Lam Research Corporation
Group Welfare Benefit Plan

Plan No. 501

Revised Effective January 1, 2015

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Article 1 Establishment and Applicability of the Plan

1.1 Background of the Plan

The Lam Research Corporation Group Welfare Benefit Plan (Plan Number 501) (the "Plan") provides health and other welfare benefits to Eligible Employees and their respective eligible Dependents under the Plan. The terms of this Plan supersede any prior oral or written versions of this Plan and any benefit plan. The terms of this Plan govern all claims for benefits hereunder.

The Plan was originally adopted by Lam Research Corporation effective January 1, 1984. This amended and restated document for the Plan shall be effective as of January 1, 2015. Further, the cafeteria plan provisions, including the flexible spending accounts, are incorporated into a separate plan, named the Lam Research Corporation Cafeteria Plan (Plan Number 502), effective as of January 1, 2015.

1.2 Component Plans

The Plan shall include those Component Plans listed in Schedule B attached to this Plan document. The Plan is a welfare benefit plan as that term is described in Section 3(1) of the Employee Retirement Income Security Act of 1974 ("ERISA").

1.3 Interpretation and Law

The Plan is intended to qualify as an accident and health plan under Internal Revenue Code ("Code") Sections 105 and 106 and as a plan providing group-term life insurance coverage for a death benefit, as described in Code Sections 79 and 101. The Plan is intended to comply with the Code, ERISA and the Public Health Service Act and the regulations and rules promulgated under each.

The Plan shall be construed and interpreted in a manner consistent with the requirements of Code Sections 79, 101, 105 and 106, and any other applicable sections of the Code, ERISA, the Public Health Service Act or any other applicable law.

1.4 Applicability of the Plan

Except as otherwise provided herein, the provisions of this Plan shall apply only to covered services and covered events (e.g., disability or death) which are provided or which occur on and after January 1, 2015 to eligible Employees who are employed by Lam Research Corporation on and after January 1, 2015, and to their eligible Dependents. In the case of services or events which are provided or which occur prior to January 1, 2015, coverage shall be available (if at all) under the terms of the applicable prior plan.

Article 2 Definitions

2.1 Definitions

The following words and phrases as used in the Plan shall have the following meanings unless a different meaning is required by the context:

(a) "**Affiliate**" means any corporation that is included with the Company in a "controlled group of corporations," as defined in Section 414(b) of the Code; any unincorporated business included with the Company in a group of trades or businesses under "common control," as defined by regulations prescribed by the Secretary of the Treasury under Section 414(c) of the Code; or any corporation included with the Company in an "affiliated service group," as defined in Section 414(m) of the Code; or any other entity required to be aggregated with the Company pursuant to regulations under Section 414(o) of the Code.

(b) "**Affordable Care Act**" or "**ACA**" means the Patient Protection and Affordable Care Act enacted on March 23, 2010 as amended by the Health Care and Education Affordability Reconciliation Act enacted on March 30, 2010, as now in effect or as hereafter amended, including any regulations and rulings promulgated thereunder and any successor statute of similar import. Reference to any section or subsection of the Affordable Care Act includes references to any comparable or succeeding provisions of any legislation that amends, supplements, or replaces such section or subsection.

(c) "**Cafeteria Plan**" means the Lam Research Corporation Cafeteria Plan.

(d) "**COBRA**" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as now in effect or as hereafter amended, including any regulations and rulings promulgated thereunder and any successor statute of similar import. Reference to any section or subsection of COBRA includes references to any comparable or succeeding provisions of any legislation that amends, supplements, or replaces such section or subsection.

(e) "**Code**" means the Internal Revenue Code of 1986, as now in effect or as hereafter amended, including any regulations and rulings promulgated thereunder, and any successor statute of similar import. Reference to any section or subsection of the Code includes references to any comparable or succeeding provisions of any legislation that amends, supplements, or replaces such section or subsection.

(f) "**Company**" means Lam Research Corporation or any successor by merger, consolidation or purchase of substantially all of its assets. The Company is the Plan Sponsor as that term is defined by ERISA.

(g) "**Component Plan**" means an employee welfare benefit that is designated on Schedule B as one of the component benefits of the Plan. Summary Plan Descriptions, Summaries of Coverage, and Summaries of Insurance describing the specific benefits provided by each Component Plan, the terms of eligibility and other terms and conditions, as they may be amended from time to time, are incorporated herein by reference.

(h) "**Covered Person**" means an Eligible Employee or eligible Dependent who is covered under a Component Plan.

(i) "**Dependent**" means individuals other than an Eligible Employee who may be eligible for, and enrolled in, coverage under a Component Plan based on their relationship to the Eligible Employee, as defined and determined under the eligibility terms of the Summary Plan Description for the Component Plan.

(j) "**Eligible Employee**" means an Employee who is an eligible to enroll in one or more Component Plan as defined in the Summary Plan Description for the Component Plan. An Eligible Employee excludes any nonresident alien without earned income from sources within the United States. The Employer may at any time and from time to time remove any one or more Employees or any other group(s) or class(es) of Employees from eligibility for participation in this Plan.

(k) "**Employee**" means an individual who renders services to the Employer for wages that the Employer determines are subject to federal income tax withholding and Federal Insurance Contributions Act (FICA) taxes payable by the Employer and classified by the Employer as a common-law employee of the Employer. "Employee" specifically excludes any individual classified by the Employer as an intern, temporary employee or independent contractor, regardless of any later classification or reclassification of any such individual as a common-law employee of the Employer by the U.S. Department of Treasury, Internal Revenue Service or other government department or agency. Leased employees within the meaning of Section 414(n)(2) of the Code shall not be considered Employees, notwithstanding their inclusion, as required by law, in applicable nondiscrimination testing under relevant Code sections.

(l) "**Employer**" means the Company and each Affiliate listed in Schedule A. The Plan Sponsor may provide that additional Affiliates are permitted to become participating Employers, pursuant to Section 9.1 of this Plan.

(m) "**ERISA**" means the Employee Retirement Income Security Act of 1974, as now in effect or as hereafter amended, including any regulations and rulings promulgated thereunder and any successor statute of similar import. Reference to any section or subsection of ERISA includes references to any comparable or succeeding provisions of any legislation that amends, supplements, or replaces such section or subsection.

(n) "**FMLA**" means the Family and Medical Leave Act of 1993, as now in effect or as hereafter amended, including any regulations and ruling promulgated thereunder and any successor statute of similar import. Reference to any section or subsection of the FMLA includes references to any comparable or succeeding provisions of any legislation that amends, supplements, or replaces such section or subsection.

(o) "**HIPAA**" means the Health Insurance Portability and Accountability Act of 1996 as now in effect or as hereafter amended, including any regulations and rulings promulgated thereunder and any successor statute of similar import. Reference to any section or subsection of HIPAA includes references to any comparable or succeeding provisions of any legislation that amends, supplements, or replaces such section or subsection.

(p) "**HMO**" means a health maintenance organization with which the Employer has entered into an HMO Contract.

(q) "**HMO Contract**" means a contract between the Employer and an HMO for the provision of one or more Component Plans.

(r) "**Insurer**" means an insurance company with which the Employer has entered into an Insurance Contract.

(s) "**Insurance Contract**" means a contract between the Employer and an Insurer for the provision of one or more Component Plans.

(t) "**Leave of Absence**" means the Employee has obtained an approved leave of absence from the Employer as provided for in the Employer's rules, policies, procedures and/or practices, including absence under the FMLA and leave for duty in the Uniformed Services. Leave of Absence shall also mean any other unpaid Leave of Absence as administered and approved by the Employer.

(u) "**Participant**" means any Eligible Employee who enrolls in the Plan in accordance with Article 3, who has commenced participation in the Plan accordingly and whose participation has not terminated under any other applicable provisions of the Plan.

(v) "**Participant Contributions**" means contributions made by a Participant under the Plan, including, without limitation, after-tax contributions and/or Salary Reduction Contributions.

(w) "**Plan**" means the Lam Research Corporation Group Welfare Benefit Plan as set forth herein, including all schedules hereto and all documents incorporated herein by reference, as each is amended from time to time.

(x) "**Plan Administrator**" means the Company or such other person or entity described in Section 5.1 that the Company designates to administer the Plan.

(y) "**Plan Sponsor**" means the sponsor of the Plan, as designated on the Form 5500 Annual Report and other government filings. On and after January 1, 2015, the Plan Sponsor is Lam Research Corporation.

(z) "**Plan Year**" means the 12-consecutive-month period beginning on each January 1 and ending on the following December 31.

(aa) "**Qualified Medical Child Support Order**" or "**QMCSO**" means an order which creates or recognizes the existence of a child's right to health benefits under the Plan and must be in the form of a judgment, decree, or order (including a settlement agreement approved by the court) issued by a court (or state administrative agency with jurisdiction) that is deciding the child support issues in a divorce or other family law action. A Qualified Medical Child Support Order must clearly specify:

(1) The name and last known mailing address of a Participant and the name and last known mailing address of each child covered by the order,

(2) a reasonable description of the type of coverage to be provided by the Plan to each child covered by the order, or the manner in which such type of coverage is to be determined,

(3) The period to which the order applies, and

(4) Each plan to which such order applies.

