Lam Research Corporation

Non-CA Short Term Disability Plan

Effective Date of Plan: January 1, 1993

The provisions of this plan apply to Disability Benefit Periods beginning on or after January 1, 2025

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Benefit Highlights

SHORT TERM DISABILITY PLAN

This Short-Term Disability plan is provided for you by Lam Research Corporation. Lam Research Corporation has arranged to have your claims administered by TRISTAR. TRISTAR (as the claims administrator) determines the benefits for which you qualify under the plan.

This Short-Term Disability plan provides financial protection by paying a portion of your income while you are disabled. The amount you receive is based on the amount you earned before your disability began. In some cases, you can receive disability payments even if you work while you are disabled. Benefits start after the elimination period.

Program Date: January 1, 2015. The provisions of this restatement of the plan apply to Disability Benefit Periods beginning on or after January 1, 2025.

Covered Classes: All United States employees of Lam Research, excluding employees working in California.

Minimum Hours Requirement: Employees must be working at least 20 hours per week.

Employment Waiting Period: Employees are eligible from Day 1 of employment.

Elimination Period: No elimination period. Benefits begin on the 1st day of Disability or Paid Family Leave.

Weekly Benefit: The weekly benefit payable hereunder, for an employee's disability, will be equal to 75% of your weekly earnings but not more than $4,800. If this amount is not a multiple of $1.00, it will be rounded to the next higher multiple of $1.00.

The weekly benefit payable hereunder, for an employee's Paid Family Leave, will be equal to 100% of your weekly earnings but not more than $4,800 for sixteen (16) weeks of Paid Family Leave.

Your benefit may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered under this plan.

Maximum Period of Benefits: The maximum benefit payable for any one period of your disability is 26 times your weekly benefit amount for disability.

The maximum benefit payable for Paid Family Leave will be sixteen (16) times 100% of your weekly benefit payable not to exceed the benefit maximum of $4,800 during the twelve-month period that begins with the first day that a valid claim is established for Paid Family Leave.

Cost of Coverage:	The Short-Term Disability plan is provided to you on a contributory basis. The cost to you will be 0.5% of your first $159,000 of base annual earnings, less any cost to you for state-mandated disability insurance to a maximum annual contribution of $795. Wages do not include bonuses, differentials, overtime, or any other forms of additional compensation.

The above items are only highlights of your coverage. For a full description please read this entire program document.

General Provisions

General Definitions used throughout this program document include:

You means a person who is eligible for coverage under the Program.

Employee means a person who is in active employment with the Employer for the minimum hours' requirement.

Plan means a line of coverage under the Program.

When Are You Eligible for Coverage?

If you are working for your Employer in a covered class, the date you are eligible for coverage is the later of:

- the plan's program date; and
- the first day of disability.

When Does Your Coverage Begin?

When your Employer pays the entire cost of your coverage under a plan, you will be covered at 12:01 a.m. on the date you are eligible for coverage, provided you are in ***active employment*** on that date.

When you and your Employer share the cost of your coverage under a plan, you will be covered at 12:01 a.m. on the latest of:

- the date you are eligible for coverage, if you apply for coverage on or before that date;
- the date you apply for coverage, if you apply within 31 days after your eligibility date; or
- the date your application is approved, if ***evidence that you qualify for coverage*** is required.

Evidence that you qualify for coverage is required if you:

- are a late applicant, which means you apply for coverage more than 31 days after the date you are eligible for coverage; or
- voluntarily canceled your coverage and are reapplying; or
- apply after any of your coverage ended because you did not pay a required contribution; or
- have not met a previous evidence requirement to become covered under any other Employer plan. A form for providing evidence that you qualify for coverage can be obtained from your Employer.

Active employment means you are working for your Employer for earnings that are paid regularly and that you are performing with reasonable continuity the substantial and material acts necessary to pursue your usual occupation. You must be working at least 20 hours per week.

Your worksite must be:

- your Employer's usual place of business;
- an alternate work site at the direction of your Employer other than your home unless clear specific expectations and duties are documented; or
- a location to which your job requires you to travel.

Normal vacation is considered active employment.

Temporary and seasonal workers are excluded from coverage.

Individuals whose employment status is being continued under a severance or termination agreement will not be considered in active employment.

Evidence that you qualify for coverage means a statement of your medical history which will be used to determine if you are approved for coverage. This evidence will be provided at your own expense.

What If You Are Absent from Work on the Date Your Coverage Would Normally Begin?

If you are absent from work due to injury, sickness, temporary layoff or leave of absence your coverage will begin on the date you return to active employment.

Once Your Coverage Begins, What Happens If You Are Temporarily Not Working?

If you are on a temporary **layoff**, you will be covered to the end of the last day worked.

If you are on a ***leave of absence***, you will be covered to the end of the last day worked.

With respect to leave under the federal Family and Medical Leave Act of 1993 (FMLA) or similar state law, continuation of coverage under the plan during such leave will be governed by your Employer's policies regarding continuation of such coverage for FMLA leave purposes and any applicable law.

