access to a dependent care flexible spending account	$5,000
Married and file a joint tax return, and your spouse has access to a dependent care flexible spending account	$5,000 (you and your spouse combined for the year)
Married and your spouse earns less than $5,000 per year	Any amount up to your spouse's annual taxable earnings

Dependent Care Flexible Spending Account (FSA)	
If You Are…	**Your Dependent Care FSA Contribution Limit Is…***
Married, and you and your spouse file separate tax returns	$2,500 for the year (if your spouse has access to a separate dependent care flexible spending account, he or she may also contribute $2,500 to his or her dependent care flexible spending account)
Married and file a joint tax return, and your spouse is a student or disabled	$5,000
** Your contribution limit includes Lam Research's 15% matching contribution.*	

Generally, you must claim the individual as a dependent for federal income tax purposes, though special rules apply to children of divorced or separated parents.

Note: Expenses incurred on behalf of a domestic partner's dependent child are generally not eligible for reimbursement due to IRS regulations.

Expenses Not Eligible for Reimbursement

You cannot be reimbursed from the Dependent Care FSA for:

- Dependent day care expenses you deduct on your income tax return;
- Transportation costs between your home and your dependent care provider;
- Services outside your home at a camp where your child, disabled spouse, or dependent stays overnight; or
- Food, clothing, or education.

Before you decide how much you want to contribute or whether you want to participate, you should plan your expenses and contribution strategy.

IRS Reporting Requirements

You will be required to include the name, address, and Social Security Number or Federal Tax Identification Number of your day care or elder care provider when you file your federal tax return (IRS Form 2441). If you do not, the money you receive from your Dependent Care FSA will become taxable income. The amount of your FSA reimbursements will be reported to the IRS, as required by law, and will appear on your Form W-2.

Using the Dependent Care FSA vs. the Tax Credit

The Dependent Care FSA may or may not offer more tax advantages than the federal dependent care tax credit. Depending upon your family income, you may be able to take a tax credit based upon a percentage of your annual dependent care expenses on your federal income tax return, whether or not you itemize your deductions.

However, you cannot use eligible expenses that you claim for reimbursement through your Dependent Care FSA when you calculate the dependent care tax credit on your federal income tax return. This means that your annual contribution to your Dependent

Care FSA must be subtracted from your total dependent care expenses before you can calculate the tax credit. Contact your tax advisor for more information.

How to Get Reimbursed

If you enroll in an FSA, ConnectYourCare (the FSA administrator) will send you a welcome packet detailing the reimbursement process.

There are several methods available for reimbursement:

- You may use the Health Care Flexible Spending Account debit card to pay for eligible health care expenses.
- You may initiate a payment online from the ConnectYourCare website at **www.ConnectYourCare.com** to have a check sent to your provider or yourself. For fastest reimbursement, we recommend you set-up direct deposit for your claim payment.
- You may initiate a payment via myCYC Mobile App.
- You may file a claim for benefits by completing an FSA Claim Form and mailing it, along with Explanations of Benefits (EOBs), itemized receipts, or other documentation, to:

  CYC Claims Department

  P.O. Box 622317
  Orlando, FL 32862-2317
  Fax# 1-443-681-4602

An FSA Reimbursement Claim Form may be downloaded from the ConnectYourCare website at **www.ConnectYourCare.com**.

Nondiscrimination Testing

The Health Care FSA and Dependent Care FSA are subject to nondiscrimination rules to ensure the Plan does not provide an unfair advantage to highly compensated employees. As a result, if you are a highly paid employee, it is possible that you may be asked to reduce your contributions if Lam Research finds that the Health Care FSA or Dependent Care FSA is at risk of violating these IRC requirements. Depending on the results of the annual tests, contributions of certain employees may be reduced or returned. You will be notified if this affects you.

If You Leave Lam Research

If you leave Lam Research, your FSA contributions normally will stop. You will be able to continue to file claims against your Health Care and Dependent Care FSA balances for any eligible expenses incurred prior to your termination date until the **earlier** of:

- Your account is exhausted; or
- 90 days after termination of your enrollment in the plan or the end of the plan year.
- Participants in Dependent Care FSA will still be allowed to file claims through the end of the plan year runout at the end of March or until their balance is exhausted.

- Under COBRA, you may also have the option to continue your participation in the Health Care FSA (but not in the Dependent Care FSA) by contributing with after-tax dollars. The only time you should consider this option is if you have money left in your Health Care FSA with no current expenses eligible for reimbursement and you expect to have eligible health care expenses after leaving Lam Research.

You cannot file for reimbursement of health care expenses you incur after you leave Lam Research unless you continue to contribute after-tax dollars through COBRA continuation of coverage.

Employee Life and Accidental Death and Dismemberment (AD&D) Insurance

Lam Research offers a variety of coverage levels for Employee Life and Accidental Death and Dismemberment (AD&D) Insurance (term insurance). Through Standard (the insurer), you choose the coverage amount that's right for your needs.

- **Employee Life Insurance** provides financial security for your family or other beneficiary in the event of your death.
- **AD&D Insurance** provides additional financial security for your family or other beneficiary if you die as the result of a covered accident or an AD&D benefit for you if you are dismembered as the result of a covered accident. A death or dismemberment must occur within 365 days following a covered accident.

You may also purchase Supplemental Life and /or AD&D coverage for your eligible dependents. You are the beneficiary of your dependent's(s') Insurance.

Employee Life and AD&D Coverage Levels

Basic Life and AD&D Insurance

For both Employee Life and AD&D, Lam Research pays the full premium cost for Basic Life and AD&D coverage, which is equal to two times your annual salary, rounded to the next higher $1,000. If you want to increase either coverage, you may elect supplemental coverage in an amount equal to an additional one to six times your annual salary, rounded to the next higher $1,000 (for total coverage up to a maximum of $2,000,000). You pay for any supplemental coverage.

Employee Life and AD&D Coverage Levels	
Basic Coverage	**Supplemental Coverage***
2 times annual salary	1, 2, 3, 4, 5, or 6 times annual pay
Or $50,000	n/a
** Maximum benefit amount (Basic and Supplemental combined) = $2,000,000*	

You have the option of electing a cap of $50,000 for your Employee Life Insurance benefit, so that you will not have any imputed income.

Supplemental Employee Life and AD&D Insurance

Your cost for Supplemental Employee Life Insurance coverage is based on your age as of January 1 of the applicable plan year and the dollar amount of the coverage you choose.

For purposes of these plans, "annual salary" is defined as your base annual base pay not including bonuses, overtime pay, or other extra compensation. **If your salary increases or decreases during the year, your coverage amount and cost will automatically increase or decrease effective on the date the salary change becomes effective.**

You are not required to choose the same coverage levels for Supplemental Employee Life and AD&D Insurance. For example, you may choose Supplemental Life Insurance

coverage of three times annual salary and Supplemental AD&D Insurance coverage of two times annual salary.

Taxes

Even though Lam Research pays the full premium cost for your Basic Life Insurance coverage, there are tax implications. The IRS requires that the value of Basic Life Insurance coverage over $50,000 is taxable to you. Lam Research must report the imputed income amount to the IRS. Consequently, you will see a line item in the “Earnings” section of your pay advice described as “Group Term Life > $50,000.” The same amount is backed out in the “Deductions” section described as “Group Term Life > $50,000 offset.” The net effect is that you pay tax on your Basic Life Insurance coverage over $50,000. Imputed income amounts vary depending on your age and coverage amount.

You have the option of electing a cap of $50,000 for your Employee Life Insurance benefit, so that you will not have any imputed income.

Beneficiaries

It’s important that you designate a beneficiary(ies) for your Employee Life and AD&D Insurance. Your beneficiary will receive your Life Insurance benefit in the event of your death (plus your AD&D benefit if your death is the result of a covered accident). You may update your beneficiary information anytime online at **https://benefits.plansource.com**.

Evidence of Insurability (EOI)

When EOI Is Required

When you are initially hired, you may elect Supplemental Life Insurance coverage equal to up to three times your annual pay without providing Evidence of Insurability (EOI). This is called “guaranteed issue.” Elections exceeding this guaranteed issue will be subject to EOI. Thereafter, you may only elect one level higher during Open Enrollment without providing EOI if you are electing less than or equal to three times your annual pay. If you elect coverage greater than three times your base pay, EOI is required.

If you previously waived Supplemental Life Insurance coverage and then elect it, you must provide EOI.

For example, during Open Enrollment, if you currently have Basic Life Insurance coverage (equal to two times your annual pay), and Supplemental Life Insurance coverage equal to one time your annual pay, you can increase your Supplemental Life Insurance coverage to two times your pay without providing EOI. If you want Supplemental Life coverage equal to three times your annual pay, you must provide EOI for the third multiple and it must be approved by Standard before the increase will be effective.

Submitting EOI

If you elect coverage that requires EOI, you will need to complete an EOI form. You will receive an email with further instructions on how to submit an online EOI form. You will be responsible for the cost of any required exams or test. Your elected coverage level and contribution amount will not go into effect until your application has been approved by Standard.

The approval process normally takes 60 days from the date Standard receives your EOI form. Until your coverage is approved, you will be covered at the highest level available to you without EOI.

Benefit Reductions

After you reach age 70, your Employee Life and AD&D Insurance coverage amounts will be reduced to the following percentages of your coverage in force as of age 69 as follows:

Employee Life and AD&D Coverage Reductions	
As of Age…	**Your Coverage Amount Based on a Percentage of Your Coverage as of Age 69**
70	65%
75	40%
80	20%

Refer to your Employee Life and AD&D coverage summaries for a complete schedule.

Options Upon Termination of Employment

If you terminate employment, you have different options available to you to continue your Life Insurance (not AD&D Insurance) coverage.

Portability

You will have the right to apply for Life Insurance coverage under the Portability Plan if you meet all of these tests:

- Your Basic Life Insurance coverage and/or Supplemental Life Insurance coverage ends for any reason other than:
  - Your failure to pay, when due, any contribution required for it.
  - The end of your employment on account of your retirement.
  - The end of the coverage for all employees when this coverage is replaced by group life insurance from any insurance company for which you are or become eligible within the next 31 days.

You meet the Active Work Requirement on the day your insurance ends. (Refer to the Standard Statement of Coverage at **www.LamBenefits.com** for the definition of "Active Work Requirement.")

- You are under age 65.
- Your amount of Life Insurance is at least $10,000 on the day your insurance ends.

You have the right to apply for coverage under the Portability Plan during the Portability Application Period, which is the 31-day period after your Basic Life Coverage or Supplemental Life Insurance ends. Evidence of insurability may be required. This requirement will be met when Standard decides the evidence is satisfactory.

For more information about Portability, see the Standard Statement of Coverage at **www.LamBenefits.com**.

Conversion

If your Life Insurance coverage ends for one of the reasons stated below, you may convert all or part of your insurance to an individual life insurance contract through Standard. Evidence of insurability is not required. You may convert all or a part of your Life Insurance if:

- Your employment ends or you transfer to a position in which you are not eligible for Employee Life Insurance coverage.
- Coverage under Employee Life Insurance ends by amendment or otherwise for your employee class, if on the date that it ends:
  - You are totally disabled and remain totally disabled until the effective date of the individual contract; or
  - You have been insured for five years for that insurance (or for that insurance and any Standard rider or group contract replaced by that insurance).

You must apply for the individual contract and pay the first premium according to the following rules:

- If you have been given written notice of the conversion privilege by the 15th day after your coverage ends, you must apply for the individual contract and pay the first premium by the 31st day after your coverage ends.
- If you have been given written notice of the conversion privilege more than 15 days after your coverage ends, you must apply for the individual contract and pay the first premium by the 25th day after you have been given the notice. However, in no event may you convert the insurance to an individual contract if you do not apply for the contract and pay the first premium before the 92nd day after your coverage ends.

For more information about Conversion, see the Standard coverage summary at **www.LamBenefits.com.**

Dependent Life and Dependent Supplemental Accidental Death and Dismemberment (AD&D) Insurance

This Benefits Information Guide highlights only the important aspects of Dependent Life and Dependent Supplemental Accidental Death and Dismemberment (AD&D) Insurance. You can obtain a Statement of Coverage free of charge from the Lam Research Benefits Information website. The Dependent Life and Dependent Supplemental AD&D Insurance Statement of Coverage describes the benefit eligibility, payment amounts, offsets, and exclusions. The Statement of Coverage is part of this Guide, so keep it with this Guide for reference. In the event of a discrepancy between this Guide and your coverage summary, the Statement of Coverage will govern.

Dependent Life insurance provides a benefit to you if your enrolled dependent dies. Dependent Supplemental AD&D Insurance provides additional financial security for you and your family if your enrolled dependent dies as the result of a covered accident or an AD&D benefit to you if your enrolled dependent is dismembered as the result of a covered accident. A death or dismemberment must occur within 365 days following a covered accident.

You must enroll in Employee Supplemental Life and Employee Supplemental AD&D Insurance to enroll your eligible dependents. If you elect Dependent Life and/or Supplemental Dependent AD&D Insurance for your eligible dependents, you pay the cost of this insurance on an after-tax basis. See the table below for Dependent Life and Dependent Supplemental AD&D Insurance coverage levels.

Spouse/Domestic Partner	Child(ren)
$5,000 to $500,000 in $5,000 increments	For children from live birth: $2,500, $5,000, $10,000, $20,000, or $30,000

Beneficiaries

You are automatically the beneficiary for any Supplemental Life and/or AD&D Insurance coverage, including any accidental dismemberment benefit paid for you or your enrolled dependent.

Evidence of Insurability (EOI)

There are no EOI requirements for Supplemental AD&D Insurance.

Benefit Reductions

After you reach age 70, your Supplemental Life and Supplemental AD&D Insurance coverage amounts on your spouse/domestic partner will be reduced to the following percentages of his or her coverage in force as of age 69 as follows:

Spouse/Domestic Partner Supplemental AD&D Coverage Reductions	
As of Age…	**Your Spouse's/Domestic Partner's Coverage Amount Based on a Percentage of His or Her Coverage as of Age 69**
70	65%
75	40%
80	20%

Refer to your Statement of Coverage for a complete schedule.

Voluntary Disability Insurance (VDI) Plan

Eligibility for VDI

The VDI Plan is available only to employees in California. If you are assigned to a Lam Research location in California and you are unable to work due to a disability, the VDI Plan provides partial wage replacement. You must be a resident of California to receive VDI Plan coverage.

"Disability" is defined as any mental or physical illness or injury which prevents you from performing your regular or customary work. It includes any non-industrial/non-occupational injury, illness, or pregnancy-related condition. An independent medical examination may be required to determine your initial or continuing eligibility for VDI Plan benefits. To apply for VDI Plan benefits, you must file a claim with TRISTAR (Lam Research's third-party administrator).

You may be eligible for Paid Family Leave (PFL) if you must take time off work to care for a family member with a serious health condition or if you want to bond with a new minor child within the first year of birth, adoption, or foster care placement of that child. Family member means child, grandchild, grandparent, parent, parent-in-law, sibling, spouse or domestic partner.