Except to the extent permitted by Section 609(a)(4) of ERISA, a Qualified Medical Child Support Order cannot require the Plan to provide any type of form of benefit, or any option, not otherwise provided under the Plan. The Plan Administrator shall adopt procedures respecting a Qualified Medical Child Support Order in accordance with Section 609 of ERISA.

(bb) "**Salary Reduction Contributions**" means amounts by which a Participant elects to reduce his or her earnings / compensation on a before-tax basis through the Cafeteria Plan in order to pay for Component Plans.

(cc) **"Spouse"** means a person of the opposite or same sex who is a husband or wife, pursuant to a legal union defined as a "marriage" conducted by any domestic or foreign jurisdiction having the legal authority to sanction marriages, which are recognized by any state, possession, or territory of the United States.

(dd) "**Summary of Coverage"** means the description of welfare plan services and benefits prepared on behalf of the Plan Administrator to describe the details of a self-insured Component Plan. A Summary of Coverage is a component of the Summary Plan Description as permitted by ERISA Reg. Section 2520.102-3(j)(2) and (3).

(ee) "**Summary of Insurance**" means the description of welfare plan services and benefits prepared by an Insurer or HMO to describe the details of a fully-insured Component Plan. A Summary of Insurance is a component of the Summary Plan Description as permitted by ERISA Reg. Section 2520.102-3(j)(2) and (3).

(ff) "**Summary Plan Description**" means a summary plan description, as defined under Section 102 of ERISA, of the Employer (and all summaries of material modifications thereto), prepared by the Plan Administrator, that designates the Plan as the applicable Plan and describes the provisions of the Plan.

(gg) "**Uniformed Services**" means the Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

(hh) "**USERRA**" means the Uniformed Services Employment and Reemployment Rights Act, as now in effect or as hereafter amended, including any regulations and rulings promulgated thereunder and any successor statute of similar import. Reference to any section or subsection of USERRA includes references to any comparable or succeeding provisions of any legislation that amends, supplements, or replaces such section or subsection.

2.2 Construction

Whenever any words are used in the singular form, they shall be construed as though they were also used in the plural form in all cases where the plural would so apply. Headings of articles and sections are inserted for convenience and reference, and they constitute no part of the Plan. Except where otherwise indicated by the context, any masculine terminology herein shall include the feminine and neuter.

Article 3 Participation

3.1 Eligibility

Employees and their Dependent(s) shall be eligible to participate in this Plan in accordance with the eligibility terms set forth in the Summary Plan Description for the applicable Component Plan.

3.2 Determination of Eligibility by Plan Administrator

The determination of eligibility to participate in the Plan shall be made by the Plan Administrator. The Plan Administrator's good faith determination shall be binding and conclusive upon all persons.

As explained in the Summary Plan Description, an Employee, classified as a regular Employee, who works at least 20 hours per week is eligible for benefits under the Plan.

The Company intends to offer medical coverage that is minimum essential coverage that meets minimum value and is affordable to all Employees who work at least 20 hours per week, in accordance with Section 4980H of the Code, as amended, and related regulations.

3.3 Commencement of Participation

All Eligible Employees and their eligible Dependents shall become Covered Persons under the Plan in accordance with the rules set forth in the Summary Plan Description for the applicable Component Plan.

3.4 Elections and Changes in Elections for Benefits

For purposes of the benefits provided under the Component Plans, the Plan Administrator may designate an annual enrollment period and the benefit options available for election for the following Plan Year. The election of the benefit options and changes thereto shall be made in the manner, and subject to the conditions, specified by the Plan Administrator.

3.5 Participation During Leaves of Absence

(a) Any Participant who is not at work because of a paid Leave of Absence shall continue benefits under the Plan in accordance with the Component Plans, the Summary Plan Description and the written Leave of Absence policies of the Employer. To continue benefits, the Participant must have elections in place before the commencement of the Leave of Absence. Regular Participant Contributions deducted from the Participant’s compensation shall continue during the Leave of Absence in the event of paid Leave of Absence.

(b) Any Participant who is not at work because of an unpaid FMLA, USERRA, or any other approved unpaid Leave of Absence, may, at the Participant’s option, continue certain benefits under the Plan that the Participant elected during the Leave of Absence so long as the Participant continues to make any required Participant Contributions. The following shall be determined in accordance with the written Leave of Absence policies of the Employer, as applicable, the Component Plans, the Summary Plan Description and any applicable law, including FMLA and USERRA:

(1) Whether such benefits are available for continuation during an unpaid Leave of Absence;

(2) Payment for such benefits continued during Leave of Absence; and

(3) The period of time during which such benefits may be continued.

(c) Any Participant returning from an FMLA, USERRA, or other approved unpaid Leave of Absence, who is treated as a continuing Employee, shall be reinstated in the same or equivalent benefits to the benefits he received prior to the unpaid Leave of Absence, adjusted for any changes in benefits that affected the workforce as a whole. Such reinstatement shall be made in accordance with the written Leave of Absence policies of the Employer, the Component Plans, the Summary Plan Description and any applicable law, including FMLA and USERRA.

3.6 Effective Dates and Conditions

In order to participate in a particular Component Plan and receive benefits under this Plan, Eligible Employees and their eligible Dependents must meet any additional participation requirements of the Component Plans. An Eligible Employee must elect any such benefits using the election process established by the Plan Administrator unless the benefit is automatically provided. Such coverage shall be effective as of the date or dates set forth in the applicable Component Plan's Summary Plan Description.

3.7 Termination of Coverage

Coverage under this Plan of any Covered Person shall terminate in accordance with the rules and procedures set forth in the applicable Component Plan's Summary Plan Description. Benefits under all Component Plans (for all Covered Persons) will cease upon termination of the Plan.

3.8 Continuation/Conversion

Notwithstanding any provision of the Plan to the contrary, opportunities to continue and/or convert coverage under this Plan, including the Component Plans, shall be provided in accordance with applicable state and federal law, including COBRA and USERRA. COBRA and USERRA rights are explained in detail in the applicable Summary Plan Description.

3.9 Incorporation of Plans and Policies

The eligibility provisions, benefit provisions and such other provisions of the applicable Component Plan's Summary Plan Description, Summary of Coverage, Summary of Insurance, Insurance Contract and/or HMO Contract as may be modified from time to time hereafter, and as are consistent with the terms and conditions of this Plan are incorporated herein by reference and shall be of the same force and effect under this Plan as if they were set forth herein. Furthermore, if any provision of a Component Plan shall at any time hereafter conflict with the provisions of this Plan, such provision of the Component Plan shall no longer be deemed a part of this Plan.

3.10 Qualified Medical Child Support Orders

The Plan shall provide benefits in accordance with the applicable requirements of any QMCSO in accordance with such written procedures as shall be established by the Plan Administrator. Except to the extent permitted by Section 609(a) of ERISA, no QMCSO shall require the Plan to provide any type or form of benefit or option not otherwise provided by the Plan. Covered Persons and beneficiaries can obtain, without charge, a copy of such procedures from the applicable party specified in the applicable Summary Plan Description.

Article 4 Benefits

4.1 Generally

Benefits hereunder shall be provided through the Component Plans. As permitted by this Section 4.1, the Company, as Plan Sponsor, has the authority to determine what Component Plans shall be offered to Eligible Employees and eligible Dependents provided the availability of such Component Plans are properly communicated to Eligible Employees in accordance with ERISA.

The persons covered and the benefits provided by each Component Plan shall be determined in accordance with the applicable Summary Plan Description, Summary of Coverage, Summary of Insurance, Insurance Contract and/or HMO Contract; provided that, except to the extent the applicable Summary Plan Description, Summary of Coverage, Summary of Insurance, Insurance Contract and/or HMO Contract expressly provides otherwise, persons who are not Eligible Employees or eligible Dependents shall not be eligible for coverage or benefits under the Plan; and provided further that, except to the extent required by applicable law, coverage and benefits under the Plan shall not be provided in excess of the coverage and benefits described in the applicable Summary Plan Description, Summary of Coverage, Summary of Insurance, Insurance Contract and/or HMO Contract.

4.2 Third Party Recovery / Subrogation

If 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 carrier, for an injury, illness or other condition, including death, the Plan shall not cover either the reasonable value of the services to treat such an injury, illness or other condition or the treatment of the applicable illness, injury or other condition. These benefits are specifically excluded.

If the Plan does advance moneys or provide care for such an injury, illness or other condition, then in consideration for participation in the Plan and the advancement of benefits under the Plan, a Covered Person acknowledges the Plan's right of recovery and agrees to promptly convey to the Plan 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 any benefits advanced or provided to the Covered Person by the Plan, regardless of whether or not:

(a) The Covered Person has been fully compensated or made whole for the Covered Person's loss.

(b) The Covered Person or any other party admits to liability.

(c) The recovery is itemized or called anything other than a recovery for any expenses incurred.