If you are working less than 20 hours per week, for reasons other than disability, and if any required contribution is paid, you will be covered to the end of the month following the month in which your reduced hours begin.

Layoff *or* ***leave of absence*** means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by your Employer, other than for reasons in connection with any severance or termination agreement. Your normal vacation time, any period of disability or FMLA leave is not considered a temporary layoff or leave of absence.

When Will Changes to Your Coverage Take Effect?

Once your coverage begins, any increased or additional coverage will take effect immediately upon the effective date of the change, if you are in active employment or if you are on a covered layoff or leave of absence. If you are not in active employment due to injury or sickness, any increased or additional coverage will begin on the date you return to active employment. Any decrease in coverage will take effect immediately upon the effective date of the change. Neither an increase nor a decrease in coverage will affect a ***payable claim*** that occurs prior to the increase or decrease.

Payable claim means a claim for which LAM RESEARCH CORPORATION is liable under the terms of the Program.

When Does Your Coverage End?

Your coverage under the Program or a plan ends on the earliest of:

- the date the Program or a plan is canceled;
- the date you are no longer a member of the covered classes;
- the date your covered class is no longer covered;
- the last day of the period for which you made any required contributions;
- the last day you are in active employment except as provided under the temporary absence from work provisions; or
- the date you are no longer in active employment due to a disability that is not covered under the plan.

Short Term Disability Coverage

BENEFIT INFORMATION

How Is Disability Defined?

During the elimination period, you are disabled when you are either ***totally disabled*** or ***partially disabled***.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

Physical Examination:

You may be required to be examined by specified doctors or other medical practitioners. Your Employer will pay for these examinations. Examinations may be required as often as it is reasonable to do so during the pendency of a claim.

Refusal to be examined may result in denial or termination of your claim.

When Are You Totally Disabled?

You are totally disabled when as a result of your ***sickness*** or ***injury***:

- you are unable to perform with reasonable continuity the ***substantial and material acts*** necessary to pursue your ***usual occupation***; and
- you are not working in your usual occupation.

Sickness means any disorder of your body or mind, but not an injury; pregnancy including abortion, miscarriage or childbirth. Disability must begin while you are covered under the plan.

Injury means physical harm or damage to the body. Injury which occurs before you are covered under the plan will be treated as a sickness. Disability must begin while you are covered under the plan.

Substantial and material acts means the important tasks, functions and operations generally required by employers from those engaged in your usual occupation that cannot be reasonably omitted or modified. In determining what substantial and material acts are necessary to pursue your usual occupation, we will first look at the specific duties required by your Employer or job. If you are unable to perform one or more of these duties with reasonable continuity, we will then determine whether those duties are customarily required of other employees or individuals engaged in your usual occupation. If any specific, material duties required of you by your Employer or job differ from the material duties customarily required of other employees or individuals engaged in your usual occupation, then we will not consider those duties in determining what substantial and material acts are necessary to pursue your usual occupation.

Usual occupation means any employment, business, trade or profession and the substantial and material acts of the occupation you were regularly performing for your Employer when the disability began. Usual occupation is not necessarily limited to the specific job you performed for your Employer.

When Are You Partially Disabled?

You are partially disabled when:

- you are not totally disabled; and
- while actually working in your usual occupation, and as a result of your sickness or injury, you are unable to earn 80% or more of your ***weekly earnings***.

When Will You Begin to Receive Disability Payments?

You will begin to receive payments when due written proof of loss is received. You will be sent a payment every week for any period for which Lam Research Corporation is liable.

How Much Will You Be Paid If You Are Disabled and Not Working?

This process will be followed to figure out your ***weekly payment***:

1. Multiply your weekly earnings by 75%. If this amount is not a multiple of $1.00, it will be rounded to the next higher multiple of $1.00.
2. Subtract from your gross disability payment any deductible sources of

income. That amount figured in item 2 is your weekly payment.

Weekly payment means your payment after any deductible sources of income have been subtracted from your gross disability payment.

Weekly benefit means the total benefit amount for which you are covered under this plan.

Gross disability payment means the benefit amount before any deductible sources of income and disability earnings are subtracted.

Deductible sources of income means income from deductible sources listed in the plan that you receive while you are disabled. This income will be subtracted from your gross disability payment.

What Are Your Weekly Earnings?

Weekly earnings means your gross weekly wages from your Employer in effect just prior to your date of disability. It does not include income received from bonuses, differentials, overtime pay, or any other forms of additional compensation.

What Will Be Used to Determine Weekly Earnings If You Become Disabled During a Covered Layoff or Leave of Absence?

If you become disabled while you are on a covered layoff or leave of absence, your weekly earnings from your Employer in effect just prior to the date your absence begins will be used.

How Much Will You Be Paid If You Work While You Are Disabled?

If you work while you are disabled, this process will be followed to figure out your weekly payment:

1. Multiply your weekly earnings by 75%. If this amount is not a multiple of $1.00, it will be rounded to the next higher multiple of $1.00. This is your gross disability payment.