How Benefits Are Calculated

If you are disabled, you will be paid 70% of your basic weekly earnings to a weekly maximum of $3,250. Partial weeks are paid at a daily rate that is 1/7th of your weekly benefit.

PFL benefits will be paid at 66-2/3% of your basic weekly earnings to a weekly maximum of $3,250 for twelve weeks of Paid Family Leave.

Payment of Benefits

If you are disabled, you may receive up to 52 weeks of VDI Plan benefits.

Once you file, you will receive a weekly rate and maximum weekly benefit amount at least equal to the California rate and Maximum Benefit Award which you would have received if you were a participant in the State Disability Insurance (SDI) program. If this award is greater than the benefits you are receiving under the VDI Plan, your benefit level will be adjusted to meet this award amount. If this award amount is less than your benefit level under the VDI Plan, you will continue to receive the VDI Plan benefit level.

VDI Plan benefits will be paid only after you meet **all** of the following requirements:

- You must be unable to do your regular or customary work for at least eight consecutive days.
- You must be employed by the Company.
- You must have lost Company wages because of your disability.
- You must be under the care and treatment of a licensed physician or accredited religious practitioner during the first seven days of your disability, and you must remain under such care and treatment to continue receiving benefits.

- You must notify TRISTAR of your claim within 60 days after the first compensable day of disability. Contact TRISTAR at 1-844-610-1885 (Lam Research) or 1-844-610-1886 (Silfex). TRISTAR will send you an information packet which includes the claim form.
- Your physician must complete the medical certification of your disability. A licensed midwife, nurse-midwife, or nurse practitioner may complete the certification for disabilities related to normal pregnancy or childbirth. (If you are under the care of a religious practitioner, request a "Practitioner's Certificate" from TRISTAR. Certification by a religious practitioner is acceptable only if the practitioner has been accredited by California's Employment Development Department.

You PFL benefits begin immediately and there is no non-payable waiting period. You may receive PFL benefits for up to 12 weeks during the 12-month benefit period. The benefits period begins the first day that you establish a valid PFL claim.

When Benefits Are Not Paid

You are ineligible for VDI Plan benefits if you meet **any** of the following criteria:

- You are not suffering a loss of wages;
- You live in a state other than California;
- You are claiming or receiving unemployment insurance or paid family leave benefits;
- You became disabled while committing a crime resulting in a felony conviction;
- You are in jail, prison, a recovery home, or any other place because you were convicted of a crime;
- You are receiving Workers' Compensation benefits at a weekly rate equal to or greater than the VDI Plan benefit rate; and/or
- You do not undergo an independent medical examination when requested to do so.

For more information about the VDI Plan, see coverage summary at **www.LamBenefits.com.**

Short Term Disability (STD) Plan

The purpose of the Lam Research Corporation Short Term Disability (STD) Plan is to assist you in meeting your reasonable income needs in the event you suffer a short-term disability and are unable to work. You pay the full cost of STD Plan coverage on an after-tax basis and are automatically enrolled in STD unless you waive coverage.

Participating in the STD Plan

To participate in the STD Plan, you must be an eligible employee assigned to a Company location outside of California and enrolled in the Plan.

The date your coverage in the Plan begins depends on when you enroll:

- If on or before the date you become eligible (usually your date of hire), your coverage begins on your eligibility date;
- If, within 30 days of becoming eligible, your coverage begins on the date you enroll; or
- If, after 30 days (or if you have voluntarily withdrawn from the STD plan but now wish to re-enroll), TRISTAR will determine your eligibility date after you provide evidence of good health, at your own expense.

You must be actively at work on the day your coverage in the STD Plan begins. If you are not actively at work on that day, your coverage will be delayed until you are back at active work.

Your coverage in the STD Plan ends when **one** of the following occurs:

- You cease being an eligible employee;
- You are laid off;
- You are no longer employed by Lam Research;
- You take an unpaid leave of absence; or
- The STD Plan ends.

You may be eligible for Paid Family Leave (PFL) if you must take time off work to care for a family member with a serious health condition or if you want to bond with a new minor child within the first year of birth, adoption, or foster care placement of that child. Family member is defined as child, grandchild, grandparent, parent, parent-in-law, sibling, spouse or domestic partner.

Payment of Benefits

Your STD benefit payments begin as of your eighth calendar day of disability or the first day of hospital confinement, provided you see a physician at some point during that period. The STD Plan's Claims Administrator—TRISTAR—determines whether you meet the STD Plan's definition of disability and the date on which you are disabled.

For purposes of the STD Plan, "disability" means:

- You suffer an injury or illness (physical or mental) which prevents you from performing the primary duties of your job (or any reasonably related job);
- Your pregnancy prevents you from doing your job;

- You contract or are exposed to a communicable disease (for example, tuberculosis or chickenpox), and your physician (or a bonafide health official) states, in writing, that you must stay away from work; orYou are under treatment for alcohol or drug abuse. You must participate in an accredited residential program to qualify for benefits. If you participate in outpatient treatment, you must attend the program for a minimum of six hours per day, five days a week. Benefits for alcohol and drug abuse treatment are limited to 90 days.

You will not be considered disabled if you are doing work of any kind for pay or profit without first obtaining approval from the Company. You will not be considered disabled if you turn down alternative employment offered by the Company that is within your capabilities and is comparable in status and pay to your regular job.

Benefits end on the **earlies**t of:

- The date your disability ends;
- Your 180th day of disability (if eligible, Long Term Disability [LTD] benefits begin on the 181st day of disability as defined under the LTD Plan); or
- The date you die.

You PFL benefits begin immediately and there is no non-payable waiting period. You may receive PFL benefits for up to 12 weeks during the 12-month benefit period. The benefits period begins the first day that you establish a valid PFL claim.

Benefit Amount

The benefit amount is 70% of your weekly earnings to a maximum of $3,250 a week. Partial weeks are paid at a daily rate that is 1/7th of your weekly benefit.

PFL benefits will be paid at 66-2/3% of your basic weekly earnings to a weekly maximum of $3,250 for twelve weeks of Paid Family Leave.

STD benefits are paid through TRISTAR.

Long Term Disability (LTD) Plan

This Benefits Information Guide highlights only the important aspects of the LTD Insurance Plan. You can obtain a coverage summary from Standard, upon request and free of charge, describing, for example, the benefit payment amounts, offsets, and exclusions, etc. of the LTD Plan. The coverage summary is part of this Guide, so please keep it with this Guide for reference. In the event of a discrepancy between this Guide and the coverage summary, the coverage summary will govern.

The LTD Plan pays benefits if you are totally disabled. In general, you are considered "totally disabled" if, as the result of illness or injury, you cannot perform the regular duties of your job and, after 24 months of total disability, you are unable to perform any of the material duties of any job for which you are reasonably suited by training, education, or experience.

Participating in the LTD Plan

The Long Term Disability (LTD) Plan is designed to replace a portion of your regular income if you cannot work as a result of a prolonged disability. You are automatically enrolled in LTD coverage, and Lam Research pays 100% of the premium cost of your coverage. (See the "Taxes" section below.)

Benefit Amount

The LTD Plan replaces 60% of your basic monthly earnings to a maximum monthly benefit of $20,000. For purposes of this plan, "pay" is defined as your base annual pay.

LTD benefit payments will coordinate with other benefit payments you may be eligible to receive during your disability. This means LTD benefit payments will be reduced dollar for dollar by any of the following other benefit payments:

- Workers' Compensation, occupational disease law, or similar laws;
- Any other disability benefits required by law;
- Any other group insurance plan;
- Social Security; and/or
- State disability benefits (where applicable).

When Benefit Payments Are Paid

Monthly benefit payments begin after you have been disabled, as defined under the STD Plan, for 180 calendar days, and you continue to see your physician.

As long as you remain disabled, you will continue to receive LTD benefit payments according to the schedule below, based on your age when you originally became disabled.

If You Are Disabled at Age:	**Your Monthly LTD Benefit Payments May Continue:**
64 & under:	Up to Social Security Normal Retirement Age
65 – 68	Up to Age 70
69 and over	1 year

Taxes

The cost of the full premium is paid by Lam Research and in turn the same full premium cost is included in your gross earnings. This means that you will pay taxes on the LTD premium amount in order for you to receive the LTD benefits tax-free.

Employee Assistance Program (EAP)

About the EAP

This Benefits Information Guide highlights only the important aspects of the Employee Assistance Program (EAP). You can obtain an EAP coverage summary free of charge from the Benefits Help Desk or go to **benefits@lamresearch.com**. The EAP coverage summary describes the benefits and exclusions of the EAP. The coverage summary is part of this Guide, so keep it with this Guide for reference. In the event of a discrepancy between this Guide and the coverage summary, the coverage summary will govern.

You are automatically enrolled in the EAP offered through Optum at no cost to you. The EAP is a confidential tool that you and members of your household can use for questions related to clinical counseling (for example, depression or stress), financial or legal services, child care or elder care services, and many other issues that may affect you.

Optum is available 24 hours a day, seven days a week, by calling 1-866-248-4096 or visiting Optum's website at www.liveandworkwell.com (Access Code: **LAMUS**).

You are entitled to unlimited telephonic consultations and, when necessary, you are also covered for up to six face-to-face clinical consultations per incident per calendar year.

Note: Lam Research does not have access to your confidential calls or consultations.

Affordable Care Act and the EAP

The EAP is technically considered a group health plan under ERISA. Accordingly, you are entitled to continued coverage under COBRA, as well as ERISA claims and appeals rights. However, Lam Research's EAP is an excepted benefit. This means that it is not eligible for the group market reforms (sometimes referred to as "consumer protections") under the ACA, such as an independent review organization following the ERISA claims and appeals process, or the preparation of a Summary of Benefits and Coverage (SBC).

Group Legal Services

Lam Research provides legal coverage through the ARAG's UltimateAdvisor™ program. This program can save you (or your family members) substantial amounts of money if you need legal services.

UltimateAdvisor

With UltimateAdvisor, you pay a flat fee for unlimited in-office benefits. The program covers services such as:

- Standard will preparation;
- Administrative hearings;
- Defense of civil damage;
- Property protection;
- Prenuptial agreements; and
- Immigration benefits.

UltimateAdvisor also provides:

- A financial and tax planning benefit through its telephone service;
- Access for you and your family, your parents, parents-in-law, and grandparents to the care-giving and legal services;
- Certain identity theft protection services, such as credit change monitoring, child ID theft monitoring, full-service identity restoration, lost wallet services, and $1,000,000 in ID theft insurance.

How to Find More Information
ARAG Group Legal information online or through hyperlinks to the Lam Research Benefits Information website at **www.LamBenefits.com**.

Situations Affecting Your Coverage

Leaves of Absence

Generally, your coverage under the Plan continues while you are on a leave of absence approved by Lam Research. If you are on an extended unpaid leave of absence for more than one month, you may elect to continue group health care coverage, including Health Care FSA participation, by paying your employee contribution by check to Basic Pacific, the COBRA administrator for Lam Research.

Family and Medical Leave Act of 1993 (FMLA)

Your medical, dental, and vision coverage; Life, AD&D, and Disability Insurance; Health Care FSA; and group legal services coverage under the Plan can remain in effect if you continue to pay your employee contributions beginning the month after your leave begins.

The Family and Medical Leave Act (FMLA), as amended, allows eligible employees to take an unpaid leave for up to a total of 12 workweeks in a 12-month period for one or more of the following reasons:

- The birth of your child and to care for your newborn child;
- The placement of a child with you for adoption or foster care;
- Your care for a family member (child, spouse, or parent) with a serious health condition;
- Your own serious health condition which makes you unable to perform the functions of your job; or
- Any qualifying exigency arising out of the fact that your spouse, child, or parent is a covered member in the armed forces on active duty (or has been notified of an impending call or order to active duty) in support of a contingency operation.

If eligible, you may also take leave for up to a total of 26 workweeks in a single 12-month period to care for a covered member of the armed forces with a serious injury or illness.

Refer to the Lam Research Leave of Absence Practice on The Point under GHR U.S. for detailed information about Lam Research's practices with respect to FMLA leaves of absence.

Paid Family Leave

If you are an eligible employee of Lam Research and are eligible for and receiving Paid Family Leave benefits, your medical, dental, vision coverage; Life, AD&D, and Disability Insurance; Health Care FSA and EAP participation; and group legal services coverage under the Plan may remain in effect during the twelve weeks of your Paid Family Leave.

Refer to the Lam Research Leave of Absence Practice on www.LamBenefits.com.

State Family and Medical Leave Laws

Lam Research must comply with any state law that provides greater family or medical leave benefits than those provided under the federal FMLA. If your leave qualifies under both the federal FMLA and under a state law, you will receive the greater benefit.

Unpaid Personal Leave

If you are on Personal Leave approved by Lam Research, your medical, dental, vision, life, AD&D, disability insurance, Health Care FSA, and group legal services coverage under the Plan remains in effect until the end of the month the leave begins. However, if you return as an eligible employee within 13 consecutive weeks from the date your leave begins, your coverage will be reinstated.

Military Leave Under the Uniformed Services Employment and Reemployment Rights Act (USERRA)

Under the Uniformed Services Employment and Reemployment Rights Act (USERRA), eligible employees called to active military duty in the "uniformed services" (that is, on military leave) may elect to continue medical, dental, and vision coverage; and Health Care FSA participation under the Plan (USERRA continuation coverage) for up to 24 months if the period of military service is 31 days or longer. The maximum duration of USERRA continuation coverage is the **lesser** of:

- The 24-month period beginning on the date on which your (the employee's) absence for the purpose of performing military service begins; or
- The period beginning on the date on which your absence for the purpose of performing military service begins and ending on the date on which you do not return from military service or apply for a position of employment as provided under USERRA.

If you're on military leave for six months or more, you are responsible for 102% of the full cost of the USERRA continuation coverage elected. If your period of leave is for under six months, your medical, dental and vision coverage will continue as if you remained employed with Lam Research. Life, AD&D, and Long Term Disability Insurance and group legal services coverage under the Plan is available to eligible employees on military leave for up to six months.

Your Life, AD&D, and Long Term Disability Insurance coverage while on a military leave is subject to limitations and exclusions for losses caused or arising out of war and active duty in the military. See the coverage summary for each plan for more information about these exclusions and limitations.

Refer to the Lam Research Leave of Absence Practice for detailed information about Lam Research's practice with respect to military leave.

If Lam Research Changes Coverage

If Lam Research offers new coverage or changes its coverage under the Program while you are on an approved leave of absence, you are eligible for the new or changed coverage, but your contributions for the coverage may change.

When Coverage Ends

Your medical, dental, and vision coverage ends on the last day of the month in which your employment with Lam Research ends. All other benefits coverage ends on the date your employment with Lam Research ends.

Coverage also ends if:

- You no longer meet the eligibility requirements of the Program or plan as designated by this Guide;
- You stop making required contributions; or
- Lam Research terminates the Program or a particular plan under the Program.