If a recovery is made, the Plan 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 Plan, the Covered Person acknowledges and agrees to the following:

(a) Acknowledge that the Plan has first priority against the proceeds of any such settlement, arbitration award, verdict or other amounts the Covered Person receives.

(b) 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 Plan.

(c) Assign to the Plan any benefits the Covered Person may have under any automobile policy or other coverage, to the extent of the Plan's claim for reimbursement.

(d) Cooperate with the Plan and its agents, provide relevant information and take actions that the Plan or its agents reasonably request to assist the Plan in making a full recovery of the value of benefits paid.

(e) Consent to the Plan's right to impress an equitable lien or constructive trust on the proceeds of any settlement to enforce the Plan's rights under this Section.

(f) Consent to the Plan's right to deduct from any future benefits otherwise payable under the Plan the value of benefits advanced under this Section to the extent not recovered by the Plan.

(g) Agree to not take any action that prejudices the Plan's rights of reimbursement.

The Plan 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 Plan in pursuit of the Plan's rights hereunder. Specifically, no court costs or attorney's fees may be deducted from the Plan's recovery without the express written consent of the Plan. 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 Plan'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 Plan's interest and the Plan shall be reimbursed in first priority from any such award or settlement.

The Plan shall recover the full amount of benefits advanced and paid hereunder, 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 Plan is subrogated to all of such Covered Person's rights against any party liable for a Covered Person's injury, illness or other condition, including death, or is or may be liable for the payment for the treatment of such injury or occupational illness (including any insurance carrier), to the extent of the value of the health and welfare benefits advanced to such Covered Person under the Plan. The Plan 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 Plan to bring an action to clarify the Covered Person's rights under the Plan. The Plan 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 Plan, at its sole discretion.

The Covered Person is obligated to cooperate with the Plan and its agents in order to protect the Plan's subrogation rights. Cooperation means providing the Plan or its agents with any relevant information requested by them, signing and delivering such documents as the Plan or its agents reasonably request to secure the Plan's subrogation claim and obtaining the consent of the Plan or its agents before releasing any party from liability for payment of any 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 Plan under this Section. In the event that a Covered Person fails to cooperate with this provision, including executing any documents required herein, the Plan may, in addition to remedies provided elsewhere in the Plan and/or under the law, offset from any future benefits otherwise payable under the Plan the value of benefits advanced under this Section to the extent not recovered by the Plan.

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

4.3 Compliance with Federal Group Health Plan Benefits and Coverage Mandates

Any Component Plan shall comply with benefit and coverage provisions to the extent required by law including, but not limited to:

(a) **Adoption**. The Plan shall provide group health benefits to Dependent children placed with Participants for adoption under the same terms and conditions as apply in the case of Dependent children who are natural children of Participants, irrespective of whether the adoption has become final, and the Plan shall not restrict coverage of such a child solely on the basis of a preexisting condition of such child at the time that such child would otherwise become eligible for coverage under the Plan, if the adoption or placement for adoption occurs while the Participant is eligible for coverage under the Plan, in accordance with Section 609(c) of ERISA.

(b) **Pediatric Vaccines**. To the extent it applies, the Plan shall not reduce the continued coverage costs of a pediatric vaccine, under Section 609(d) of ERISA.

(c) **FMLA and USERRA**. The Plan shall provide coverage for Participants on a Leave of Absence to the extent required under the FMLA or under USERRA.

(d) **Mothers and Newborns**. A Component Plan that is not an exempt or an excepted benefit, as defined in Section 732 of ERISA, shall continue coverage for mothers and newborns in accordance with Section 711 of ERISA.

(e) **Mental Health Parity**. A Component Plan that is not an exempt or an excepted benefit, as defined in Section 732 of ERISA, that provides mental health or substance use disorder benefits (MH/SUD), shall provide such MH/SUD benefits in accordance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Section 712 of ERISA.

(f) **Womens' Health and Cancer Rights Act**. A Component Plan that is not an exempt or an excepted benefit, as defined in Section 732 of ERISA, shall provide coverage for reconstructive surgery following mastectomy to the extent required by Section 713 of ERISA.

(g) **Group Market (Insurance) Reforms**. A Component Plan that is not an exempt or an excepted benefit, as defined in Section 732 of ERISA, shall comply with the applicable group market (insurance) reforms that apply to a group health plan under the Affordable Care Act. None of the medical benefit packages under the Plan are "grandfathered health plans," as explained ERISA Reg. Section 2590.715-125 and related guidance. Accordingly, the Plan shall comply with the expanded list of group market reforms that apply to medical benefit packages that do not maintain grandfathered health plan status and such compliance shall occur not earlier than the time required for a group health plan with a calendar year plan year. The Plan Administrator has determined that the employee assistance program does not provide significant benefits in the nature of medical care or treatment and otherwise meets the requirements to be an excepted benefit under Section 732 of ERISA and, therefore, is not subject to any group market reform requirements. The dental and vision benefit packages are limited-scope, excepted benefits under Section 732 of ERISA and, therefore, are not subject to any of the group market reform requirements.

As explained in Section 715 of ERISA and related regulatory and sub-regulatory guidance, the Affordable Care Act group market (insurance) reforms that apply to all Component Plans that are considered group health plans that are not exempt or excepted benefits under Section 732 of ERISA are:

(1) Prohibition of preexisting condition exclusions under PHSA 2704 and ERISA reg. section 2590.715-2704;

(2) Prohibiting discrimination against participants and beneficiaries based on a health factor under PHSA 2705 and ERISA reg. section 2590.715-2705;

(3) Prohibition on waiting periods that exceed 90 days under PHSA 2708 and ERISA reg. section 2590.715-2708;

(4) Prohibition on lifetime or annual dollar limits on essential health benefits under PHSA 2711 and ERISA reg. section 2590.715-2711;

(5) Prohibition on rescissions under PHSA 2712 and ERISA reg. section 2590.715-2712;

(6) Eligibility of children until at least age 26 under PHSA 2714 and ERISA reg. section 2590.715-2714;

(7) Summary of benefits and coverage and uniform glossary under PHSA 2715 and ERISA reg. section 2590.715-2715; and,

(8) Solely with respect to insured Component Plans, the medical loss ratio requirements under PHSA 2718.

As explained in Section 715 of ERISA and related regulatory and sub-regulatory guidance, the Affordable Care Act group market (insurance) reforms that apply to all Component Plans that are considered group health plans that have lost grandfathered health plan status and are not exempt or excepted benefits under Section 732 of ERISA are:

(9) Accommodations in connection with coverage of preventive health services under PHSA 2713 and ERISA reg. section 2590.715-2713A;

(10) Internal claims and appeals and external review process as discussed in Article 6 of the Plan and under PHSA 2719 and ERISA reg. section 2590.715-2719;

(11) Consumer patient protections (choice of health care professional and coverage of emergency services) under PHSA 2719A and ERISA reg. section 2590.715-2719A;

(12) Provider non-discrimination under PHSA 2706(a);

(13) Limitations on cost sharing (i.e., the out-of-pocket expense maximum requirements) under PHSA 2707(b); and,

(14) Coverage for individuals participating in approved clinical trials under PHSA 2709.

While not referenced in this Plan document, the Component Plans that are subject to the group market (insurance) reforms will comply with respect to both regulatory and sub-regulatory guidance. To the extent that the U.S. Department of Labor, Internal Revenue Service or Department of Health and Human Services, as applicable, implements additional group market (insurance) reforms required by the Affordable Care Act, the Plan shall comply to the extent necessary.

4.4 Benefit Election

During the enrollment period, a Participant may elect to either receive any or all of the benefits described in the Component Plans for which the Participant and any eligible Dependent(s) is eligible. Each Participant shall be notified of the Eligible Employee's share of the cost, if any, of each benefit option prior to the enrollment period for the Plan Year.

4.5 Coordination of Benefits

The Component Plans may contain special procedures for coordinating benefits when a Covered Person has group health coverage under two or more plans. The coordination of benefits procedures to be followed by the Covered Person to obtain payment of benefits under this Plan shall be in accordance with the rules and procedures set forth in the Component Plans. In addition, the Plan shall comply with the Medicare Secondary Payer rules of the Social Security Act set forth at 42. U.S.C. Section 1395y(b), including any regulatory and sub-regulatory guidance.

4.6 Dual Coverage Rules

The Component Plans may contain special procedures for providing benefits to a Covered Person who is an eligible Dependent and an Eligible Employee under the Plan. Such special procedures may limit such Covered Person's eligibility for participation and/or the amount of benefits available under the Plan.

4.7 Payment of Benefits

The Component Plans shall be paid for by the Plan. The Plan (or the Plan Sponsor acting on behalf of the Plan) may contract with an HMO, an Insurer, or another third party to provide a particular Component Plan under the Plan. The liability of the Plan, the Employer, the Plan Administrator, and, if applicable, the HMO, the Insurer or other third-party provider to provide benefits under a Component Plan shall be limited by the terms of this Plan instrument and the applicable Summary Plan Description, Summary of Coverage, Summary of Insurance, Insurance Contract, and/or HMO Contract.