Your dependents' coverage ends when they no longer meet the eligibility requirements or when your coverage ends, whichever occurs first. However, for medical, dental and vision benefits, your dependents' coverage ends on the last day of the month in which they no longer meet the eligibility requirements or your coverage ends, whichever occurs first.

You may be able to elect COBRA continuation coverage for health coverage, including medical, dental, vision, the Health Care FSA, and the EAP. (See the **Coverage Continuation Rights Under COBRA** section for more information.)

You also may be able to convert your Life and/or Dependent Life to individual policies. See your coverage summaries for your Life, and Dependent Life, coverage for more information about your conversion rights.

Coverage Continuation Rights Under COBRA

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (**COBRA**), created the right to continue health care coverage (that is, medical, dental, vision, and EAP coverage, and/or Health Care FSA participation) under the Program.

This section:

- Contains important information about your right to COBRA continuation coverage;
- Explains when COBRA continuation coverage may become available; and
- Describes what you need to do to protect your right to receive COBRA continuation coverage.

Basic Pacific administers COBRA continuation coverage. You can contact Basic Pacific by calling the COBRA Help Desk at **1-800-699-7755** or by fax at **1-866-305-9622** or in writing at:

Basic Pacific
P.O. Box 2170
Rocklin, CA 95677

For additional information about your COBRA continuation coverage rights and obligations under the Program and under federal law, contact Basic Pacific by calling the COBRA Help Desk at **1-800-699-7755**.

Note: The ACA also allows individuals to purchase coverage through the health insurance marketplace (or exchange) following the loss of group health care plan coverage. The exchange may offer more or less expensive coverage options than are available to you through COBRA. If you elect COBRA, however, you may have to wait until the next annual insurance exchange enrollment period (usually starting in November) to obtain coverage through the exchange. Each individual situation is unique, so you should review your options carefully.

What COBRA Continuation Coverage Is

COBRA continuation coverage is a temporary continuation of health care coverage when it otherwise would end because of a “qualifying event.” (Specific qualifying events are listed later in this section.)

After a qualifying event, COBRA continuation coverage must be offered to each “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if you are covered under a health care plan on the day before the qualifying event and that coverage is lost because of the qualifying event. Qualified beneficiaries also include any children born to you or placed for adoption with you during the COBRA continuation period.

Qualified beneficiaries who elect COBRA continuation coverage must pay for it on an after-tax basis.

COBRA Qualified Beneficiaries

COBRA qualified beneficiaries include:

- You (the employee). You are eligible for COBRA continuation coverage if you lose your coverage under a health care plan because of one of the following qualifying events:
  - Your hours of employment are reduced; or
  - Your employment ends for any reason other than your gross misconduct.
- Your spouse. Your spouse is eligible for COBRA continuation coverage if he or she loses coverage under a health care plan because of one of the following qualifying events:
  - You die;
  - Your hours of employment are reduced;
  - Your employment ends for any reason other than your gross misconduct;
  - You become divorced or legally separated from your spouse; or
  - You enroll in Medicare benefits (under Part A, Part B, or both).
- Your dependent children. Your dependent children are eligible for COBRA continuation coverage if they lose coverage under a health care plan because of one of the following qualifying events:
  - You die;
  - Your hours of employment are reduced;
  - Your employment ends for any reason other than your gross misconduct;
  - You and your spouse divorce or legally separate;
  - The child loses eligibility for coverage as a "dependent child" under the health care plans; or
  - You enroll in Medicare benefits (under Part A, Part B, or both).

Note: Domestic partners and their children, if covered under the Plan's health benefits, are not "qualified beneficiaries" under COBRA. However, they are eligible to elect continued health coverage under the Plan that is similar to COBRA continuation coverage, under the following rules.

When COBRA Continuation Coverage Is Available

The health care plans offer COBRA continuation coverage to qualified beneficiaries only after PlanSource or Basic Pacific has been notified that a qualifying event has occurred. (See "Additional Information" in the **Other Plan Information** section for contact information.)

Notification of Qualifying Events

When the qualifying event is the end of employment or reduction in hours of employment or death of the employee, Lam Research will notify PlanSource/Basic Pacific of the qualifying event.

For other qualifying events (your divorce or legal separation or your spouse's or a dependent child's losing eligibility for coverage, or the occurrence of a second qualifying event), **you or the qualified beneficiary must notify PlanSource or Basic Pacific** within 60 days after the later of the date the qualifying event occurs or the date you lose coverage on account of the qualifying event. If you or the qualified beneficiary does not notify PlanSource or Basic Pacific within 60 days after this date, you or your dependent will not be entitled to elect COBRA continuation coverage.

How COBRA Continuation Coverage Is Offered

After PlanSource/Basic Pacific receives notice that a qualifying event has occurred, COBRA continuation coverage is offered to each qualified beneficiary.

Lam Research alerts PlanSource/Basic Pacific within 30 days. Then Basic Pacific provides a COBRA enrollment notice by mail within 14 days after receiving notice of the qualifying event.

Note: Each qualified beneficiary has an independent right to elect COBRA continuation coverage.

Enrolled employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. It is critical that you (or anyone who may become a qualified beneficiary) maintain a current address with PlanSource/Basic Pacific to ensure that you receive a COBRA enrollment notice following a qualifying event.

You and/or your eligible dependents have 60 days from the date coverage ends due to a qualifying event or from the date of your COBRA notice, whichever is later, to elect COBRA continuation coverage. If you or your eligible dependent does not elect COBRA continuation coverage within the applicable timeframe, you and/or your dependent will lose the opportunity to continue coverage under COBRA.

How Long COBRA Continuation Coverage Lasts

COBRA continuation coverage is a temporary continuation of coverage. Your dependents can continue coverage for up to 36 months when the qualifying event is:

- Your death;
- Your divorce; or
- A dependent child losing eligibility as a dependent child.

You and your dependents can continue coverage for up to 18 months when the qualifying event is the end of employment or reduction in your hours of employment.

Note: The two bullets that follow regarding "Disability extension of 18-month period of COBRA continuation coverage" and "Second qualifying event extension of 18-month period of COBRA continuation coverage" are not applicable to domestic partners.

The 18-month period of COBRA continuation coverage can be extended in two ways:

- **Disability extension of 18-month period of COBRA continuation coverage**. If a qualified beneficiary who is a member of your family and is covered under the health care plans is determined by the Social Security Administration to be disabled and you notify Basic Pacific in a timely manner, you and all other qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA

continuation coverage, for a maximum of 29 months, if all of the following conditions are met:

- — Your COBRA qualifying event was a termination of employment or reduction in hours;
- — The disability started at some time before the 60th day of COBRA continuation coverage and lasts at least until the end of the 18-month period of COBRA continuation coverage;
- — A copy of the Notice of Award from the Social Security Administration is provided to Basic Pacific within 60 days of receipt of the notice and before the end of the initial 18 months of COBRA continuation coverage; and
- — An increased premium of 150% of the monthly cost is paid, beginning with the 19th month of COBRA continuation coverage.

- **Second qualifying event extension of 18-month period of COBRA continuation coverage.** If another qualifying event occurs during the first 18 months of COBRA continuation coverage, your spouse and dependent children can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to Basic Pacific. This extension may be available to your spouse and any dependent children receiving COBRA continuation coverage if you die, become entitled to Medicare benefits (under Part A, Part B, or both), if you and your spouse divorce or are legally separated, or if your dependent child is no longer eligible under the health care plans as a dependent child, but only if the event would have caused your spouse and/or dependent child to lose coverage under the health care plans had the first qualifying event not occurred.

COBRA Qualifying Events

Qualifying Event	Maximum Continuation Period (Months) for:		
	You	Spouse	Child
You lose coverage because of reduced work hours	18	18	18
You terminate employment for any reason (other than gross misconduct)	18	18	18
You or your dependent is disabled, as defined by the Social Security Act, at the time of the qualifying event or during the first 60 days of COBRA continuation coverage	29 (initial 18 months, plus additional 11 months)	29 (initial 18 months, plus additional 11 months)	29 (initial 18 months, plus additional 11 months)
Your child no longer qualifies as a dependent	N/A	N/A	36
You die	N/A	36	36
You and your spouse divorce or legally separate	N/A	36	36

Medicare Extension for Your Dependents

If the qualifying event is your termination of employment or reduction in work hours and you become enrolled in Medicare (Part A, Part B, or both) within the 18 months before the qualifying event, your dependents may continue coverage through COBRA for up to 36 months after the date you become enrolled in Medicare. You may continue coverage through COBRA for up to 18 months from the date of your employment termination or reduction in work hours.

How Long Health Care FSA Participation Can Last Under COBRA

You and your eligible dependents may be able to continue participation in the Health Care FSA (not in the Dependent Care FSA) **for the remainder of the plan year** in which participation otherwise would end.

To qualify, you and your eligible dependents must elect COBRA continuation coverage within 60 days after the **later** of the date:

- Health Care FSA participation ends due to a qualifying event; or
- You receive your COBRA notice.

To continue Health Care FSA participation through COBRA, the following applies:

If the cost of COBRA continuation coverage for the remainder of the plan year does not exceed the amount the qualified beneficiary could recover in benefits for the remainder of the plan year (that is, the account is "under spent"), the qualified beneficiary may elect COBRA continuation coverage.

For example, you elect to contribute $1,200 to the Health Care FSA for the current plan year at a rate of $100 a month. You have a qualifying event on June 30 and have already submitted $400 in reimbursable expenses under the Health Care FSA. The amount of potential reimbursement remaining through the end of the plan year is $800 ($1,200 - $400 = $800), and the cost of COBRA continuation coverage for the six months remaining in the Plan Year is $612 ($100 a month x 6 months = $600 x 102% [see "What COBRA Continuation Coverage Costs" below] = $612). Since the cost of COBRA continuation coverage does not exceed the amount of potential reimbursement, you have the right to elect COBRA continuation coverage for Health Care FSA participation, but only for the period from the date of the qualifying event through the end of the plan year in which the qualifying event occurs.

If, on the other hand, you had submitted $900 in reimbursable expenses as of the date of the qualifying event, COBRA continuation coverage for Health Care FSA participation would not be offered because the cost of COBRA continuation coverage—$612—exceeds $300 ($1,200 - $900 = $300), the amount for which you could still be reimbursed for the plan year.

If you or your eligible dependent does not elect COBRA continuation coverage within the applicable timeframe, that individual will lose the opportunity to continue Health Care FSA participation under COBRA.

As described previously (See the **Flexible Spending Accounts (FSAs)** section), the Health Care FSA has a provision that permits up to $500 of the remaining balance in an active employee's Heath Care FSA at the end of the plan year to be automatically carried over for use in the following plan year.

This same carryover applies to a qualifying beneficiary. If a qualifying beneficiary elects COBRA for the Health Care FSA, but still has a balance at the end of the plan year, the qualifying beneficiary has the right to the carryover, with no further COBRA premium due.

What COBRA Continuation Coverage Costs

COBRA participants must pay monthly premiums for COBRA continuation coverage.

Premiums are based on the full cost of health benefits per covered person set at the beginning of the plan year, plus 2% for administrative costs. Dependents making separate elections are charged the same rate as a single employee electing COBRA continuation coverage. An increased premium of 150% of the cost of health benefits must be paid in the case of disability, beginning with the 19th month of COBRA continuation coverage.

Your first payment is due when you enroll, but you have a 45-day grace period from the postmark of the date you mail your enrollment form to make the initial payment. The initial payment includes COBRA continuation coverage for the current month, plus any previous month(s). COBRA continuation coverage is not effective until the COBRA premium is actually paid; if payment is not made with enrollment, COBRA continuation coverage will be retroactively activated back to the date of enrollment upon receipt of payment.

Ongoing monthly payments are due on the first of each month, but there is a 30-day grace period (for example, June payment is due June 1, but will be accepted if postmarked by June 30).

Changing Your COBRA Continuation Coverage Election

If you or your dependent elects COBRA continuation coverage:

- You or your dependent can keep the same level of health coverage you had as an active employee or choose a lower level of health coverage.
- Your or your dependent's COBRA continuation coverage is effective as of the date of the qualifying event. However, if you waive COBRA continuation coverage and then revoke the waiver within the 60-day election period, your elected COBRA continuation coverage begins on the date you revoke your waiver.

- You or your dependent may change your COBRA continuation coverage:
  - During the Open Enrollment period;
  - If you have a qualifying life event; or
  - If you have a change in circumstance recognized by the IRS and Lam Research.
- You may enroll any newly-eligible spouse or child under Plan rules.

When COBRA Continuation Coverage Ends

COBRA continuation coverage ends before the maximum continuation period if **one** of the following occurs:

- You or any of your enrolled dependents becomes covered under another health care plan not offered by Lam Research, provided the other plan does not have a legally valid pre-existing condition exclusion or limitation affecting the qualified beneficiary;
- You or your enrolled dependent does not make contributions by the due date as required;
- Lam Research stops providing health care coverage to any employee; or
- The Social Security Administration determines that the qualified beneficiary is no longer disabled (if entitled to 29 months of COBRA continuation coverage under the special disability rule), in which case the extended portion of the COBRA continuation coverage will end with the month that begins more than 30 days after the Social Security Administration's determination.

COBRA continuation coverage also may be terminated for any reason the health plan would terminate coverage of a participant or beneficiary not receiving COBRA continuation coverage (such as fraud).

Trade Act

Federal law provides for a tax credit for certain individuals who become eligible for Trade Adjustment Assistance ("TAA") benefits, particularly in the event of terminations of employment that are related to international trade, and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation ("PBGC"). Under these tax provisions, eligible individuals can either take a tax credit or get advance payment for a portion of the premiums paid for qualified health coverage, including COBRA continuation coverage.

In addition, if you initially decline COBRA continuation coverage and, within 60 days after your loss of health coverage under the Program, you are deemed eligible, by the U.S. Department of Labor or a state labor agency, for TAA benefits and the tax credit, you may be eligible for a special 60-day COBRA election period. The special election period begins on the first day of the month that you become TAA benefits-eligible if the election is made within six (6) months after the date of the TAA-related loss of health coverage. If you elect COBRA continuation coverage during this special election period, COBRA continuation coverage will be effective on the first day of the special election period and end on the same day that it would have ended if COBRA continuation coverage had been elected during the regular election period available as a result of your trade-related termination of employment or reduction in work hours (generally, 18

months, unless you experience one of the events discussed under "When COBRA Continuation Coverage Ends" above).

If you receive a determination that you are TAA benefits-eligible, you must notify the Plan Administrator immediately. More information about these TAA provisions is available at www.doleta.gov/tradeact.

Cal-COBRA Under Kaiser California Plans Only

Once a qualified beneficiary's federal COBRA continuation coverage of 18 months is exhausted, California's continuation coverage law, Cal-COBRA, permits that qualified beneficiary to elect to extend continuation coverage for another 18 months. If a qualified beneficiary's federal COBRA continuation coverage lasted 36 months, that individual cannot obtain more continuation coverage under Cal-COBRA.