4.8 Tax Withholding

The amount of any benefit paid from the Plan to, or in respect of, a Covered Person under a Component Plan shall be reduced by the amount of any income tax or employment tax that is required to be withheld pursuant to any applicable federal, state, or local law, or any applicable foreign law.

4.9 Other Adjustments—Overpayment Provision

If, for any reason, any benefit payable under the Plan is erroneously paid or exceeds the amount appropriately payable under the Plan to a Covered Person, the Covered Person shall be responsible for refunding the overpayment to the Plan. In addition, if the Plan makes any payment that, according to the terms of the Plan, should not have been made, the Plan Administrator, the Company (or designee), or the applicable Insurer may recover that incorrect payment, whether or not it resulted from the Plan Administrator, the Company, an Insurer, an HMO, or any other third party provider's own error, from the person to whom it was made or from any other appropriate party.

In the sole discretion of the Plan Administrator, the refund or repayment may be made in one or a combination of the following methods (a) in the form of a single lump-sum payment, (b) as a reduction of the amount of future benefits otherwise payable under the Plan, or (c) any other method as may be permitted in the sole discretion of the Plan Administrator, Insurer or HMO and as permitted by law.

With respect to Component Plans provided through an Insurer or HMO, the contract language may contain information regarding the Plan's right to subrogate or seek reimbursement of erroneously paid benefits (including payments in excess of the amount appropriately payable). With respect to self-insured component benefit programs, subrogation or reimbursement rights may be set forth in the Summary Plan Description or other governing documentation.

4.10 Payment to Participant

(a) Except as otherwise provided in subsection (b) below, benefit payments under a Component Plan shall be made to the Participant.

(b) To the extent permitted under a Component Plan, payments may be made to a third party to whom a Participant has made a valid assignment of his right to receive such payments. In addition, if the Plan Administrator determines that a Participant is unable to care for his own affairs, the Plan Administrator may authorize the Plan to make benefit payments to the court-appointed legal guardian of the Participant, to an individual who has become the legal guardian of the Participant by operation of state law, or to another individual who the Plan Administrator determines to be entitled to receive such payments on behalf of the Participant.

(c) If a payment of benefits is made under a Component Plan to a third party in accordance with subsection (b), above, the Plan, the Employer, the Plan Administrator, and, if applicable the HMO, the Insurer or other third-party provider shall be relieved, to the fullest extent permitted by law, of any obligation to make a duplicate payment to or on behalf of such Participant.

4.11 Unclaimed Benefits

If, within twelve (12) months after any amount becomes payable hereunder to a Covered Person and the same shall not have been claimed or any check issued under the Plan remains uncashed, provided

reasonable care shall have been exercised in attempting to make such payments, the amount thereof shall be forfeited and shall cease to be a liability of the Plan.

Article 5 Administration

5.1 Plan Administrator

The Plan Administrator shall have the discretionary authority to interpret the Plan, including each Component Benefit, and to decide any and all matters arising hereunder. The Plan Administrator's discretionary authority shall include, but shall not be limited to, the following authority:

(a) To make and enforce such rules and regulations as it shall deem necessary or proper for the efficient administration of the Plan;

(b) To construe and interpret the Plan, to decide all questions concerning the Plan, including without limitation the discretionary authority to resolve questions of fact and to remedy possible ambiguities, inconsistencies, and/or omissions, in the Plan and related documents by general rule or particular decision, and to determine the eligibility of any person to participate in the Plan and the entitlement of any person to any benefits thereunder;

(c) To establish and maintain the Component Plans and to maintain records of Salary Reduction Contributions;

(d) To prescribe procedures to be followed and the format to be used by Eligible Employees and participants to make elections pursuant to this Plan, including any Component Plan;

(e) To prepare and distribute information explaining this Plan and the benefits under this Plan or any Component Plan in such manner as the Plan Administrator determines to be appropriate;

(f) To make available to each Participant or Covered Person under the Plan his records and related Plan materials as required by ERISA to the extent that a Component Benefit is subject to ERISA;

(g) To request and receive from all Employees and Covered Persons such information as the Plan Administrator shall from time to time to determine to be necessary for the proper administration of the Plan

(h) To appoint, remove, or substitute agents, counsel, accountants, consultants, actuaries, or other persons to assist in administering the Plan or any Component Plan;

(i) To designate specified other persons to carry out any of its responsibilities under the Plan or any Component Plan to the extent necessary;

(j) To sign documents for purposes of administering the Plan, or to designate an individual or individuals to sign documents for purposes of administering this Plan;

(k) To secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and

(l) To prepare, file, and disseminate all reports and disclosures required by applicable law.

The Plan Administrator's determination on any and all questions arising out of the interpretation or administration of the Plan and any Component Plan shall be final, conclusive, and binding on all parties.

5.2 Records and Reports of the Plan Administrator

The Plan Administrator shall keep such written records as it shall deem necessary or proper, which records shall be open to inspection by the Company. The Plan Administrator shall prepare and submit to the Company an annual report which shall include such information as the Plan Administrator deems necessary or advisable.

5.3 Named Fiduciary

(a) The Plan Administrator shall be a "named fiduciary" with respect to the Plan for purposes of ERISA Section 402(a)(1), and shall have only those duties, responsibilities and obligations (referred to collectively as "fiduciary duties") as specifically are given them under the Plan, the Component Plans or as otherwise are imposed by applicable law. The fiduciary duties of the named fiduciaries shall be exercisable separately and not jointly, and each named fiduciary's duties will be limited to the specific areas indicated for such named fiduciary. However, the named fiduciaries may by written agreement allocate fiduciary duties among themselves.

(b) The documents governing any Component Plan may designate other persons or entities as fiduciaries with respect to the Plan, each with complete authority to review all claims for benefits and determine all issues under the Plan with respect to which it has been designated named fiduciary. In exercising its fiduciary duties with respect to the Plan, each named fiduciary designated hereunder shall have the fullest discretionary authority permitted under law to determine whether and to what extent Covered Persons are entitled to Plan benefits and to construe disputed or doubtful terms. Each named fiduciary shall be responsible for construing and interpreting the particular provisions of the Plan for which it has been designated a named fiduciary in accordance with ERISA and the terms of any contracts or policies entered into between the Plan and the named fiduciary. Each named fiduciary designated hereunder shall be deemed to have properly exercised such authority unless it has abused its discretion hereunder by acting arbitrarily and capriciously.

(c) The designation of any entity as a named fiduciary under the Plan shall not create any right or expectation on the part of such entity to continue in such position for any particular period of time. The Plan may, in its sole and absolute discretion and at any time, terminate, replace, substitute or otherwise remove any named fiduciary designated under the Plan.

(d) Each named fiduciary may appoint and/or employ a person or persons other than a named fiduciary under the Plan to render advice with regard to any responsibility such fiduciary has under the Plan. Any such appointment or employment shall be solely at the expense of that named fiduciary, and shall be effective only with the written consent of the Plan Administrator.

5.4 Reliance on Participants and Tables

The Plan Administrator may rely upon the direction, information, or election of a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant.

In administering the Plan, the Plan Administrator shall be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by, or in accordance with the instructions of, accountants, counsel or other experts employed or engaged by the

Plan Administrator. All actions taken in a good faith reliance on advice from such advisors are conclusive and binding upon all persons.

5.5 Indemnification

The Employer agrees to indemnify any person acting in good faith in his or her role as Plan Administrator, or an Employee of the Employer who is a delegate of any committee administering the Plan, against any and all liabilities, financial penalties, or damages, including attorney's fees, as a result of a lawsuit against the Plan or its fiduciaries occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

5.6 Delegations of Authority by the Plan Administrator

The Plan Administrator may, in its discretion, delegate to any other person or persons authority to act on behalf of the Plan Administrator, including but not limited to the authority to make any determination or to sign checks, warrants, or other instruments incidental to the operation of the Plan or any Component Plan (or portion thereof) that the Plan Administrator administers, or to the making of any payment specified therein.

5.7 Employment of Assistants

The Plan Administrator and the Plan Sponsor are authorized to employ counsel and to employ persons to provide such actuarial, clerical, or other services as they may require in carrying out their duties under the Plan or any Component Plan.

5.8 Availability of Documents

A copy of the Plan and any and all future amendments and such records and data as are required under ERISA shall be available to any Participant, Employee, or an employee organization that represents Employees of the Employer at reasonable times during normal business hours at the business office of the Plan Administrator.

5.9 Legal Process

The Plan Administrator shall be the agent for service of legal process unless it designates another person to be such agent. Service of legal process involving the Plan may be delivered to the Plan Administrator in care of:

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5.10 Administrative Expenses

All expenses incurred prior to termination of the Plan that shall arise in connection with the administration of the Plan, including but not limited to administrative expenses, and compensation and other expenses and charges of any actuary, accountant, counsel, specialist or other person who shall be employed by the Plan Administrator in connection with the Plan administration, shall be paid by the Plan Sponsor.