Note: The opportunity to extend continuation coverage under Cal-COBRA is only available for qualified beneficiaries participating in the Kaiser CDHP or Kaiser HMO Medical Plan option.

See your Kaiser Permanente coverage summary or contact Kaiser Permanente directly for more information about how to elect Cal-COBRA continuation coverage and the costs associated with such coverage.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I Enroll In Medicare Instead Of COBRA Continuation Coverage After My Group Health Plan Coverage Ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[3] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may

[3] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare

Claims for Plan Benefits

Disagreements about benefit eligibility or benefit amounts can arise. This section explains the steps you or your authorized representative is required to take to file an ERISA claim or appeal.

Each of the coverage summaries describes the procedure for submitting claims under that portion of the Plan and for requesting a review in the event that any claim for benefits is denied (that is, appealing the claim denial).

All claims for benefits must be submitted on the claim forms made available by the relevant Claims Administrator or insurance company, in accordance with the instructions provided by the Claims Administrator or insurance company. If the Claims Administrator or insurance company of the benefit plan is unable to resolve the disagreement, Lam Research has formal appeal procedures in place for Employee Retirement Income Security Act of 1974 (ERISA) covered plans.

Timeframes for Filing Claims

You must request your benefits or file a claim within one year of the receipt of service or onset of illness or injury, whichever is later, or your claim will be denied. If you are filing a claim for a fully-insured benefit, the insurance company will specify the timeframe for submitting claims. If no timeframe is specified, it is presumed that the timeframe will be one year.

Health Care Claims and Appeals Procedures

The claims and appeals procedure applicable to your self-insured ERISA-governed health care benefits (certain medical, prescription drugs, dental, and vision plans, and the Health Care FSA) are covered here.

Since some of the Medical Plan options and the EAP are fully-insured, it's critical that you contact the applicable insurance company for its specific claims and appeals procedures. The procedures set forth in this wrap-around SPD with respect to your insured medical and EAP benefits are ***illustrative*** of ERISA's procedures. The insurance company, as the claims and appeals fiduciary, may have slightly different procedures that comply, at a minimum, with the procedures outlined here.

For health care claims, the procedure is slightly different, depending on whether you have an "eligibility" claim ("eligibility claim") or a "benefit" claim ("benefit claim").

Eligibility Claim

An "eligibility claim" is a claim to participate in a benefit plan or plan option or to change an election to participate during the plan year.

To file an eligibility claim, the claimant should send a letter or email to the Lam Research Benefits Department stating that he or she wants to file an eligibility claim. (A mere inquiry about eligibility does not initiate the ERISA claims and appeals procedures described below.) The Lam Research Benefits Department will then provide the claimant with the information needed to file the eligibility claim.

Benefit Claim

A "benefit claim" is a claim for a particular benefit under a benefit plan. It typically will include a claimant's initial request for benefits.

Health care benefit claims and appeals are divided into four categories:

- **Post-service**. A claim for reimbursement of services already received. This is the most common type of claim.
- **Pre-service**. A claim for a benefit for which prior authorization is required by the plan.
- **Concurrent care**. A claim for ongoing treatment over a period of time or a number of treatments. For example, if the claimant has been authorized to receive seven treatments from a therapist and, during the treatment, the therapist suggests 10 treatments, the claim is a concurrent care claim. Some concurrent care claims also are urgent care claims.
- **Urgent care**. A claim for medical care or treatment that, if the longer timeframes for non-urgent care were applied, the delay:
  - Could seriously jeopardize the health of the claimant or his or her ability to regain maximum function; or
  - In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that could not be managed without the care or treatment that is the subject of the claim.

The chart that follows summarizes the steps and timeframes for each type of health care claim. (See also "Additions to the Benefit Claim Procedures Under the Affordable Care Act for Medical Benefits" following the chart.)

Step 1: Filing a Claim (Internal Claims and Appeals Process)
How to File a Benefit Claim The claimant (or his or her authorized representative) must write to the health care plan's Claims Administrator. See "Additional Information" in the **Other Plan Information** section for the Claims Administrator's contact information or, if applicable, refer to the telephone number and/or website shown on the back of the health care insurance card. The claimant must include: • A description of the benefits for which the claimant is applying; • The reason(s) for the request; and • Relevant documentation. If the benefit claim is considered urgent, the claimant should call the health care plan or insurance company and state that he or she is filing an urgent care claim.
What Happens If the Claimant Does Not Follow Procedure If the claimant misdirects his or her claim but provides sufficient information to an individual who is responsible for benefits administration, the claimant will be notified of the proper procedure.

General Procedure	Post-Service Claim	Pre-Service Claim	Concurrent Care Claim	Urgent Care Claim
The claimant must receive notification within these timeframes following receipt of the claim information.	Not applicable. Response timeframe does not begin until claim is properly filed.	5 days	Not applicable. Response timeframe does not begin until claim is properly filed. If claim involves urgent care: 24 hours.	24 hours
When the Claimant Will Be Notified of the Claim Decision				
General Procedure	**Post-Service Claim**	**Pre-Service Claim**	**Concurrent Care Claim**	**Urgent Care Claim**
The claimant will be notified of the claim decision within these timeframes following receipt of the Claim Initiation Form or the Claims Administrator's receipt of the claim letter.	30 days. This period may be extended for 15 days. The claimant will be notified within the initial 30-day period if an extension is needed.	15 days. This period may be extended for an additional 15 days. The claimant will be notified within the initial 15-day period if an extension is needed.	Sufficiently in advance to allow the claimant to appeal and obtain a response to reduction or denial. If urgent, within 24 hours (if the claimant submits the claim at least 24 hours before reduction or denial); otherwise, within 72 hours.	As soon as possible, taking into account the medical exigencies, but not later than 72 hours.
Failure to Provide Sufficient Information Procedure				
If the claimant does not provide sufficient information, the claim **may** be decided based on the information provided. Otherwise, the Lam Research Benefits Committee or Claims Administrator may request additional information before deciding the claim.				

General Procedure	Post-Service Claim	Pre-Service Claim	Concurrent Care Claim	Urgent Care Claim
Timeframe for notifying the claimant that additional information is needed.	30 days	15 days	Decision is based on information provided. If the claim is urgent, see the urgent care timeframe.	As soon as possible, but not later than 24 hours.
Timeframe for the claimant to provide the additional information. (Otherwise, the claim is decided based on information originally provided.)	45 days	45 days		As soon as possible, but not later than 48 hours.
If the claimant provides additional information, the claimant will be notified of the decision by the Lam Research Benefits Department or Claims Administrator within these timeframes.	The timeframe remaining for the initial claim.	The timeframe remaining for the initial claim.		48 hours

How the Claimant Will Be Notified of the Claim Decision

The claimant will be notified in writing. For benefit claims that are approved, this notification is commonly referred to as an Explanation of Benefits (EOB). If the claim is denied, in whole or in part, the denial notice will contain the following information:

- The specific reason(s) for the denial;
- The benefit plan provisions on which the denial was based;
- Any additional material or information the claimant may need to submit to complete the claim;
- Any internal procedures or clinical information on which the denial was based (or a statement that this information will be provided, free of charge, upon request); and
- The benefit plan's appeal procedures.

If the claim is urgent and it is denied, the Claims Administrator will notify the claimant by telephone with written notification within three days of the denial decision. The denial notice also will explain the expedited review process.

Under the Affordable Care Act, *medical* claim denials will also include:

- Information sufficient to identify the claim involved (date of service, the health care provider, claim amount [if applicable], and, upon request, the availability of the diagnosis and treatment codes and their corresponding meanings); and
- The availability of and contact information for any office of health insurance consumer assistance or ombudsman available to assist with the appeals process.

Further, the notice will be written in a culturally and linguistically appropriate manner. Depending on where the claimant lives, the claimant may be able to receive the denial notice in Spanish, Tagalog, Chinese, or Navajo.

If the Lam Research Benefits Department or insurance company relies on new evidence to deny the claim, the claimant will be notified in advance, free of charge, with the rationale so that he or she can respond in advance of the final internal adverse benefit determination.

The claimant has a right to review his or her claim file.

Step 2: Appealing a Denied Claim (Internal Claims and Appeals Process)

About Appeals and the Claims Fiduciary

Before the claimant can bring any action at law or in equity to recover benefit plan benefits, the claimant must exhaust this appeals process. Specifically, the claimant must file an appeal or appeals, as explained in this Step 2, and the appeal(s) must be finally decided by the claims fiduciary. The claims fiduciary is authorized to finally determine appeals and interpret the terms of the benefit plan in its sole discretion. All decisions by the claims fiduciary are final and binding on all parties.

The Plan Administrator is the claims fiduciary for all **eligibility** claims and appeals.

The Plan Administrator has delegated its authority to finally determine **benefit** claims and appeals to the Claims Administrators identified under "Additional Information" in the **Other Plan Information** section.

How to File an Appeal

If the claim is denied, in whole or in part, and the claimant wants to appeal it, the claimant must file an appeal. The claimant should include:

- A copy of the claim denial notice;
- The reason(s) for the appeal; and
- Relevant documentation.

The claimant may request access, free of charge, to all documents relating to the appeal.

If the claimant has an appeal, he or she should write to the contact identified in the claim denial notice.

<table>
<tr><th>General Procedure</th><th>Post-Service Claim</th><th>Pre-Service Claim</th><th>Concurrent Care Claim</th><th>Urgent Care Claim</th></tr>
<tr><td>The claimant must file the appeal within these timeframes following the date he or she receives notice of the denied claim.</td><td>180 days</td><td>180 days</td><td>Within a reasonable period of time, considering the timeframe scheduled for reduction or termination of benefits.</td><td>180 days
The claimant may verbally file the appeal. Ask the Lam Research Benefits Department or Claims Administrator (as applicable) to give instructions on filing the appeal. The claimant must identify that he or she is appealing an urgent care claim.</td></tr>
<tr><td colspan="5">Reviewing the Appeal
The individual/committee (and any medical expert) reviewing the appeal will be independent from the individual/committee who reviewed the initial claim. In addition, if the appeal involves a medical judgment, the Claims Administrator will consult with a health care professional who has appropriate relevant experience and who was not consulted in connection with the denied claim that is the subject of the appeal or a subordinate of that person. The claimant is entitled to learn the identity of such an expert, upon request. No deference to the initial claim denial will be afforded upon appeal.</td></tr>
<tr><td colspan="5">When the Claimant Will Be Notified of the Appeal Decision
The Lam Research Benefits Department's or Claims Administrator will notify the claimant of the decision on the appeal. Note: The Lam Research Benefits Department provides only one level of appeal for eligibility claims.</td></tr>
</table>

General Procedure	Post-Service Claim	Pre-Service Claim	Concurrent Care Claim	Urgent Care Claim
The claimant will be notified of the decision on the appeal within these timeframes following receipt of the appeal.	60 days, if the Claims Administrator provides one level of mandatory appeal.[4] 30 days, if the Claims Administrator provides two levels of mandatory appeal.	30 days, if the Claims Administrator provides one level of mandatory appeal.[3] 15 days, if the Claims Administrator provides two levels of mandatory appeal.	Before a reduction or termination of benefits would occur. 72 hours[5] if the concurrent claim involves urgent care.	72 hours, if the Claims Administrator provides one level of mandatory appeal.[3] 15 days, if the Claims Administrator provides two levels of mandatory appeal.

How the Claimant Will Be Notified of the Appeal Decision

Once a decision has been made regarding the appeal, the claimant will be notified in writing.

If the appeal is **denied**, in whole or in part, the denial notice will contain:

- The specific reason(s) for the denial;
- A statement regarding the documents to which the claimant is entitled, upon request and free of charge;
- An explanation of the voluntary appeal procedures (external review for Medical Plan benefit appeals), if any, and the claimant's right to bring a civil action under Section 502(c) of ERISA;
- Any internal procedures or clinical information on which the denial was based (or a statement that this information will be provided free of charge, upon request);
- The plan provisions on which the denial was based; and
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency."

Under the Affordable Care Act, *medical* claim denials will also include:

- Information sufficient to identify the claim involved (date of service, the health care provider, claim amount [if applicable], and, upon request, the availability of the diagnosis and treatment codes and their corresponding meanings);
- The availability of and contact information for any office of health insurance consumer assistance or ombudsman available to assist with the appeals process; and

[4] If the Claims Administrator provides more than one level of mandatory appeal, the response timeframe is shorter, as noted above. The Claims Administrator also may offer a **voluntary** level of appeal. You are not required to file a voluntary appeal before filing a civil action; however, you may find it helpful. The Claims Administrator will provide you with information regarding its voluntary appeal, if applicable. A voluntary appeal is not subject to the same timeframes as mandatory appeals.

[5] If the Claims Administrator provides two mandatory appeals, both appeals must occur within the 72-hour timeframe.

- Information pertaining to the claimant's right to an external review (and if applicable, any second level of internal appeal).

Further, the notice will be written in a culturally and linguistically appropriate manner. Depending on where the claimant lives, the claimant may be able to receive the denial notice in Spanish, Tagalog, Chinese, or Navajo.

Step 3: Additional Appeals

Eligibility Claims

For eligibility claims, no further appeals are available.

Benefit Claims

When Anthem is the Claims Administrator, only one, mandatory first level appeal of a benefit claim is available. If the claimant is dissatisfied with Anthem's mandatory first level appeal decision, a voluntary second level appeal may be available. If the outcome of the mandatory first level appeal is adverse to the claimant, he or she may be eligible for an independent **external** review. The claimant is not required to complete a voluntary second level appeal before submitting a request for an independent external review. No lawsuit or legal action of any kind related to a benefit decision may be filed by the claimant in a court of law or in any other forum, unless it is begun within three years of Anthem's decision on the claim or other request for benefits. If Anthem decides an appeal is untimely, Anthem's latest decision on the merits of the underlying claim or benefit request is the final decision date. The claimant must exhaust Anthem's **internal** appeals procedure, but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against Anthem and/or the Plan.

Other Claims Administrators may offer:

- One mandatory appeal;
- Two mandatory appeals; or
- One mandatory appeal and one voluntary appeal.

If the Claims Administrator offers one level of mandatory appeal, the Claims Administrator will not review the matter again, unless new facts are presented. The claimant has a right to bring a civil action.

If the Claims Administrator offers two levels of mandatory appeal, the claimant may appeal to the Claims Administrator a second time. The claimant must submit the second appeal within 180 days from the date that he or she received the denial of the first appeal. In addition, the Claims Administrator will provide the claimant with an independent medical review, upon request, in conjunction with this second and final appeal.

If the Claims Administrator offers one level of mandatory appeal and one level of voluntary appeal, the claimant may appeal to the Claims Administrator a second time. The Claims Administrator will provide the claimant with information regarding its voluntary appeal procedure, if it applies. As indicated in "footnote 3" above, the claimant is not required to file a voluntary appeal before filing a civil action; however, the claimant may find it helpful.