5.11 Bonding

To the extent required by ERISA or other applicable law with respect to benefits subject to ERISA, every fiduciary of the Plan, including any Component Plan, including every person handling funds of the Plan or a Component Plan shall be bonded. The Plan Administrator may apply for and obtain fiduciary liability

insurance insuring the Plan against damages by reason of breach of fiduciary duty at the Plan's expense and insuring each fiduciary against liability to the extent permissible by law at the Plan Sponsor's expense.

5.12 Several Fiduciary Liability

To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act, except for its own willful misconduct or willful breach of this Plan.

5.13 Nondiscrimination

The Plan Administrator shall not operate the Plan in a manner that causes discrimination in favor of those Participants or Employees who are (or were) officers or highly compensated employees or key employees of the Employer (as defined in the Code). In addition, whenever in the administration of the Plan, any discretionary action by the Plan Administrator is required the Plan Administrator shall exercise its authority in a nondiscriminatory manner so that all persons similarly situated shall receive substantially the same treatment.

5.14 Electronic Administration and Authorization of Payroll Deductions

The Plan Administrator may distribute and collect information or conduct transactions by means of electronic media, including, but not limited to, electronic mail systems, Internet, or voice response system, except when a specific provision of the Code, ERISA or other guidance of general applicability sets forth rules or standards regarding the media through which such dissemination of information or transaction may be conducted. By using electronic media, a Participant consents to deductions from his compensation in accordance with his elections made through the system.

5.15 Coordination with Component Plans

This Article 5 applies with respect to each Component Plan which appears in Schedule B unless the Component Plan specifically addresses these issues in a manner that is consistent with applicable state and federal law. However, any references to "Plan Administrator" shall be construed in accordance with the definition and description of duties contained in this Article 5.

Article 6 Claims and Appeals Procedures

6.1 Claims and Appeals Procedures

(a) The claim procedures to be followed by Covered Persons to obtain payment of benefits covered under this Plan shall be in accordance with the rules and procedures set forth in the Summary Plan Description of the Component Plans. The Component Plans shall govern the claims and appeals procedures in accordance with the requirements of ERISA. Notwithstanding the foregoing, unless a Component Plan's Summary Plan Description specifically provides otherwise, a claim for benefits must be submitted not later than 12 months after the date that the claim arises (i.e., the date a medical service is provided and the charge is incurred). In the event that a claim, as originally submitted, is not complete, the claimant may be notified and the claimant shall then have the responsibility for providing the missing information within the timeframe stated in such notification.

(b) The claim procedure to be followed by Employees for eligibility under this Plan shall be in accordance with the rules and procedures set forth in the Summary Plan Description for the Component Plans. The Plan Administrator shall have the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to eligibility for the Plan.

(c) The claims procedures applicable to claims made for benefits under this Plan do not apply to casual or general inquiries regarding particular Component Plan benefits that may be provided under the Plan. In order for an inquiry to constitute a claim for benefits or an appeal of a denial of a claim for benefits, a Participant must follow the claim procedures under the applicable Summary Plan Description for the Component Plans.

(d) For purposes of the determination of the amount of, and entitlement to, benefits of the Component Plans provided under Insurance Contracts or HMO Contracts, the respective Insurer or HMO is the named fiduciary under the Component Plan, with the full power to interpret and apply the terms of the Component Plan as they relate to the benefits provided under the applicable Insurance Contract or HMO Contract.

To obtain benefits from the Insurer or HMO of a Component Plan, a claimant must follow the claims procedures described in the applicable Summary of Insurance, which may require a claimant to complete, sign and submit a written claim on the Insurer's or HMO's form. The Insurer or HMO shall decide a claim in accordance with its reasonable claims procedures, as required by ERISA, applicable state insurance law or other applicable law as required.

The Insurer or HMO has the right to secure independent medical advice and to require such other evidence, as it deems necessary, in order to decide a claim. If the Insurer or HMO denies a claim, in whole or in part, a claimant will receive a written notification setting forth the reason(s) for the denial.

If a claim is denied, a claimant may appeal to the Insurer or HMO for a review of the denied claim. The Insurer or HMO will decide the appeal in accordance with its reasonable claims procedures, as required by ERISA.

Upon a final decision to deny a claim for benefits under a Component Plan that is a non-grandfathered group health plan, the claimant may request an external review that follows the state external review process applicable to and binding on, that Component Plan, per 29 CFR 2590.715-2719(c). To the extent that a Component Plan is not required to comply with a state external review process under 29 CFR 2590.715-2719(c), it must comply with the federal external review process as set forth in 29 CFR 2590.715-2719(d). External review is not available for a denial, reduction, termination, or failure to provide payment for a benefit based on a determination that an Employee or Dependent fails to meet the requirements for eligibility under the terms of the Component Plan.

(e) For purposes of the determining the amount of, or the entitlement to, benefits under a Component Plan provided through a self-funded arrangement, the applicable designated claims fiduciary (as provided in the Summary Plan Description) is the named fiduciary under the Component Plan, with the full power to interpret and apply the terms of the Component Plan as they relate to the benefits provided under the applicable self-funded arrangement. In addition, such procedures shall be described in the applicable Summary Plan Description, in accordance with the timing required under ERISA's reporting and disclosure rules. The Summary Plan Description shall specify the claims fiduciary for each Component Plan that is subject to ERISA.

The designated claims fiduciary will decide a claim in accordance with reasonable claims procedures, as required by ERISA. The designated claims fiduciary has the right to secure independent medical advice and to require such other evidence, as it deems necessary, in order to decide a claim. If the designated claims fiduciary denies a claim, in whole or in part, a claimant will receive a written notification setting forth the reason(s) for the denial.

If a claim is denied, the claimant may appeal to the designated claims fiduciary for a review of the denied claim. The designated claims fiduciary will decide the claimant's appeal in accordance with reasonable claims procedures, as required by ERISA.

Upon a final decision to deny a claim for benefits under a self-funded Component Plan that is a non-grandfathered group health plan, the claimant may request an external review that follows the federal external review requirements set forth in 29 CFR 2590.715-2719(d), the terms of which are hereby incorporated by reference. External review is not available for a denial, reduction, termination, or failure to provide payment for a benefit based on a determination that an Employee or Dependent fails to meet the requirements for eligibility under the terms of the Component Plan.

(f) Unless specified otherwise in the Summary Plan Description of a Component Plan or prohibited by federal law, any claimant seeking benefits must initiate legal action against the Plan no later than six (6) months following the claimant's exhaustion of the Component Plan's administrative remedies.

6.2 Prohibition Against Rescission

The Plan Administrator is prohibited from rescinding or retroactively terminating the coverage of a Covered Person under a Component Plan that is a group health plan subject to the Affordable Care Act, unless such Covered Person commits an act, practice, or omission that constitutes fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a Dependent; provided, however, that the foregoing prohibition shall not

prohibit retroactive termination in the event: (i) a Participant fails to timely pay premiums towards the cost of coverage; (ii) the Plan erroneously covers an ex-spouse of a Participant because the Participant failed to timely report a divorce to the Plan Administrator; (iii) the Plan erroneously covers a Participant due to a reasonable administrative delay in terminating coverage; or (iv) any other circumstance under which retroactive termination would not violate the Affordable Care Act.

The Plan Administrator shall provide a Covered Person with 30 days' prior written notice of intent to rescind coverage. The Covered Person may appeal the rescission of coverage as a denial of a post-service claim under this Article 6. In the event the Plan Administrator rescinds a Covered Person's coverage on account of an act, practice, or omission that constitutes fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a Dependent, such rescission shall not cause the individual to incur a "qualifying event" as provided under COBRA.

Article 7 Funding and Contributions

7.1 Plan is a Single Plan—Funding

Plan is a Single Plan. The Plan and all of its Component Plans shall be a single plan for purposes of ERISA.

All costs of the Plan, including Plan benefits, Plan administrative expenses, and the retention of experts and advisors, are paid out of the Plan Sponsor's general assets and, in some cases, Insurance Contracts and HMO Contracts. Nothing in the Plan is intended to require the establishment of a trust.

Benefits may be provided though one or more Insurance Contracts or HMO Contracts or such other funding vehicles established with respect to the Component Plans. The Plan may maintain reinsurance or stop-loss insurance to protect the Plan in the event claims exceed projections.

Component Plans under the Plan may be provided on an insured or self-insured basis, or a combination thereof, at the discretion of the Company. The Summary Plan Description shall set forth whether a particular Component Benefit is provided on an insured or self-insured basis.

Notwithstanding the foregoing, in the event that the Plan Administrator determines, in its sole and absolute discretion, that the Plan is required by law to establish and maintain a trust to hold Participant Contributions or pay benefits, payments under the Plan shall be paid out of such a trust, administered in compliance with Federal law, established for this purpose. Any interest earned on amounts placed in such trust shall be used to pay administrative expenses of the Plan or for such other purpose as may be set forth in the trust.

7.2 Contributions to the Plan

(a) **Employer Contributions**. The Employer shall make such contributions in such amounts and at such times as the Plan Administrator shall direct, in accordance with the funding policy and methods of the Plan.

(b) **Participant Contributions**.

(1) To be eligible to receive benefits under any Component Plan for which Participant Contributions are required (which may be pre-tax or after-tax, subject to the terms of the Cafeteria Plan provisions and applicable Component Plan), each Participant shall make any required Participant Contributions in such amounts and at such time as the Plan Administrator shall from time to time direct, as outlined in the Summary Plan Description, Summaries of Coverage, Summaries of Insurance, enrollment materials, and/or the Cafeteria Plan. Participant Contributions shall be transmitted by the Company directly to an Insurer, as soon as practicable after such amounts have been deducted from an Eligible Employee's Compensation or otherwise received in accordance with Department of Labor Regulation section 2510.3-102(c) and shall only be used for the reason such amounts were collected.

(2) Failure of a Participant to make Participant Contributions with respect to any Component Plan by the required due date shall be deemed an election by such Participant to cease participation in such Component Plan as of the date established by the Summary Plan

Description, Summary of Coverage, or Summary of Insurance or as directed by the Plan Administrator, for which the missed Participant Contribution was due; provided however, that termination of benefits under any Component Plan shall in all instances be subject to and in accordance with applicable legal requirements, including but not limited to coverage requirements imposed by the FMLA.

(3) If a Participant fails to pay Participant Contributions during a Leave of Absence and the Plan Administrator in its discretion continues coverage under any Component Plan in effect during such Leave of Absence, any unpaid Participant Contributions during such period shall be collected in arrears through payroll deductions through the Cafeteria Plan, or as otherwise directed by the Plan Administrator upon the Participant's return to employment with the Employer or expiration of the Participant's Leave of Absence, as applicable.

Article 8 Insurance and HMOs

8.1 Insurance and HMOs Generally

To the extent that benefits are provided under an Insurance Contract or an HMO Contract, the Participant's right to such benefits shall be limited to the amounts payable by such Insurance Contract or HMO Contract and the receipt thereof shall be subject to satisfaction of all of the terms, covenants, conditions, rules and regulations of the Insurance Contract or HMO Contract. The Plan shall not have any independent obligation or duty to provide benefits to Covered Persons to the extent that such benefits are to be provided by an Insurance Contract or HMO Contract. The Plan Administrator shall have the right from time to time to change the coverages or Insurers of any one or more Insurance Contracts or HMO Contracts.

8.2 Provisions Relating to Insurers and HMOs

No Insurer shall be required or permitted to issue an Insurance Contract or HMO Contract that is inconsistent with the purposes of this Plan, nor be bound to take any action not in accordance with the terms of any Insurance Contract or HMO Contract in connection with this Plan.

8.3 Conflicting Provisions

If any provision of any Insurance Contract or HMO Contract conflicts with the provisions of this Plan, the provisions of the Insurance Contract or HMO Contract shall prevail.

Article 9 Plan Adoption, Amendment, or Termination

9.1 Employers

An Affiliate may become a participating Employer under the Plan only upon the Affiliate's adoption of the Plan with the written consent of the Plan Sponsor. The Plan Administrator shall list those participating Employers on Schedule A. An Affiliate may withdraw from the Plan and cease being a participating Employer upon providing advance written notice of the withdrawal to the Plan Sponsor and Plan Administrator.

9.2 Amendment or Termination

The Plan was established with the bona fide intention and expectation that it will be continued indefinitely. However, the Company, as Plan Sponsor reserves the right to amend or terminate the Plan or any Component Plan at any time and from time to time and to any extent and in any manner that it deems advisable, by written resolution of the Board of Directors of the Company (the "Board"). The Board may, by written resolution, delegate to one or more persons the authority to exercise this right on its behalf, but the Board shall also retain at all times its own authority to exercise this right. Any delegation of authority pursuant to this Section 9.2 shall remain in effect until the Company revokes this delegation by written resolution of the Board, unless a shorter duration is specified in the initial delegation. In the case of any amendment that increases the benefits under the Plan of any person to whom the authority has been delegated under this Section 9.2 to amend the Plan, such amendment shall not become effective until approved by the Board by written resolution, unless such amendment applies generally to all Plan Participants or to all Participants of a Component Plan.

In the event that the Plan or a Component Plan is discontinued or terminated, all elections and agreements relating to the discontinued or terminated program shall terminate. No additional amounts shall be credited to Participants under such program, and payments under such program shall be made only with regard to expenses incurred during the remainder of the Plan Year, in accordance with the provisions of this Plan or a Component Plan, as the case may be. Written notice of any termination of the Plan and the effective date of such termination shall be provided to Participants.

The termination of a Component Plan (including terminating an Insurance Contract through which such benefits are provided); rather, it is an amendment to the Plan.

9.3 Termination of Insurance or HMO Contract

In the case of any Component Plan paid by an Insurer or HMO pursuant to an Insurance Contract or an HMO Contract, as the case may be, the Plan Administrator may terminate such Contract at any time by providing the Insurer or HMO with such notice as may be required under the terms of such Contract. The Plan Administrator may enter into Contracts with other Insurers or HMOs or through other funding arrangements as the Plan Sponsor may establish for the purpose of providing the Component Plan.

9.4 Amendment of Schedules A and B

The Plan Administrator may amend Schedule A to add or remove an Affiliate from the list of participating Employers. Any such modification shall not necessitate a formal amendment to this Plan document.

The Plan Administrator may amend Schedule B to add or remove a Component Plan. Any such modification shall not necessitate a formal amendment to this Plan document.

9.5 Effect of Amendment or Termination

(a) No amendment to or termination of the Plan or any Component Plan shall cause or permit the assets of the Plan to be used for any purpose other than to defray administrative expenses with respect to Component Plans and to pay benefits provided for under such Component Plans.

(b) All changes to this Plan shall become effective as of a date established by the Plan Administrator, as appropriate, except that no increase or reduction in benefits shall be effective with respect to covered expenses incurred prior to the date a change was adopted by such person(s), regardless of the effective date of the change. Upon termination or discontinuance, contributions and benefits (including benefit) elections relating to the Plan shall terminate.

(c) Upon termination of any Component Plan, the assets of the Plan funding such Component Plan shall be used to pay benefits that Participants have become entitled to receive under the terms of such Component Plan (or, if applicable, to pay premiums due to an Insurer or HMO with respect to such Component Plan) as of the date of termination, and to pay the administrative expenses incurred by the Plan before and in connection with the termination, all in accordance with the written direction of the Plan Administrator. The remaining assets shall be used to pay other Component Plans and to pay the related administrative expenses of such other Component Plans in accordance with the written direction of the Plan Administrator. In no event shall the assets of the Cafeteria Plan inure to the benefit of the Company.

(d) Upon termination of the Plan, the assets of the Plan shall be used to pay benefits that Participants have become entitled to receive under the terms of a Component Plan, and to pay the administrative expenses incurred by the Plan relating to such Component Plan before and in connection with the termination, both in accordance with the written direction of the Plan Administrator. The Plan's remaining assets shall be disposed of in accordance with the written direction of the Plan Administrator. In no event shall the assets inure to the benefit of the Company.

9.6 Certain New or Divested Employees

To the extent authorized by the Plan Administrator (or its designee), special provisions or accommodations may be made for individuals who become Participants by virtue of an acquisition by, or other transaction involving, the Company or an Affiliate and for individuals who cease to be Participants by virtue of a divestiture by, or other transaction involving, the Company or an Affiliate.

Article 10 Miscellaneous

10.1 Governing Law

(a) This Plan shall be construed, administered and enforced according to the federal laws, including ERISA, governing employee benefit plans and, to the extent not inconsistent or preempted therewith, in accordance with the laws of the State of California. Any provision of this Plan in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

(b) Except as otherwise provided in a Component Plan or in subsection (c), below, the Component Plans shall be governed by and administered under ERISA, the Code, and, to the extent not preempted thereby, under the laws of the State of California.

(c) In the case of Component Plans provided by an Insurer or HMO under an Insurance Contract or an HMO Contract, as the case may be, the Insurance Contract or HMO Contract shall be governed by ERISA, the Code, and, to the extent not preempted thereby, under such state law as is applicable to such Insurance Contract or HMO Contract.

(d) Such federal laws, to the extent applicable to a particular Component Plan, shall include but shall not be limited to:

1. **Continuation of Coverage under COBRA**. For each benefit made available under this Plan that is considered to be a "group health plan" under Section 5000(b)(1) of the Code due to Employees and their Spouses and Dependents being provided with health care benefits within the meaning of Section 213(d)(1) of the Code, the Plan shall provide health care continuation coverage to qualified beneficiaries in the manner and to the extent required by Section 4980B of the Code and Sections 601-608 of ERISA and related regulations, including applicable amendments to such sections.

2. **USERRA**. For each Component Plan that is subject to continuation coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994, the Plan shall comply.

3. **HIPAA**. The Plan shall administer the provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") dealing with special enrollment rights in the manner and to the extent required by the applicable requirements of Section 701 of ERISA to the extent applicable, as well as the provisions of the HIPAA Privacy Rule and the HIPAA Security Rule, as explained in Article 11 of this Plan.