No lawsuit or legal action of any kind related to a benefit decision may be filed by the claimant in a court of law or in any other forum, unless it is begun within three years of the Claims Administrator's decision on the claim or other request for benefits. If the Claims Administrator decides an appeal is untimely, the latest decision on the merits of the underlying claim or benefit request is the final decision date. The claimant must exhaust the Claims Administrator's **internal** appeals procedure, but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the Claims Administrator and/or the Plan.

If the Claims Administrator Provides Two Levels of Mandatory Appeal

The claimant will receive a response from the Claims Administrator following his or her receipt of the second and final appeal request. If this appeal is denied, the Claims Administrator will

not review the claim again, unless new facts are presented. The claimant has a right to bring a civil action.

Additions to the Benefit Claim Procedures Under the Affordable Care Act for Medical Benefits

In addition to the above claims and appeals procedures, and because the Company-sponsored Medical Plan options are governed by the Affordable Care Act (ACA), the following also applies to the claims and appeals process for the Medical Plan options:

Steps 1 and 2 of the claims and appeals process are referred to as the "internal claims and appeals process."

- Generally, medical benefit claims, including claims regarding a rescission of coverage (see "Rescission of Coverage" in the **Eligibility** section) are eligible for an external review by an independent review organization (IRO). (This does not apply to eligibility claims.)
  - The claimant will be provided with information regarding the external review process if the claim is still denied after completing Step 2 of the internal claims and appeals process. The claimant cannot request an external review unless he or she has exhausted the internal appeals process (received a denial at Steps 1 and 2). The details applicable to the external review process can be obtained from the Medical Plan Claims Administrator.
  - To be eligible for the external review, the claimant's request must be filed within four months after the date of receipt of a notice of a final internal adverse benefit determination (completion of Step 2).
  - The medical benefit claim must involve:
    - Medical judgment (that is, the Medical Plan option's requirements for medical necessity, health care setting, level of care, etc.);
    - Effectiveness of a covered benefit;
    - A determination that a treatment is experimental or investigational, excluding claims that involve only contractual or legal interpretation without any use of medical judgment as determined by the external reviewer; or
    - A rescission (a retroactive termination of medical coverage).
  - Within five business days following the date of receipt of the external review request, the Medical Plan must complete a preliminary review of the request to determine whether:
    - The claimant is or was covered under the Medical Plan at the time the medical care, item, or service was requested;
    - The adverse benefit determination does not relate to the claimant's failure to meet the eligibility requirements under the terms of the Medical Plan, except for a rescission (again, external review does not apply to eligibility-type requests or claims);
    - The claimant has exhausted the Medical Plan's internal appeal process; and

– The claimant has provided all of the information and forms required to process the external review.

— The Claims Administrator must assign an IRO to conduct the external review. The IRO will timely notify the claimant, in writing, of the request's acceptance for external review. Specific timeframes for corresponding with claimant apply based on interim final rules issued by the U.S. Department of Labor and related agencies.

Lam Research continues to monitor guidance issued by the U.S. Department of Labor and related agencies. If you have any questions regarding the ERISA claims and appeals process, the U.S. Department of Labor website at **http://www.dol.gov/ebsa/healthreform/** will maintain up-to-date information, or you can contact the Claims Administrator.

Disability Claims and Appeals Procedures

The claims and appeals procedures for disability claims are slightly different, depending on whether the claimant has an eligibility claim for benefits or a benefit claim. An "eligibility claim" is a claim for benefits to participate in a plan or plan option or to change an election to participate during the plan year. An eligibility claim requires the claimant to submit a Claim Initiation Form. (A mere inquiry about eligibility does not initiate the ERISA claims and appeals procedures described below.) A "benefit claim" is a claim for a particular benefit under a plan. It typically will include the initial request for benefits.

Step 1: Filing a Claim	
How to File a Claim	
Disability Plan Eligibility Claims Procedure	**Disability Plan Benefit Claims Procedure**
To file an **eligibility** claim, request a Claim Form from TRISTAR (STD) or Standard (LTD). The claimant (or authorized representative) must return the form to the Lam Research Benefits Department at the address listed on the form. The claimant must include: • A description of the benefits he or she is applying for; • The reason(s) for the request; and • Relevant documentation.	■ To file a **benefit** claim, call TRISTAR at **844-610-1885 (Lam Research) / 1-844-610-1886 (Silfex)** for a VDI or STD claim. Call Standard at**1-888-937-4783**) for an LTD claim form. Mail the completed claim form to the address listed on the form. The claimant must include: • A description of the benefits he or she is applying for; • The reason(s) for the request; and • Relevant documentation.
When the Claimant Will Be Notified of the Claim Decision The claimant will be notified of the claim decision within 45 following receipt of the written claim (75 or 105 days, when special circumstances apply).	

Failure to Provide Sufficient Information

If the claimant does not provide sufficient information, the claim may be decided based on the information provided. However, the claimant may be notified within either the 75- or 105-day extension period that additional information is needed.

The claimant will have 45 days to provide the additional information. Otherwise, the claim will be decided based on the information originally provided.

If the claimant provides additional information, a decision will be made and the claimant will be notified of the decision no later than 105 days after the initial claim was submitted, not including the time that it takes to provide the additional information.

How the Claimant Will Be Notified of the Claim Decision

If the claim is **approved**, the claimant will be notified in writing.

If the claim is **denied**, in whole or in part, the written denial notice will contain the following information:

- The specific reason(s) for the denial;
- The plan provisions on which the denial was based;
- Any additional material or information the claimant may need to submit to complete the claim;
- Any internal procedures (or clinical information if applicable) on which the denial was based (or a statement that such information will be provided free of charge, upon request); and
- The plan's appeal procedures.

Step 2: Appealing a Denied Claim

About Appeals and the Claims Fiduciary

Disability Plan Eligibility Claims Procedure	Disability Plan Benefit Claims Procedure
Before the claimant can bring any action at law or in equity to recover plan benefits, the claimant must exhaust this process. Specifically, the claimant must file an appeal as explained in this Step 2, and the appeal must be finally decided by the Lam Research Benefits Department. The Lam Research Benefits Department is the claims fiduciary and is authorized to finally determine eligibility appeals and interpret the terms of the plan in its sole discretion. All decisions by the Lam Research Benefits Department are final and binding on all parties.	Before the claimant can bring any action at law or in equity to recover plan benefits, the claimant must exhaust this process. Specifically, the claimant must file an appeal as explained in this Step 2 and the appeal must be finally decided by the Claims Administrator (TRISTAR/Standard). The Plan Administrator has delegated its authority to finally determine claims to TRISTAR/Standard. As such, TRISTAR/Standard is the claims fiduciary and is authorized to finally determine benefit appeals and interpret the terms of the plan in its sole discretion. All decisions by TRISTAR/Standard are final and binding on all parties, unless it is later proven that TRISTAR/Standard's decision was an abuse of discretion.

How to File an Appeal

If the claim is denied and the claimant wants to appeal it, the claimant must file the appeal within 180 days from the date he or she receives written notice of the denied claim. The claimant must include:

- A copy of the claim denial notice;
- The reason(s) for the appeal; and
- Relevant documentation.

The claimant may request access, free of charge, to all documents relating to the appeal.

Disability Plan Eligibility Claims Procedure	Disability Plan Benefit Claims Procedure
To file the appeal, the claimant should write to the address listed on the claim denial notice. The individual/committee reviewing the appeal will be independent from the individual/ committee who reviewed the initial claim.	To file the appeal, the claimant should write to TRISTAR or Standard at: The Standard 900 SW Fifth Avenue, Portland OR 97204 TRISTAR P.O. Box 32363 Long Beach, CA 90832
Reviewing the Appeal	
The individual/committee reviewing the appeal will be independent from the individual/ committee who reviewed the claim.	The review of the appeal will be conducted by an individual who is neither the individual who made the initial decision to deny the claim that is the subject of the appeal, nor the subordinate of such individual. No deference to the initial claim denial will be afforded upon appeal. In addition, if the appeal involves a medical judgment, TRISTAR or Standard will consult with a health care professional who has appropriate training and experience and who was not consulted in connection with the denied claim that is the subject of the appeal. The health care professional will not be the subordinate of any health care professional(s) consulted in connection with the claim that resulted in the denial. The claimant will be provided with the identity of any medical or vocational expert(s) whose advice was obtained in connection with the claim denial, without regard to whether the advice was relied upon in making such determination. In some instances, TRISTAR or Standard may need the claimant to agree to an independent medical exam (IME).
When the Claimant Will Be Notified of the Appeal Decision The Lam Research Benefits Department's or Claims Administrator will notify the claimant of the decision on the appeal within 45 days after receipt of the appeal (90 days when special circumstances apply).	

How the Claimant Will Be Notified of the Appeal Decision

The claimant will be notified in writing. If the appeal is denied, in whole or in part, the written denial notice will contain:

- The specific reason(s) for denial;
- The plan provisions on which the denial was based;
- Any internal procedures (or clinical information if applicable) on which the denial was based (or a statement that it will be provided free of charge, upon request);
- A statement regarding the documents that the claimant is entitled to receive;
- A statement of the claimant's right to bring an action under Section 502(a) of ERISA (benefit claims only);
- The plan's voluntary appeal procedures, if any (eligibility claims only); and
- The following statement: "You and your plan may have other voluntary dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state's insurance regulatory agency."

Step 3: Additional Appeals

How to Proceed If Necessary

Disability Plan Eligibility Claims Procedure	Disability Plan Benefit Claims Procedure
The decision on the claimant's appeal is final. As a result, the Lam Research Benefits Department will not review the claim again, unless new facts are presented. The claimant has a right to bring a civil action.	The decision on the claimant's appeal is final. The claimant has a right to bring a civil action under Section 502(a) of ERISA.
No lawsuit or legal action of any kind related to an eligibility decision may be filed by the claimant in a court of law or in any other forum, unless it is begun within three years of the decision on the claim. The claimant must exhaust the appeals procedure before filing a lawsuit or taking other legal action of any kind against the Plan.	No lawsuit or legal action of any kind related to a benefit decision may be filed by the claimant in a court of law or in any other forum, unless it is begun within three years of the decision on the claim or other request for benefits. The claimant must exhaust the appeals procedure before filing a lawsuit or taking other legal action of any kind against the Claims Administrator and/or the Plan.

Additional Claims and Appeals Procedures for Disability Claims

This section describes additional procedures pertaining to disability benefit claims and appeals made under the Plan.

Claims and appeals will be determined in a manner designed to ensure the independence and impartiality of the individuals involved in making the benefit determination. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims administrator or medical or vocational expert) will not be made based upon the likelihood that the individual will support the denial of benefits.

An **adverse benefit determination** means:

- A denial, reduction, termination of, or failure to provide or make payment (in whole or in part) for a benefit, including any denial, reduction, termination of, or failure to provide or make payment that is based on a determination of the claimant's eligibility to participate in the Plan.
- Any rescission of the claimant's coverage (whether or not the rescission has an adverse effect on any particular benefit at that time). For this purpose, "rescission" means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required contributions towards the cost of coverage.

A document, record, or other information will be considered **relevant to a claim** if it:

- Was relied upon in making the benefit determination;
- Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the determination;
- Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination; or
- Constitutes a statement of policy or guidance concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether the advice or statement was relied upon in making the benefit determination.

The Plan will be providing relevant notices in a **culturally and linguistically appropriate manner** when it:

- Provides oral language services (such as a telephone customer assistance hotline) that include answering questions in any applicable non-English language and providing assistance with filing claims and appeals (including an external review) in any applicable non-English language;
- Provides, upon request, a notice in any applicable non-English language; and
- Includes in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Plan.

With respect to an address in any United States county to which a notice is sent, a non-English language is an applicable non-English language if 10 percent or more of the population residing in that county is literate only in the same non-English language, as determined in guidance published by the United States Secretary of Labor.

The Plan Administrator's **notification of any adverse benefit determination** will also include:

- A discussion of the determination, including an explanation of the basis for disagreeing with or not following:
  - The views presented by the claimant of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
  - The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the determination, without regard to whether the advice was relied upon in making the determination; and

  - A disability determination regarding the claimant made by the Social Security Administration;
- If the determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that the explanation will be provided free of charge upon request;
- Either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the determination or, alternatively, a statement that such rules, guidelines, protocols, standards, or criteria of the Plan do not exist; and
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The notification will be provided in a culturally and linguistically appropriate manner.

For the claimant's opportunity to **appeal an adverse benefit determination**, the Plan will also provide:

- The claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by (or at the direction of) the Plan, insurer, or other person making the benefit determination on review, as soon as possible and sufficiently in advance of the date on which the notice of determination is required to be provided to give the claimant a reasonable opportunity to respond prior to that date; and
- The claimant, free of charge, with any new or additional rationale, as soon as possible and sufficiently in advance of the date on which the notice of determination is required to be provided to give the claimant a reasonable opportunity to respond prior to that date.

The Plan Administrator's **notification of the benefit determination on review** will also include:

- A description of any applicable contractual limitations period that applies to the claimant's right to bring a civil action under ERISA Section 502(a), including the calendar date on which the contractual limitation period expires for the claim;
- A discussion of the determination, including an explanation of the basis for disagreeing with or not following:
  - The views presented by the claimant of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
  - The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the determination, without regard to whether the advice was relied upon in making the determination; and
  - A disability determination regarding the claimant made by the Social Security Administration;
- If the determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's

medical circumstances, or a statement that the explanation will be provided free of change upon request; and

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

The notification will be provided in a culturally and linguistically appropriate manner.

If the Plan fails to strictly adhere to all the claims and appeals procedures, the claimant shall be **deemed to have exhausted these claims and appeals procedures** (except as provided in below), and the claimant may pursue any available remedies under ERISA Section 502(a) on the basis that the Plan failed to provide reasonable claims and appeals procedures that would yield a decision on the merits of the claim. If the claimant chooses to pursue remedies under ERISA Section 502(a) under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

However, these claims and appeals procedures will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the claimant, as long as the Plan demonstrates that the violation was for good cause or due to matters beyond the Plan’s control and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the claimant. The claimant may request a written explanation of the violation from the Plan, and the Plan will provide the explanation within 10 days, including a specific description of its basis, if any, for asserting that the violation should not cause these claims and appeals procedures to be deemed exhausted. If a court rejects the claimant's request for immediate review on the basis that the Plan met the standards for this exception, the claim shall be considered as re-filed on appeal upon the Plan's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Plan will provide the claimant with notice of the resubmission.

All Other ERISA-Related Benefit Claims and Appeals Procedures

The following explains the steps the claimant or authorized representative is required to take to file an ERISA claim or appeal for all other ERISA-related benefit claims, such as life insurance. The procedure is slightly different, depending on whether the claimant has an eligibility claim for benefits or a benefit claim. An “eligibility claim” is a claim for benefits to participate in a plan or plan option or to change an election to participate during the plan year. An eligibility claim requires the claimant to submit a Claim Initiation Form. A mere inquiry about eligibility does not initiate the ERISA claims and appeals procedures described below. A “benefit claim” is a claim for a particular benefit under a plan. It typically will include the initial request for benefits.