4. **GINA**. The Plan shall comply with the provisions of GINA and accordingly, shall not, unless expressly permitted by GINA or corresponding regulations, restrict enrollment or adjust premiums based on genetic information, or require or request genetic information or genetic testing, prior to, or in connection with, enrollment.

5. **Affordable Care Act**. The Plan shall comply with the relevant provisions of the Affordable Care Act.

10.2 No Vested Rights

To the maximum extent permitted by law, no person shall acquire any right, title, or interest in or to any portion of an Insurance Contract or an HMO Contract otherwise than by the actual payment or distribution

of such portion under the provisions of the Plan or a Component Plan, or acquire any right, title, or interest in or to any benefit referred to or provided for in the Plan or any Component Plan otherwise than by actual payment of such benefit. Further, no person has any right, title, or interest in or to the assets of the Employer because of the Plan.

10.3 Information to be Furnished

Any person eligible to receive benefits hereunder shall furnish to the Plan Administrator, its delegate, or to an Insurer or HMO, as applicable, any information or proof requested by the Plan Administrator, its delegate, or any such Insurer or HMO and reasonably required for the proper administration of the Plan or a Component Plan. Failure on the part of any person to comply with any such request within a reasonable period of time shall be sufficient ground for delay in the payment of any benefits that may be due under the Plan or a Component Plan until such information or proof is received by the Plan Administrator, its delegate, Insurer, or HMO, as the case may be. If any person claiming benefits under the Plan or a Component Plan makes a false statement that is material to such person's claim for benefits, the Plan Administrator, Insurer, or HMO, as the case may be, may offset against future payment any amount paid to such person to which such person was not entitled under the provisions of the Plan or a Component Plan. Further, the Plan Administrator has the authority to take such additional action, as may be deemed necessary, to make the Plan whole, in accordance with the law.

10.4 Non-Alienation

To the extent permitted or required by law, the rights or interests of any Participant or his beneficiary to any benefits hereunder shall not be subject to attachment or garnishment or other legal process by any creditor of any such Participant or beneficiary, nor shall any such Participant or beneficiary have any right to alienate, anticipate, commute, pledge, encumber or assign any of the benefits which he may expect to receive, contingently or otherwise, under this Plan, and any attempt to anticipate, alienate, commute, pledge, encumber, or assign any right to benefits hereunder shall be void. Notwithstanding the foregoing, the Plan Administer may pay Plan benefits directly to the provider of services. Such payment shall fully discharge the Plan Administrator from further liability under the Plan.

10.5 Non-Guarantee

Neither the Employer nor any fiduciary shall be held or deemed in any manner to guarantee the Plan or a Component Plan against loss or depreciation.

10.6 No Guarantee of Employment

Neither the establishment and maintenance of this Plan, nor any modification thereof, nor the creation of any account, nor the payment of any benefits shall be construed as giving to any Employee or other person, any legal right or equitable right against the Employer, any officer, director or other Employee of the Employer, or against the Plan Administrator, except as herein provided. Under no circumstances shall the terms of employment of any Participant or Employee be modified or in any way affected by this Plan nor shall such establishment or continuance interfere with the right of the Employer to discharge any Employee or any other person or to deal with him or her without regard to the existence of the Plan or the Component Plan.

10.7 No Guarantee of Tax Consequences

Neither the Employer nor the Plan Administrator makes any commitment or guarantee that any amounts paid or allocated to or for the benefit of a Covered Person under the Plan will be excludable from

Participant's gross income for federal, state, and/or local income tax purposes, or that any other federal, state, and/or local tax treatment will apply or be available to any Participant. It shall be the obligation of each Participant to determine whether any coverage, benefit, or other payment under the Plan is excludable from the Participant's gross income for federal, state, and/or local income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment treated by the Employer as nontaxable is, in fact, not so excludable.

If the Plan Administrator determines that any benefits which an Employer had treated as nontaxable to any Participant for federal, state, and/or local income tax purposes are, in fact, taxable to the Participant due to any reason, including but not limited to erroneous information provided by the Participant or otherwise used by the Employer, such Participant shall pay all such taxes (including any related penalties and interest) directly or reimburse the Employer for any such taxes (including any related penalties and interest) paid by the Employer.

10.8 Death

Unless otherwise provided under the terms of an applicable Summary Plan Description, Summary of Coverage, Summary of Insurance, Insurance Contract, or HMO Contract, claims on behalf of a Participant after the Participant's death may be made by, and, unless denied, shall be paid to, the Participant's estate. Payments made pursuant to this Section 11.9 shall completely discharge the Plan, the Employer, the Plan Administrator, and, if applicable, the Insurer or HMO, of any liability to the Participant or other person arising under the Plan.

10.9 Clerical Error / Delay

Clerical errors made on the records of the Plan Administrator and delays in making entries on such records shall not invalidate coverage or cause coverage to be in force or to continue in force. Rather, the effective dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any Participant Contributions with respect to Covered Persons have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such Participant Contributions shall be made.

10.10 Participant Responsibilities

The provisions of any health benefit program under the Plan shall not be construed to limit a Covered Person with regard to the choice of medical treatment or services, such choices including, but not limited to, the kind, type, duration, amount, or results thereof. Obtaining medical or other health care treatment or services and determining which services to utilize shall be at the sole discretion of the Covered Person and shall not be construed, interpreted, or deemed as resulting from the Plan.

Each Covered Person shall be solely responsible for deciding the health care that the Covered Person receives and shall make such a decision as to his or her health care independent of any determinations to whether reimbursement shall or shall not be made under the Plan for a health care service or supply. The determination of whether or not a service or supply is medically necessary is made solely for purposes of determining whether benefits shall be paid under the Plan, and is not intended to be advice to a Covered Person concerning that Covered Person's health care treatment. Each Covered Person shall be solely responsible for selecting the health care professionals, hospitals, and other institutions that will provide health care services and supplies to that Covered Person.

Each Participant shall be responsible for providing the Plan Administrator and/or the Company with the Participant's current U.S. mailing address and/or electronic address. Any notices required or permitted to be given hereunder shall be deemed given if directed to such address furnished by the Participant and mailed either by regular U.S. mail or by electronic means as specified in Section 2520.104b-1(c) of ERISA. The Plan Administrator and the Company shall not have any obligation or duty to locate a Participant. In the event that a Participant becomes entitled to a payment under this Cafeteria Plan and such payment is delayed or cannot be made:

(b) Because of conflicting claims to such payments; or

(c) For any other reason, the amount of such payment, if and when made, shall be determined under the provisions of this Plan without payment of any interest or earnings.

10.11 No Examination or Accounting

Neither the Plan nor any action taken thereunder shall be construed as giving any person the right to an accounting or to examine the books or affairs of the Employer.

10.12 Severability

If any provision of the Plan is held illegal or invalid for any reason, such illegality or invalidity shall not affect the remaining parts of the Plan, and the Plan shall be construed and enforced as if the illegal or invalid provision had not been included in the Plan. The Employer shall have the privilege and opportunity to correct and remedy those questions of invalidity or illegality by amendment as provided in the Plan.

10.13 Waiver

The failure of the Plan Administrator to strictly enforce any provision of this Plan shall not be construed as a waiver of the provision. Rather, the Plan Administrator shall have the right to strictly enforce each and every provision of this Plan at any time regardless of the prior conduct of the Plan Administrator and regardless of the similarity of the circumstances or the number of prior occurrences.

10.14 Headings

The headings used in this Plan are for the purpose of convenience or reference only. Covered Persons are advised not to rely on any provisions because of the heading. In all cases, the full text of this Plan shall control.

10.15 Legal Actions

In any action or proceeding involving the Plan assets or any property constituting part or all thereof, or the administration thereof, no Employee, former Employee, Covered Person, Dependent, or any other person having or claiming to have an interest in this Plan shall be necessary parties and no such person shall be entitled to any notice or process, except to the extent required by applicable law. Any final judgment which is not appealed or appealable that may be entered in any such action or proceeding shall be binding and conclusive on the parties hereto and upon all persons having or claiming to have any interest in this Plan.

10.16 Misrepresentation or Fraud

A person who receives a benefit under the Plan as a result of false information or a misleading or fraudulent representation shall repay all amounts paid by the Plan and shall be liable for all costs of collection, including attorneys' fees.

10.17 Force Majeure

Should the performance of any act required by the Plan be prevented or delayed by reason of a natural catastrophe, strike, lock-out, labor dispute, war, riot, or any other cause beyond the Plan's control, the time for performance of the act shall be extended for a reasonable period of time, and non-performance of the act during the period of delay shall be excused. In such event, however, all parties shall use reasonable efforts to perform their respective obligations under the Plan.

Article 11 HIPAA

The Plan shall comply with the provisions of the HIPAA Privacy and Security Rules.

11.1 HIPAA Privacy Rule

The Plan shall comply with the following provisions referred to as the "Privacy of Protected Health Information," under HIPAA. Capitalized terms used in this Section and not defined in the Plan shall have the meanings set forth in the Privacy Rule.