Step 1: Filing a Claim	
How to File a Claim	
Eligibility Claims Procedure	**Benefit Claims Procedure**
To file an **eligibility** claim, request a Claim Initiation Form from the Lam Research Benefits Department. The claimant (or authorized representative) must return the form to the Lam Research Benefits Department at the address listed on the form. The claimant must include: • A description of the benefits for which he or she is applying; • The reason(s) for the request; and • Relevant documentation.	To file a **benefit** claim, the claimant (or authorized representative) should write to the Claims Administrator for the plan. The claimant must include: • A description of the benefits for which he or she is applying; • The reason(s) for the request; and • Relevant documentation. See "Additional Information" in the **Other Plan Information** section for the Claims Administrator's contact information.
When the Claimant Will Be Notified of the Claims Decision The claimant will be notified of the decision within 90 days following receipt of the written claim (180 days when special circumstances apply).	
Failure to Provide Sufficient Information The claimant will be notified of the deadline to submit additional information, if applicable.	
How the Claimant Will Be Notified of the Claim Decision If the claim is **approved**, the claimant will be notified in writing. If the claim is **denied**, in whole or in part, the written denial notice will contain this information: • The specific reason(s) for the denial; • The plan provisions on which the denial was based; • Any additional material or information the claimant may need to submit to complete the claim; and • The plan's appeal procedures.	

Step 2: Appealing a Denied Claim	
About Appeals and the Claims Fiduciary	
Before the claimant can bring any action at law or in equity to recover plan benefits, the claimant **must** exhaust this process. Specifically, the claimant must file an appeal as explained in this Step 2 and the appeal must be finally decided by the Lam Research Benefits Department. As the claims fiduciary, the Lam Research Benefits Department is authorized to finally determine eligibility appeals and interpret the terms of the plan in its sole discretion. All decisions by the Lam Research Benefits Department are final and binding on all parties.	Before the claimant can bring any action at law or in equity to recover plan benefits, the claimant **must** exhaust this process. Specifically, the claimant must file an appeal as explained in this Step 2 and the appeal must be finally decided by the Claims Administrator. Lam Research has delegated its authority to finally determine claims to the Claims Administrator (TRISTAR/Standard). As such, TRISTAR/Standard is the claims fiduciary and is authorized to finally determine benefit appeals and interpret the terms of the plan in its sole discretion. All decisions by TRISTAR/Standard are final and binding on all parties.

How to File an Appeal	
If the claim is denied and the claimant wants to appeal it, the claimant must file the appeal within 180 days from the date you receive written notice of your denied claim. You should include: • A copy of the claim denial notice; • The reason(s) for the appeal; and • Relevant documentation. The claimant may request access, free of charge, to all documents relating to the appeal.	
Eligibility Claims Procedure	**Benefit Claims Procedure**
To file the appeal, the claimant should write to the address listed on the claim denial notice.	To file the appeal, the claimant should write to the Claims Administrator for the plan.
When the Claimant Will Be Notified of the Appeal Decision	
The Lam Research Benefits Department or Claims Administrator will notify the claimant of the decision on the appeal within 60 days after receipt of the appeal (120 days when special circumstances apply).	
How the Claimant Will Be Notified of the Appeal Decision	
The claimant will be notified in writing. If the appeal is denied, in whole or in part, the written denial notice will contain: • The specific reason(s) for denial; • The plan provisions on which the denial was based; • A statement regarding the documents that the claimant is entitled to receive; and • A statement of the claimant's right to bring an action under Section 502(a) of ERISA (benefit claims only).	
Step 3: Additional Appeals	
How to Proceed If Necessary	
The decision on the claimant's appeal is final. As a result, the Lam Research Benefits Department or Claims Administrator will not review the matter again, unless new facts are presented. The claimant has a right to bring a civil action.	
No lawsuit or legal action of any kind related to an appeal decision may be filed by the claimant in a court of law or in any other forum, unless it is begun within three years of the decision on the claim or other request for benefits. The claimant must exhaust the appeals procedure before filing a lawsuit or taking other legal action of any kind against the Claims Administrator and/or the Plan.	

Legal Actions

No lawsuit can be brought to recover a benefit under the Plan (including each type of benefit under the Plan) until the claimant has done all of the following:

- Initiated a claim as required under the relevant part of the Plan;
- Received a written denial of the claim; if the Plan Administrator or Claims Administrator does not give a written response to the claim within the required timeframe, the claimant may consider the claim denied;
- Filed a written request for an appeal/review of the denied claim with the Plan Administrator or Claims Administrator; and

- Received written notification that the denial of the claim has been affirmed (provided, however, that this notification is not required for legal action if the Plan Administrator or Claims Administrator has not acted on the request for appeal/review within the specified timeframe described above).

Compliance With the HIPAA Privacy and Security Standards

The Plan Administrator and any designee(s) of the Plan Administrator, acting on behalf of the Plan, will have access to and may use or disclose your Protected Health Information (**PHI**) as necessary to carry out the duties of the Plan Administrator as described herein including, but not limited to, the receiving, processing, and paying of claims made under the Plan, quality assurance, auditing, and monitoring of the administration and operations of the Plan. PHI means information which:

- Is created or received by, or on behalf of, the Plan;
- Relates to your past, present, or future physical or mental health condition, treatment received for that condition, or payment for that treatment; and
- Identifies you or could reasonably be used to identify you.

The Plan Administrator will safeguard your PHI as required by law and will implement appropriate physical, administrative, and technical safeguards to protect the privacy of your PHI. Disclosures of PHI to the Company in its role as Plan Sponsor will be made in accordance with the information provided below.

The Plan Administrator may disclose PHI, to the extent minimally necessary, to the Plan Sponsor for the proper administration of the Plan after the Plan Sponsor has certified to the Plan that the Plan has been amended as set forth in sub-paragraphs (1) through (11), below, and that the Plan Sponsor will abide by the standards listed in this section.

The Plan Sponsor may use or disclose PHI to the extent permitted by law, including, but not limited to, quality assurance, claims processing, claims payment, auditing, and performing claims administration and resolution functions. Any uses or disclosures of PHI made by the Plan Sponsor must be consistent with the HIPAA Privacy Standards. In addition, the Plan Sponsor must:

(1) Not use or disclose your PHI other than as permitted by the Plan or as required by law as set forth in the HIPAA Privacy Standards;

(2) Ensure that any agents, including subcontractors, to whom the Plan Sponsor provides your PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with regard to that PHI;

(3) Not use or disclose your PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor (unless the other benefit plan is a “health plan” as defined in the HIPAA Privacy Standards participating in an organized health care arrangement with the Plan);

(4) Report to the Plan any use or disclosure of your PHI, of which the Plan Sponsor becomes aware, that is inconsistent with the terms of the Plan document, as well as any “security incident” (as defined below) involving your PHI of which the Plan Sponsor becomes aware;

(5) Make your PHI available to you in accordance with the HIPAA Privacy Standards;

(6) Make PHI available for you to amend, and to incorporate any amendment made to your PHI, in accordance with the HIPAA Privacy Standards;

(7) Make available information necessary to provide you with an accounting of disclosure of your PHI in accordance with the HIPAA Privacy Standards;

(8) Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining the Plan's compliance with the HIPAA Privacy Standards;

(9) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction not feasible;

(10) Provide reasonable and appropriate physical, administrative, and technical safeguards that protect the confidentiality, integrity, and availability of PHI, including electronic PHI, and reasonably and appropriately safeguard electronic PHI created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan; and

(11) Ensure adequate separation between the Plan and the Plan Sponsor by describing the employees or classes of employees that will be given access to PHI; restricting access to and use of PHI by the employees or classes of employees for which such access and use is proper, providing an effective mechanism for resolving any issues of noncompliance with provisions of the Plan document in the manner set forth below, and implementing reasonable and appropriate security measures to support such adequate separation with respect to electronic PHI:

    (i) The classes of employees of the Plan Sponsor identified in **Appendix A: Employee Classes With Protected Health Information (PHI) Access Authorization**, at the end of this Guide, may have access to PHI received from the Plan to be used and disclosed only in accordance with this section. The classes of employees identified in Appendix A encompass all employees who receive PHI relating to payment under health care operations of, or other matters pertaining to, the Plan in the ordinary course of business.
    (ii) The classes of employees identified in Appendix A may use and disclose PHI only in accordance with standards identified this section and only for purposes of performing Plan administration functions.
    (iii) Any violation, or alleged violation of the standards identified this section by the classes of employees listed above may be the subject of a complaint submitted in accordance with the Plan's Notice of Privacy Practices.

If you believe that the Plan or the Plan Sponsor has misused your PHI, you may file a complaint under the complaint procedure in the Plan's Notice of Privacy Practices.

The Plan Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan.

The Plan Sponsor will report to the Plan any security incident of which the Plan Sponsor becomes aware. A "security incident" means the successful or attempted unauthorized

access, use, disclosure, modification, or destruction of information or interference with information system operations.

Your Privacy Rights Under HIPAA

Summary of Notice of Privacy Practices

Lam Research's Notice of Privacy Practices for Protected Health Information (the "Notice") contains important information about your privacy rights. Lam Research recognizes that the Notice is lengthy and detailed. You still should read the entire document carefully.

This summary highlights some of the important points in the Notice. However, this summary is not a substitute for the Notice.

- The Notice applies to information about your health care and payment for your health care created or received by, or on behalf of, Lam Research's group health, dental and vision plans, health care reimbursement flexible spending plan, and employee assistance program. The Notice does not apply to health information in employment records.
- The Notice explains how Lam Research will use and disclose your protected health information without your written permission.
- The Notice explains how you can exercise certain rights. These rights include the right to access your protected health information, the right to amend your protected health information, and the right to receive an accounting of when and why Lam Research has disclosed your protected health information to others.
- The Notice explains how you can file a complaint, either with Lam Research or with the federal government, if you believe Lam Research has violated the policies and procedures stated in the Notice.
- The Notice provides contact information for the person who can answer your questions or respond to your complaints about Lam Research's use and disclosure of your protected health information.

Notice of Privacy Practices for Protected Health Information

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Introduction

Lam Research sponsors and administers a group medical, dental and vision plan, health care reimbursement flexible spending plan, and employee assistance program. This Notice applies to all of these health plans. This Notice refers to Lam Research's health plans as the "Plans."

The Plan's Duties

- **Safeguard The Privacy Of Your Protected Health Information ("PHI").** Federal law requires that the Plans safeguard the privacy of your "protected health information" or PHI. "PHI" includes individually identifiable information created, received or maintained by, or on behalf of, the Plans relating to your past, present or future physical or mental health condition, treatment for that condition, or payment for that treatment.

- **Notify You Of The Plans' Privacy Policies.** Federal law requires that the Plans notify you of their legal duties and privacy policies and procedures with respect to your PHI. This Notice is intended to satisfy that requirement.
- **Use And Disclose Your PHI Only As Described In This Notice.** The Plans will abide by the terms of this Notice as long as it remains in effect. The Plans will use and disclose your PHI without first obtaining your written authorization only as described in this Notice. If the Plans obtain your written authorization for a use or disclosure not described in this Notice, you may revoke or modify that authorization at any time by submitting the appropriate form to the Privacy Official designated below. The Privacy Official will provide you with a copy of the form upon request.

How the Plans Will Use and Disclose Your PHI Without Your Authorization

- **Uses And Disclosures For Treatment.** The Plans may use and disclose your PHI for "treatment." "Treatment" includes the provision, coordination or management of health care and related services by one or more health care providers. For example, the group health plan may assist in coordinating health care and related benefits.
- **Uses And Disclosures For Payment.** The Plans will use and disclose your PHI for "payment." "Payment" includes, but is not limited to, claims processing, claims payment, payroll deductions, eligibility determinations, and claims disputes. For example, the Plans will use your PHI to determine whether you are entitled to benefits, and, if you are, to determine your benefits.
- **Uses And Disclosures For Health Care Operations.** The Plans will use and disclose your PHI for "health care operations." "Health care operations" include, but are not limited to, securing or placing a contract for reinsurance of risk relating to claims for health care; arranging for medical review, legal services, and auditing functions; fraud and abuse detection programs; business planning and development; investigating and resolving complaints of privacy violations; and business management and general administrative activities. For example, the Plans may disclose PHI as part of an investigation into a fraudulent claim.
- **Disclosures To The Plans' Sponsor.** The sponsor of the Plans is Lam Research. The Plans will disclose your PHI to Lam Research employees responsible for "plan administration functions." Plan administration functions include, but are not limited to, claims processing, eligibility determinations, and appeals from denials of coverage. Lam Research employees are prohibited from using or disclosing your PHI for employment-related decisions.
- **Disclosures To Business Associates.** The Plans have contracted with one or more third parties (referred to as a business associate) to use and disclose your PHI to perform services for the Plans. The Plans will obtain each business associate's written agreement to safeguard your PHI.
- **Information-Sharing Among The Plans.** Lam Research's health plans will share PHI with each other, and with business associates, as permitted by state and federal law, to carry out treatment, payment or health care operations.

How the Plans Will Use and Disclose Your PHI Without Your Authorization

Federal law generally permits the Plans to make certain uses or disclosures of PHI without your permission. Federal law also requires the Plans to list in the Notice each of these categories of uses and disclosures. The listing is below.

- **Uses Or Disclosures Required By Law.** The Plans may use or disclose your PHI as required by any statute, regulation, court order or other mandate enforceable in a court of law.
- **Disclosures For Workers' Compensation Purposes.** The Plans may disclose your PHI as required or permitted by state or federal workers' compensation laws.
- **Disclosures To Family Members Or Close Friends.** The Plans may disclose your PHI to a family member or close friend who is involved in your care or payment for your care if (a) you are present and agree to the disclosure, or (b) you are not present or you are not capable of agreeing, and Lam Research determines that it is in your best interest to disclose the information.
- **Disclosures For Judicial And Administrative Proceedings.** The Plans may disclose your PHI in an administrative or judicial proceeding in response to a subpoena or a request to produce documents. The Plans will disclose your PHI in these circumstances only if the requesting party first provides written documentation that the privacy of your PHI will be protected.
- **Disclosures For Law Enforcement Purposes.** The Plans may disclose your PHI for law enforcement purposes to a law enforcement official, such as in response to a grand jury subpoena.
- **Incidental Uses And Disclosures.** The Plans may use or disclose your PHI in a manner which is incidental to the uses and disclosures described in this Notice.
- **Disclosures For Public Health Activities.** The Plans may disclose your PHI to a government agency responsible for preventing or controlling disease, injury, disability, or child abuse or neglect. The Plans may disclose your PHI to a person or entity regulated by the Food and Drug Administration ("FDA") if the disclosure relates to the quality or safety of an FDA-regulated product, such as a medical device.
- **Disclosures For Health Oversight Activities.** The Plans may disclose your PHI to a government agency responsible for overseeing the health care system or health-related government benefit programs.
- **Disclosures About Victims Of Abuse, Neglect, Or Domestic Violence.** The Plans may disclose your PHI to the responsible government agency if (a) the Privacy Official reasonably believes that you are a victim of abuse, neglect, or domestic violence, and (b) the Plans are required or permitted by law to make the disclosure. The Plans will promptly inform you that such a disclosure has been made unless the Plans' Privacy Official determines that informing you would not be in your best interests.
- **Uses And Disclosures To Avert A Serious Threat To Health or Safety.** The Plans may use or disclose your PHI to reduce a risk of serious and imminent harm to you, another person or to the public.

- **Disclosures To HHS.** The Plans may disclose your PHI to the United States Department of Health and Human Services ("HHS"), the government agency responsible for overseeing the Plans' compliance with federal privacy law and regulations regulating the privacy of PHI.
- **Uses And Disclosures For Research.** The Plans may use or disclose your PHI for research, subject to conditions. "Research" means systemic investigation designed to contribute to generalized knowledge.
- **Disclosures In Connection With Your Death Or Organ Donation.** The Plans may disclose your PHI to a coroner for identification purposes, to a funeral director for funeral purposes, or to an organ procurement organization to facilitate transplantation of one of your organs.
- **Uses And Disclosures For Specialized Government Functions.** The Plans may disclose your PHI to the appropriate federal officials for intelligence and national security activities authorized by law or to protect the President or other national or foreign leaders. If you are a member of the U.S. Armed Forces or of a foreign armed forces, the Plans may use or disclose your PHI for activities deemed necessary by the appropriate military commander. If you were to become an inmate in a correctional facility, the Plans may disclose your PHI to the correctional facility in certain circumstances.

If applicable State law does not permit the disclosure described above, the Plans will comply with the stricter State law.

The Plans' Disclosures With Your Prior Authorization

The Plans are required to obtain your written authorization in the following circumstances: to use or disclose psychotherapy notes (except when needed for payment purposes or to defend against litigation filed by you); (b) to use your PHI for marketing purposes; (c) to sell your PHI; and (d) to use or disclose your PHI for any purpose not previously described in this Notice. The Plans also will obtain your authorization before using or disclosing your PHI when required to do so by (a) state law, such as laws restricting the use or disclosure of genetic information or information concerning HIV status; or (b) other federal law, such as federal law protecting the confidentiality of substance abuse records.

Prohibition On The Plans' Use And Disclosure Of Your PHI

The Plans are prohibited from using or disclosing your PHI that is genetic information for "underwriting purposes." Underwriting purposes includes determination of eligibility for, or benefits under, any of the Plans; computation of premium or contribution amounts under any of the Plans; and other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

Your Privacy Rights As A Participant In One Or More Of The Plans

As a participant in the Plans, you may exercise the rights described below. The forms referenced below can be obtained from the Company's Privacy Official (the "Privacy Official").

- **Right To Access Your PHI.** You may ask to review your PHI on file with the Plans, or to receive copies of it in paper or electronic form, by submitting the appropriate form to the Privacy Official. The Plans will provide access, or will deliver copies to you, within 30 days of your request. The Plans may extend the deadline by up to an additional 30 days. The Plans will provide you with a written explanation of any denial of your request for access or copies. The Plans may charge you a reasonable, cost-based fee for copies or for delivery. If there will be a charge, the Privacy Official will first contact you to determine whether you wish to modify or withdraw your request.
- **Right To Amend Your PHI.** You may amend your PHI on file with the Plans by submitting the appropriate request form to the Privacy Official. The Plans will respond to your request within 60 days. The Plans may extend the deadline by up to an additional 30 days. If the Plans deny your request to amend, the Plans will provide a written explanation of the denial. You would then have 30 days to submit a written statement explaining your disagreement with the denial. Your statement of disagreement would be included with any future disclosure of the disputed PHI.
- **Right To An Accounting Of Disclosures Of Your PHI.** You may request an accounting of the Plans' disclosures of your PHI by submitting the appropriate form to the Privacy Official. The Plans will provide the accounting within 60 days of your request. The Plans may extend the deadline by up to an additional 30 days. The accounting will exclude the following disclosures: disclosures for "treatment," "payment," or "health care operations"; (b) disclosures to you or pursuant to your authorization; (c) disclosures to family members or close friends involved in your care or in payment for your care; (d) disclosures as part of a data use agreement; and (e) incidental disclosures. The Plans will provide the first accounting during any 12-month period without charge. The Plans may charge a reasonable, cost-based fee for each additional accounting during the same 12-month period. If there will be a charge, the Privacy Official will first contact you to determine whether you wish to modify or withdraw your request.
- **Right To Request Additional Restrictions On The Use Or Disclosure Of Your PHI.** You may request that the Plans place restrictions on the use or disclosure or your PHI for "treatment," "payment," or for "health care operations" in addition to the restrictions required by federal law by submitting the appropriate request form to the Privacy Official. The Plans will notify you in writing within 30 days of your request whether the Plans will agree to the requested restriction. The Plans are not required to agree to your request.
- **Right To Request Communications By Alternative Means Or To An Alternative Location.** The Plans will honor your reasonable request to receive PHI by alternative means, or at an alternative location, if you submit the appropriate request form to the Privacy Official.

- **Right To Receive Notice Of A Breach Of Your Unsecured PHI.** If the Plans discover a breach of your unsecured PHI, the Plans will notify you of the breach and provide the information required by law.
- **Right To A Paper Copy Of This Notice.** You may request at any time that the Privacy Official provide you with a paper copy of this Notice.

A Note About Personal Representatives

- All of the rights described above may be exercised by your personal representative after the personal representative has provided proof of his or her authority to act on your behalf. Proof of authority may be established by (a) a power of attorney for health care purposes, or a general power of attorney, notarized by a notary public; (b) a court order appointing the person to act as your conservator or guardian; or (c) any other document which the Privacy Official, in his or her sole and absolute discretion, deems appropriate.

Your Right to File a Complaint

If you believe that your privacy rights have been violated because any of the Plans has used or disclosed your PHI in a manner inconsistent with this Notice, because any of the Plans has not honored your rights as described in this Notice, or for any other reason, you may file a complaint in one, or both, of the following ways:

- **Internal Complaint:** Within 180 days of the date you learned of the conduct, you can submit a complaint using the appropriate complaint form to the Privacy Official, c/o Ray Allsup, Lam Research, 4650 Cushing Parkway, Fremont CA 94538, or call 510-572-0200 and ask for the HIPAA Privacy Official. You can obtain a complaint form from the Privacy Official.
- **Complaint To HHS:** Within 180 days of the date you learned of the conduct, you may submit a complaint by mail to the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Ave., S.W., Washington, D.C. 20201.

The Plans' Anti-Retaliation Policy

The Plans will not retaliate against you for submitting an internal complaint, a complaint to HHS, or for exercising your other rights as described in this Notice or under applicable law.

Whom To Contact For More Information About The Plans' Privacy Policies And Procedures

If you have any questions about this Notice, or about how to exercise any of the rights described in this Notice, you should contact the Plans' Privacy Official by mail c/o Ray Allsup, Lam Research, 4650 Cushing Parkway, Fremont CA 94538, or call **510-572-0200** and ask for the HIPAA Privacy Official.

Revisions To The Privacy Policy And To The Notice

The Plans have the right to change this Notice or the Plans' privacy policies and procedures at any time. If the change to the Plans' privacy policies and procedures would have a material impact on your rights, the Plans will notify you of the change by mailing (either electronically or by U.S. Postal Service) a revised Notice to you, in accordance with applicable regulations, which reflects the change. Any change to the Plans' privacy policies and procedures, or to the Notice, will apply to your PHI created or received before the revision.

Effective Date Of This Notice

The effective date of this notice is September 23, 2013.

Other Plan Information

Future of the Plan

The Company expects to maintain the Plan indefinitely; however, it reserves the right to amend or terminate the Plan (or any benefit provided under the Plan) at any time and for any reason, if the Company considers that to be desirable or necessary. No amendment may take away from you any benefit to which you become entitled before the amendment becomes effective.

Plan Administrator and Plan Sponsor

The official "Plan Administrator" and "Plan Sponsor," for purposes of the Employee Retirement Income Security Act of 1974 ("ERISA"), is the Company. However, all routine claims for benefits under each plan are handled by the relevant insurance company (or the Claims Administrator), as described in each of the coverage summaries and this Guide. Appeals of denied claims are handled by the Plan Administrator in the case of the FSAs and by the party defined in each of the coverage summaries, as appropriate.

No Right to Continued Employment

Nothing in the Plan gives you a right to remain in employment or affects the Company's right to terminate your employment at any time, with or without cause, and that right is hereby reserved.

Plan Documents

Complete details of each of the components of the Plan can be found in the official Plan documents (including insurance contracts and HMO agreements) that govern the operation of the Plan. All statements made in this Guide and the coverage summaries are subject to the provisions and terms of those documents.

Copies of the official Plan documents, the annual reports of Plan operations, this Guide, and the coverage summaries are available for review by any Plan participant at:

Lam Research Corporation
c/o Benefits Department
4300 Cushing Parkway
Fremont, CA 94538-6470
benefits@lamresearch.com

Coverage summaries can also be accessed at www.LamBenefits.com.

You may also request copies of Plan documents by writing to the address above. The document(s) will be sent within 30 days after the Lam Research Benefits Department receives your request. You may be asked to pay a reasonable copying fee.

Company's Right to Use Your Social Security Number for Administration of Benefits

The Company will require that you and your dependents provide Social Security numbers at the time of enrollment so that the Company can comply with various governmental reporting requirements.

The Company retains the right to use your Social Security number for benefit administration purposes, including tax reporting. If a state law restricts the use of Social Security numbers for benefit administration purposes, the Company generally takes the position that ERISA preempts such state laws.

Outcome of Covered Services and Supplies

The Company is not responsible for, and makes no guarantees concerning, the outcome of the covered services or supplies for which you receive payments under the Program.

You are solely responsible for your choice of health care providers, services, and/or supplies. Obtaining health care and determining which provider, service, and/or supply to use shall not be construed, interpreted, or deemed as resulting from the Plan, the Program, or any coverage summary.

You must make a decision as to your health care independent of any determinations to whether payment will or will not be made under the Program for that health care. The determination of whether or not health care is medically necessary is made solely for purposes of determining whether benefits will be paid under the Program and is not intended to be advice to you about your health care.

Unclaimed Funds

If any amount becomes payable to you under the Program, and you do not either claim that amount or cash any check issued under the Program within 12 months, and provided the Plan Administrator has exercised reasonable care in attempting to make the payments to you, the amount of any unclaimed funds shall be forfeited and shall cease to be a liability of the Program.

However, for a fully-insured benefit, the applicable coverage summary will govern the handling of any unclaimed funds.

Non-Assignment of Benefits

You cannot assign, pledge, borrow against, or otherwise promise any benefit payment provided by the Program before receipt of that benefit payment. However, benefits will be provided to your child if required by a Qualified Medical Child Support Order. In addition, subject to your written direction, all or a portion of benefit payments provided by the Program may, at the option of the Program, and unless you request otherwise in writing, be paid directly to the provider rendering a service to you. Any benefit payment made by the Program in good faith pursuant to this provision shall fully discharge the Program and the Company to the extent of such payment.

In addition, you may not assign your rights to bring a lawsuit under the Program to any providers or other persons who may provide or render any treatment or services to you or your dependents.

Coordination of Benefits

Coordination of benefits procedures will be as described in the coverage summaries. To the extent that the coverage summaries do not have any provisions for coordination of benefits, the procedures described below shall govern.

If you or your dependent(s) is covered by more than one health plan (for example, this Program and your spouse's/domestic partner's plan), you should understand how plans

work together to pay for covered services. The coordination of benefits provision is designed to prevent duplicate payments for the same expenses.

You should file all claims with each plan. However, you generally cannot be reimbursed twice for an expense that is covered by both plans. This Program is not designed to bring you up to 100% reimbursement (unless you have met your out-of-pocket maximum). Claims are coordinated so that you will receive no more than the benefits allowable under the Program.

Order of Benefit Determination Rules

The primary plan is the plan that determines and provides or pays health benefits without taking into consideration the existence of any other plan. The secondary plan is the plan that determines, and can reduce its benefits after taking into consideration, the health benefits provided or paid by the primary plan.

A plan that does not have a coordination of benefits rule consistent with this section will always be the primary plan. If the plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

- The plan that covers a person as an employee or retiree shall be the primary plan and the plan that covers that person as a dependent will be the secondary plan.
- For a dependent child whose parents are not divorced or legally separated, the primary plan will be the plan that covers the parent whose birthday falls first in the calendar year.
    - This Program pays first if your birthday (month/day) comes before your spouse's/domestic partner's birthday in the calendar year (for example, if your birthday is March 1 and your spouse's/domestic partner's birthday is June 1);
    - If you and your spouse/domestic partner have the same birthday, the plan covering you or your spouse/domestic partner longer pays first; and
    - If your spouse's/domestic partner's plan does not use the birthday rule, the rules of that plan determine which plan pays first.
- For the dependent of divorced or separated parents, benefits for the dependent will be determined in the following order:
    - First, according to the provisions of a qualified medical child support order ("QMCSO") or other court decree, if the court decree states that one parent is responsible for the child's health benefits and the plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
    - Then, the plan of the parent with custody of the child;
    - Then, the plan of the spouse of the parent with custody of the child;
    - Then, the plan of the noncustodial parent of the child; and
    - Finally, the plan of the spouse of the noncustodial parent.

- If none of the above rules determines the order of benefits, the plan that has covered you for the longer period of time will be the primary plan.

Benefits payable under this Program will be secondary to benefits provided or required by any group or individual automobile, homeowner's, or premises insurance, including medical payments, personal injury protection, or no-fault coverage, regardless of any provision to the contrary in any other policy of insurance.

Effect on Benefits of This Program

If this Program is the secondary plan, it will pay the difference between what it normally would pay if there were no coordination (after any deductible or copayment) and what the primary plan pays.

Recovery of Excess Benefits

If the Program pays for health benefits that should have been paid by the primary plan, the Program will have the right to recover such payments.

The Program will have sole discretion to seek such recovery from any person to whom, or for whom, or with respect to whom, such health benefits were provided or such payments were made by any other plan. If the Plan Administrator requests, you must execute and deliver such instruments and documents as the Plan Administrator determines are necessary to secure the right of recovery for the Program.

Right to Receive and Release Information

The Plan Administrator, without consent or notice to you, may obtain information from and release information to any other plan with respect to you in order to coordinate your health benefits pursuant to this section. You must provide the Plan Administrator with any information it requests in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information (including an Explanation of Benefits (EOB) paid under the primary plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

Coordination of Health Benefits for Medicare Eligible Individuals

If you continue to be actively employed by the Company after you reach age 65, your health benefits remain in effect even though you are eligible for Medicare. Your spouse may also continue to be covered under the Program if he or she reaches age 65 and is eligible for Medicare. You may voluntarily elect Medicare as your primary coverage, but only if you waive all medical and prescription drug benefits under the Program. Once you are enrolled in Medicare, beginning your first month of Medicare coverage, you are no longer eligible to make or receive HSA contributions, although you may still submit qualified medical expenses for reimbursement or payment from your HSA.