(a) **General Rule**. The Plan shall use, disclose, store, retain and, if applicable, destroy a Covered Person's Protected Health Information in accordance with the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E (the "Privacy Rule"). For this purpose, the Plan is deemed a Hybrid Entity under the Privacy Rule and the provisions of this Article shall be administered and interpreted to apply only to that portion of the Plan that constitutes a Covered Entity under the Privacy Rule.

(b) **Use or Disclosure for Payment and Health Care Operations**. The Plan may use or disclose a Covered Person's Protected Health Information without the consent or authorization of the Covered Person for purposes of Payment, Health Care Operations, and any other purpose for which use or disclosure is permitted or required under the Privacy Rule or by law.

(c) **Disclosure to Plan Sponsor**. The Plan may not disclose a Covered Person's Protected Health Information to the Company, its Subsidiaries, and Affiliates, except as permitted in this Article 11. The Plan may disclose a Covered Person's Protected Health Information to the Company as provided in subsection (11) below. In addition, the Plan may disclose a Covered Person's Protected Health Information to the Company solely in the Company's capacity as Plan Sponsor in order for the Company to carry out Plan administration functions, as defined in the Privacy Rule. The Plan may only disclose such Protected Health Information to members of the Company's workforce (as designated in Section (d) of this Section 11.1) involved in Plan administration functions and only those designated members of the workforce shall have access to such Protected Health Information. The amount of Protected Health Information that the Plan discloses to the Company for such purpose shall not exceed the Minimum Necessary amount of Protected Health Information to accomplish the intended purpose of the disclosure. The Plan shall limit disclosures of Protected Health Information, to the extent practicable, to the Limited Data Set (as defined in 45 CFR Section 164.514(e)(2)) or if needed by the Plan, to the Minimum Necessary amount of Protected Health Information to accomplish the intended purposes of the disclosure. No such disclosure shall occur unless and until the Plan receives a certification from the Company stating the Plan document incorporates the following provisions of subsections (1) through (11) and that the Company, as Plan Sponsor, agrees to such provisions. Accordingly, the Company, as Plan Sponsor, certifies that the Plan document incorporates such subsections (1) through (11) as provided below in this Article 11 and in accordance with 45 CFR Section 164.504(f)(2)(ii):

(1) The Company shall use or further disclose Protected Health Information only as permitted or required by the Plan or as required by law.

(2) The Company shall require that any agents or subcontractors to whom it provides Protected Health Information agree to the same restrictions and conditions that apply to the Company with respect to such Protected Health Information.

(3) The Company shall not use or disclose Protected Health Information for employment-related actions or decisions or in connection with other employee benefits or employee benefit plans.

(4) The Company shall report to the Plan any uses and disclosures of Protected Health Information of which it becomes aware that are inconsistent with uses and disclosures provided for under this Article.

(5) The Company shall provide for adequate separation between the Plan and the Company, as Plan Sponsor, as required under 45 CFR Section 164.504(f)(2)(iii). The Company shall limit access to Protected Health Information to those members of the Company's workforce (or classes thereof) entitled to use or disclose such Protected Health Information under this Article, and shall require that these members of the workforce only may use or disclose such Protected Health Information for Plan administration functions, as defined in the Privacy Rule. If the persons to whom Protected Health Information is disclosed violate this Section, or applicable law, the Plan shall cease disclosing such Protected Health Information to such persons and shall otherwise resolve any such instances of noncompliance. Those members of the Company's workforce (or classes thereof) that perform functions on behalf of the Plan and that may have access to Protected Health Information are designated in subsection (d) of this Section 11.1.

(6) The Company shall make available any Protected Health Information it holds under this certification in order for the Plan to comply with the access requirements under 45 CFR Section 164.524.

(7) The Company shall make available any Protected Health Information it holds under this certification in order for the Plan to comply with the amendment requirements under 45 CFR Section 164.526, and shall incorporate any amendments to Protected Health Information it holds, as required in 45 CFR Section 164.526.

(8) The Company agrees to document and provide a description of any disclosures of Protected Health Information, and information related to such disclosures, as would be required for the Plan to respond to a request by a Covered Person for an accounting of disclosures of Protected Health Information in accordance with 45 CFR Section 164.528.

(9) The Company agrees to make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of the U.S. Department of Health and Human Services, for purposes of the Secretary determining the Plan's compliance with the Privacy Rule.

(10) The Company shall, if feasible, return or destroy all Protected Health Information received from the Plan that the Company maintains in any form, and retain no copies of such Protected Health Information, when it is no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, the Company shall limit further uses or disclosures of the Protected Health Information to those purposes that make the return or destruction of the Protected Health Information infeasible.

(11) In the absence of the above certification, the Plan may disclose to the Company, as Plan Sponsor, only Summary Health Information and, with respect to a Covered Person, enrollment and disenrollment information. In addition and notwithstanding anything herein to the contrary, the Plan may disclose Protected Health Information to the Company in

accordance with a Covered Person's authorization or as otherwise permitted or required by the Privacy Rule.

(d) **Access to Protected Health Information**. The following members of the Company's workforce (or classes thereof) that perform functions on behalf of the Plan may have access to Protected Health Information:

(1) Benefits Department

(2) Benefits Manager

(3) Payroll Department

In addition, support staff assisting the above members of the Company's workforce, including, but not limited to, clerical, mailroom, fax delivery, and information technology staff may have access to Protected Health Information. In addition, members of the Company's workforce with management, supervisory, or oversight responsibility for such groups, departments, committees, teams, and support staff may have access to Protected Health Information.

Other persons or classes of persons may be furnished with access to Protected Health Information with respect to administrative functions that the Company performs for the Plan; provided that the Plan Sponsor designates such persons or classes of persons in a writing furnished to the Plan.

(e) **Organized Health Care Arrangement**. The Plan (including the Component Plans offered under the Plan), and the other fully-insured and self-insured plans providing medical care offered or maintained by the Company shall be deemed part of an Organized Health Care Arrangement, to the fullest extent permitted under the Privacy Rule.

(f) **Interpretation**. The Plan and this Section shall be interpreted and administered in accordance with the Privacy Rule, any applicable Federal or State law, and any other applicable regulation or other official guidance issued thereunder. In the event of a conflict between this Section and the Privacy Rule, statute, regulation, or guidance, such Privacy Rule, statute, regulation, or guidance shall govern. The Plan shall adopt written policies and procedures to implement the provisions of this Section.

11.2 HIPAA Security Rule

For the Security Standards for the Protection of Electronic Protected Health Information as set forth in 45 CFR Parts 160 and 162 and Part 164, Subpart C (the "Security Standards"), the Plan shall comply with the following provisions referred to as the "Security of Protected Health Information," under HIPAA. Capitalized terms used in this Section and not defined in the Plan shall have the meanings set forth in the Security Standards.

(a) **Implementation of Security Safeguards**. The Company shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Plan, consistent with the requirements of the Security Standards.

(b) **Support of Adequate Separation Requirement by Security Measures**. The Company shall ensure that the adequate separation requirement set forth in 45 CFR Section164.504(f)(2)(iii) is supported by reasonable and appropriate security measures, consistent with the requirements of the Security Standards.

(c) **Agents and Subcontractors**. The Company shall take reasonable steps to ensure that any agent, including a subcontractor, to whom it provides the Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Electronic Protected Health Information.

(d) **Reporting Obligation**. The Company shall report to the Plan any Security Incident of which it becomes aware.

(e) **Interpretation**. The Plan and this Section shall be interpreted and administered in accordance with the Security Standards, any applicable Federal or State law, and any other applicable regulation or other official guidance issued thereunder. In the event of a conflict between this Section and the Security Standards, statute, regulation, or guidance, such Security Standards, statute, regulation, or guidance shall govern. The Plan shall adopt written policies and procedures to implement the provisions of this Section.

Schedule A. Participating Employers under the Lam Research Corporation Group Welfare Benefit Plan

Effective as of January 1, 2015, the following Affiliates have adopted the Lam Research Corporation Group Welfare Benefit Plan and have been given consent by the Plan Sponsor, Lam Research Corporation, to offer the Component Plans to Eligible Employees and their eligible Dependents:

- Silfex

Schedule B. Component Plans

The Lam Research Corporation Group Welfare Benefit Plan shall provide for the following benefits:

- Medical and Prescription Drugs *
- Dental plan *
- Vision plan *
- Employee Assistance Program (or EAP) *
- Business Travel Benefits
- Basic Group Term Life Insurance *
- Voluntary Supplemental Life Insurance
- Voluntary Dependent Life Insurance
- Basic Accidental Death and Dismemberment Insurance *
- Supplemental Accidental Death and Dismemberment Insurance
- Long-Term Disability Benefits *
- Short-Term Disability Benefits *
- California Voluntary Disability Insurance (VDI) for California residents only
- Group Legal Benefits *
- Voluntary Auto, Home and Pet Insurance
- Critical Illness Insurance
- Health Care Flexible Spending Account *

All Component Plans are described in the Summary Plan Description. A Summary Plan Description that describes benefits under this Plan will reference the name of the Plan as the Lam Research Corporation Group Welfare Benefit Plan.

*A Component Plan that is subject to ERISA.