If you and/or your spouse is enrolled in Medicare because of your age, the Program pays first and Medicare pays second, as long as you remain actively employed by the Company.

If you, your spouse, or your dependent child is enrolled in Medicare because of a disability, the Program pays first and Medicare pays second, as long as you remain actively employed by the Company.

If you, your spouse, or your dependent child is enrolled in Medicare because of end stage renal disease ("ESRD"), the Program pays first for the first 30 months that Medicare benefits are available because of ESRD, and Medicare pays second for that 30-month period. However, after the end of the 30-month period, Medicare will pay first and the Program will pay second.

When Medicare is primary, the Plan Administrator will give consideration to the benefits available under Medicare when determining the Program benefits to be paid for your covered services. The process used in determining your medical and prescription drug benefits under the Program is as follows:

- The Program will determine what the payment for a covered benefit would be without regard to the COB provisions of the Program;
- The Program will deduct from this amount the amount paid or payable by Medicare; and
- The difference, if any, is the amount that will be paid under the Program. If you are eligible for Medicare, the amount payable by Medicare will be deducted whether or not you have enrolled and/or received payment from Medicare.

Right of Recovery

If, for some reason, a benefit is paid that is larger than the amount allowed by the Program, the Program has a right to recover the excess amount from the person or agency that received or holds this benefit. This excess amount is subject to a constructive trust in favor of the Program. The person receiving or holding Program benefits must produce any instruments or papers necessary to ensure this right of recovery.

Third Party Recovery/Subrogation

If you or any other person (a **covered person**) has received, or in the future may receive, a recovery for damages (by settlement, verdict, or otherwise, including a recovery from any insurance company) for an injury, illness, or other condition, including death, the Program will not cover either (1) the reasonable value of the services to treat that injury, illness, or other condition, or (2) the treatment of that illness, injury, or other condition. These benefits are specifically excluded under the Program.

If the Program does advance moneys or provide care for such an injury, illness, or other condition, then, in consideration for participation in the Program and the advancement of benefits under the Program, the covered person acknowledges the Program's right of recovery and agrees to promptly convey to the Program moneys or other property that the covered person receives from any settlement, arbitration award, verdict, insurance proceeds, or monetary recovery from any party for the reasonable value of the benefits advanced or provided to the covered person by the Program, regardless of whether or not:

- The covered person has been fully compensated or made whole for his or her loss;
- The covered person or any other party admits to liability; or
- The recovery is itemized or called anything other than a recovery for benefit expenses incurred.

If a recovery is made, the Program has first priority to receive reimbursement for any payments made on the covered person's behalf, before payment is made to the covered person or any other party. This reimbursement is required from any recovery the covered person makes, including uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners, or otherwise), Workers' Compensation settlement, compromises or awards, other group insurance (including student plans), and direct recoveries from liable parties.

In consideration for the advancement of benefits under the Program, the covered person acknowledges and agrees to the following:

- Acknowledge that the Program has first priority against the proceeds of any such settlement, arbitration award, verdict, or other amounts the covered person receives;
- Acknowledge that any proceeds of settlement or judgment, including the covered person's claim to such proceeds held by the covered person or any other person, are being held for the benefit of the Program;
- Assign to the Program any benefits the covered person may have under any automobile policy or other coverage, to the extent of the Program's claim for reimbursement;
- Cooperate with the Program and its agents, provide relevant information, and take actions that the Program or its agents reasonably request to assist the Program in making a full recovery of the value of benefits paid;
- Consent to the Program's right to impress an equitable lien or constructive trust on the proceeds of any settlement to enforce the Program's rights under this section;
- Consent to the Program's right to deduct from any future benefits otherwise payable under the Program the value of benefits advanced under this section to the extent not recovered by the Program; and
- Agree to not take any action that prejudices the Program's rights of reimbursement.

The Program is responsible only for those legal fees and expenses to which it agrees in writing. A covered person may not incur any expenses on behalf of the Program in pursuit of the Program's rights under this section. Specifically, no court costs or attorney's fees may be deducted from the Program's recovery without the express written consent of the Program. Any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right.

In cases of occupational illness or injury, the Program's recovery rights shall apply to all sums recovered, regardless of whether the illness or injury is deemed compensable under any Workers' Compensation or other coverage. Any award or compromise settlement, including any lump-sum settlement, shall be deemed to include the Program's interest, and the Program shall be reimbursed in first priority from any such award or settlement.

The Program shall recover the full amount of benefits it advanced and paid, without regard to any claim or fault on the part of covered person, whether under comparative negligence or otherwise.

In consideration for the advancement of benefits to each covered person, the Program is subrogated to all of the covered person's rights against any party who (1) is liable for the covered person's injury, illness, or other condition, including death, or (2) is or may be liable for the payment for the treatment of the injury or occupational illness (including any

insurance company), to the extent of the value of the benefits advanced to the covered person under the Program. The Program may assert this right independently of the covered person. This right includes, but is not limited to, the covered person's rights under uninsured and underinsured motorist coverage, any no fault insurance, medical payment coverage (auto, homeowners, or otherwise), Workers' Compensation coverage, or other insurance, as well as the covered person's rights under the Program to bring an action to clarify the covered person's rights under the Program. The Program is not obligated in any way to pursue this right independently or on the covered person's behalf but may choose to pursue its rights to reimbursement under the Program, at its sole discretion.

The covered person is obligated to cooperate with the Program and its agents in order to protect the Program's subrogation rights. Cooperation means providing the Program or its agents with any relevant information requested by them, signing and delivering such documents as the Program or its agents reasonably request to secure the Program's subrogation claims, and obtaining the consent of the Program or its agents before releasing any party from liability for payment of benefit expenses.

If a covered person enters into litigation or settlement negotiations regarding the obligations of other parties, the covered person must not prejudice, in any way, the subrogation rights of the Program under this section. In the event that a covered person fails to cooperate with this provision, including executing any documents required under this section, the Program may, in addition to remedies provided elsewhere in the Plan documents, the coverage summaries, and/or under the law, offset from any future benefits otherwise payable under the Program the value of benefits advanced under this section to the extent not recovered by the Program.

The Program's subrogation right is a first priority right and must be satisfied in full prior to a covered person's other claims, regardless of whether the covered person is fully compensated for damages. The costs of legal representation of the Program in matters related to subrogation shall be borne solely by the Program. The costs of a covered person's legal representation are borne solely by the covered person.

Additional Information

Name of Plan:	Lam Research Corporation Group Welfare Benefit Plan
Employer Sponsoring Plan:	Lam Research Corporation 4300 Cushing Parkway Fremont, CA 94538-6470 Employees may obtain a complete list of other employers that sponsor the Plan, upon written request to the Plan Administrator, and receive information as to whether a particular employer is a sponsor of the Plan, with that employer's address.
Employer Identification Number:	94-2634797
Plan Number:	501
Plan Year:	January 1 – December 31
Plan Administrator:	Lam Research Corporation c/o Benefits Department 4300 Cushing Parkway Fremont, CA 94538-6470 **1-877-291-9494**

The following benefits are fully-insured through policies or contracts of insurance and benefits are paid for by the insurance companies and HMO indicated below.

Insurance Company and HMO Information (for Fully-Insured Benefits)		
Benefit	**Insurance Company/HMO**	**Source of Contributions**
Medical Plan Option: CDHP, HMO **(California Only)**	Kaiser Permanente P.O. Box 12923 Oakland, CA 94604-2923 *(Contract Number 9540)* **1-800-464-4000**	Employer and employee contributions
Medical Plan Option: CDHP, HMO **(Oregon and Washington Only)**	Kaiser Permanente 500 NW Multnomah Portland, OR 97232 (*Contract Number 18927*) **1-800-813-2000**	Employer and employee contributions
• **Basic Life Insurance** • **Supplemental Life Insurance** • **Dependent Life Insurance** • **Accidental Death and Dismemberment (AD&D) Insurance**	The Standard Life Benefits Department PO Box 2800 Portland, OR 97208 *(Contract Number 754416-A)* **1-800-628-8600**	• Basic Life Insurance – Employer contributions • Supplemental Life and AD&D Insurance – Employee contributions • Dependent Life Insurance – Employee contributions • Basic AD&D Insurance – Employer contributions;

Insurance Company and HMO Information (for Fully-Insured Benefits)		
Benefit	**Insurance Company/HMO**	**Source of Contributions**
		• Supplemental AD&D Insurance – Employee contributions
Long Term Disability (LTD) Insurance	The Standard 900 SW Fifth Avenue, Portland, OR 97204 *(Contract Number 754416-B)* **1-888-937-4783**	Employer contributions
Employee Assistance Program	Optum United Behavioral Health 425 Market Street San Francisco, CA 94105 *(Contract Number 1500981)* **1-866-248-4096**	Employer contributions

The following benefits are self-insured, which means they are paid out of Lam Research's general assets.

Claims Administrators (for Benefits That Are Self-Insured):		
Benefit	**Claims Administrator**	**Source of Contributions**
Medical Plan Options: CDHP and Base PPO	Anthem Blue Cross ATTN: Appeals P.O. Box 54159 Los Angeles, CA 90054 *(Contract Number C18939)* **1-800-879-4526**	Employer and employee contributions
Prescription Drugs (including the Anthem CDHP and Base PPO)	CVS Caremark P.O. Box 52116 Phoenix, AZ 85072-2116 *(Contract Number 0434)* **1-800-378-0780**	Employer and employee contributions
Dental Coverage	Delta Dental P.O. Box 997330 Sacramento, CA 95899 *(Contract Number 5659)* **1-800-765-6003**	Employer and employee contributions
Vision Care Coverage	Vision Service Plan PO Box 385018 Birmingham, AL 35238-5018 *(Contract Number 00495122)* **1-800-877-7195**	Employer and employee contributions

Claims Administrators (for Benefits That Are Self-Insured):		
Benefit	**Claims Administrator**	**Source of Contributions**
Flexible Spending Accounts (FSAs)	ConnectYourCare Claims Administrator PO Box 622317 Orlando, FL 32862-2317 Phone: **1-866-808-5214** Fax: **1-443-681-4602**	Employee contributions and employer (15% Lam Research match on Dependent Care FSA)
Short Term Disability (STD) Plan	TRISTAR P.O. Box 32363 Long Beach, CA 90832 *(Contract Number 51354)* **Lam Research: 1-844-610-1885** **Silfex: 1-844-610-1886**	Employee contributions
Voluntary Disability Insurance (VDI)	TRISTAR P.O. Box 32363 Long Beach, CA 90832 *(Contract Number 99-1414)* **Lam Research: 1-844-610-1885** **Silfex: 1-844-610-1886**	Employee contributions

The Plan Administrator’s Authority Under the Plan

The Plan Administrator has:

- The authority to make final determinations regarding eligibility and benefit claims under the Plan; and
- Discretionary authority to:
  — Interpret the Plan based on provisions and applicable law and make factual determinations about claims arising under the Plan;
  — Determine whether a claimant is eligible for benefits;
  — Decide the amount, form, and timing of benefits; and
  — Resolve any other matter under the Plan that is raised by a participant or a beneficiary or that is identified by the Plan Administrator.

The decision of the Plan Administrator is final and binding on all individuals dealing with or claiming benefits under the Plan.

The Delegation of Discretionary Authority to Claims Administrators and the Insurance Companies Discretionary Authority Under the Plan

The Plan Administrator has delegated its authority to make final determinations regarding benefit claims to the Claims Administrators identified under "Additional Information" above. A claim for a benefit under a plan or the Program is only paid if the Claims Administrator for the applicable plan or Program benefit decides, in its discretion, that the applicant or participant is entitled to the benefit claimed.

In the case of the Program's self-insured benefits, the insurance companies identified in "Additional Information" above that act as third-party Claims Administrators have complete discretionary authority to make final determinations regarding a claim for a self-insured benefit.

The Claims Administrators and insurance companies have:

- The authority to make final determinations regarding benefit claims under the health and welfare plans described in this Guide.
- Discretionary authority to:
  - Interpret the health and welfare plans based on provisions and applicable law and make factual determinations about claims and appeals arising under the health and welfare plans;
  - Decide the amount, form, and timing of benefits; and
  - Resolve any other matter under the health and welfare plans that is raised by a participant or a beneficiary or that is identified by the Claims Administrator.

In case of an appeal, the Claims Administrators' and insurance companies' decisions are final and binding on all parties to the full extent permitted under applicable law, unless the participant or beneficiary later proves that a Claims Administrator's or insurance company's decision was an abuse of administrator discretion.

Agent for Service of Legal Process

Service of legal process may be made upon the Plan Administrator or the Company's Legal Department.

Type of Plan

The Program is an employee welfare benefit plan. All benefits are provided by the insurance companies and HMOs identified above, or, in the case of the Anthem Medical Plan options, CVS Caremark prescription drug coverage, the Dental Plan options, the Vision Plan options, the STD Plan, the VDI Plan, and the FSAs, through the general assets of Lam Research.

The benefits are not insured by the Pension Benefit Guaranty Corporation, as that program does not apply to health and welfare benefit plans.

Your ERISA Rights

As a participant in the Lam Research Corporation Group Welfare Benefit Plan (the Program), you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Program participants are entitled to:

Receive Information About Your Program and Benefits

- Examine, without charge, at the Lam Research Benefits Department and at other specified locations, all documents governing the Program, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of all plan documents, including insurance contracts, copies of the latest annual report (Form 5500 series) and the latest SPD. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, your spouse/domestic partner and/or your dependent children if there is a loss of coverage under the health care plan as the result of a qualifying event. You, your spouse/domestic partner, and/or your dependent children may have to pay for such coverage. Review this Guide, the health care plans' coverage summaries, and official Plan documents for the rules governing your COBRA continuation rights. COBRA, which stands for the Consolidated Omnibus Budget Reconciliation Act, gives you and your spouse/domestic partner, and your dependent children the right to temporarily continue health care coverage for a period of time if your health care plans' coverage ends due to a qualifying event.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Program participants, ERISA imposes duties upon the people who are responsible for the operation of the Program. The people who operate your plans, called "fiduciaries" of the plans, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

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

Enforce Your Rights

If your claim for a 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 Program 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 (as indexed) 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 that is denied or ignored, in whole or in part, and you have exhausted the Program's internal claims and appeals process, you may file a suit in a state or federal court.
- If you disagree with the Program's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.
- 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 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 the cost and fees; for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your plan, you should contact your Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or write to:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Appendix A: Employee Classes With Protected Health Information (PHI) Access Authorization

Classes of employees authorized to access PHI to perform plan administration functions are listed below:

- Sr. Director of Global Benefits
- Benefits Program Manager
- Wellness Program Manager
- Senior HR Representative – Benefits
- Staff HR Representative – Benefits
- Senior Payroll Analyst
- Payroll Analyst
- Legal Department Representative
- The Privacy Official
- The Security Official
- Administrative Assistants (to those listed above)
- Global Information Systems Personnel
- Benefits Committee