2. Subtract from your gross disability payment any deductible sources of income. This is your weekly payment.

3. Your weekly payment will be adjusted by any ***disability earnings*** as follows:

   While working, add your weekly disability earnings to your gross disability payment. If this amount is less than or equal to 100% of your weekly earnings, your weekly payment will not be further reduced. If this amount is more than 100% of your weekly earnings, the amount over 100% will be subtracted from your weekly payment.

You may be required to send proof of your weekly disability earnings on a weekly basis. As part of your proof of disability earnings, you may be required to send appropriate financial records, including copies of your IRS federal income tax return, W-2's and 1099's, which are necessary to substantiate your income.

Disability earnings means the earnings which you receive for work performed while you are disabled and working for:

- your Employer; or
- another employer, but only if you became employed after your disability began.

Salary continuance paid to supplement your disability earnings will not be considered payment for work performed.

What Are Deductible Sources of Income?

The following deductible sources of income will be deducted from your gross disability payment:

1. The amount that you receive as temporary disability benefits under an occupational disease law, or any other ***act*** or ***law,*** with similar intent, other than workers' compensation.

2. The amount that you receive under a workers' compensation law.

3. The amount that you receive as loss of time disability income payments under any state compulsory benefit act or law.

If you are eligible for benefits under item 3 above, your payments will be reduced by an

estimated benefit amount as described in the “What If You Qualify for Deductible Income Benefits?” section.

Law, plan or act means the original enactment of the law, plan or act and all amendments.

What Are Not Deductible Sources of Income?

Income you receive from, but not limited to, the following sources will not be deducted from your gross disability payment:

- 401(k) plans;
- profit sharing plans;
- thrift plans;
- tax sheltered annuities;
- stock ownership plans;
- non-qualified plans of deferred compensation;
- pension plans for partners;
- military pension and disability income plans;
- credit disability insurance;
- franchise disability income plans;
- a retirement plan from another Employer;
- individual retirement accounts (IRA);
- motor vehicle insurance.

What If Subtracting Deductible Sources of Income Results in a Zero Benefit? (Minimum Benefit)

The minimum weekly payment is $50.00.

This amount may be applied toward an outstanding overpayment.

What Happens When You Receive Certain Increases from Deductible Sources of Income?

Once any deductible source of income has been subtracted from your gross disability payment, your payment will not be further reduced due to a cost-of-living increase from that source.

What If You May Qualify for Deductible Income Benefits?

If you are eligible for benefits under item 3 in the deductible sources of income section, you are obligated to apply for such benefits. If you have not applied for those benefits, or if you have failed to pursue them with reasonable diligence, and there is a reasonable, good faith belief that you are entitled to such benefits, your payments will be reduced by an estimated benefit amount.

The state disability statutes will be used as a means of reasonably estimating the amount payable.

If your payment has been reduced by an estimated amount, your payment will be adjusted when proof is received:

- of the amount awarded; or
- that benefits have been denied and all required appeals have been completed. In this case, a lump sum refund of the estimated amount will be made to you.

What Happens If You Receive a Lump Sum Payment?

If you receive a lump sum payment from any deductible source of income, the lump sum will be pro-rated on a weekly basis over the time period for which the sum was given. If no time period is stated, a reasonable one will be used.

How Long Will Payments Continue to Be Sent to You?

A payment will be sent to you every week up to the ***maximum period of payment***. Your maximum period of payment is 26 weeks during a continuous period of disability.

Payments will no longer be sent to you on the date you fail to submit proof of continuing disability in accordance with the rules in the CLAIM INFORMATION section.

Payments will no longer be sent to you and your claim will end on the earliest of the following:

1. The end of the maximum period of payment.
2. The date you are no longer disabled under the terms of the plan.
3. The date your weekly disability earnings exceed 80% of your weekly earnings. But, if your disability earnings are expected to fluctuate widely from week to week, then, for the purpose of this item 3, your weekly disability earnings means the average of your disability earnings over the most recent 3 weeks.
4. The date you die.

Maximum period of payment means the longest period of time payments will be made to you for any one period of disability.

What Disabilities Are Not Covered Under Your Plan?

Your plan does not cover any disabilities caused by, contributed to by, or resulting from your:

- intentionally self-inflicted injuries;
- active participation in a riot; or
- commission of a felony for which you have been convicted under state or federal law.

If you apply for coverage more than 31 days after the date you are eligible for coverage; your plan does not cover a disability which:

- begins within 12 months of the date your coverage under the plan becomes effective; and
- is due to a pre-existing condition.

Your plan does not cover a disability due to war, declared or undeclared, or any act of war.

Payment will not be made for any period of disability during which you are incarcerated as a result of a conviction.

What Is a Pre-Existing Condition?

You have a pre-existing condition if you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines, or followed treatment recommendation in the 3 months just prior to your effective date of coverage.

What Happens If You Return to Work Full Time and You Become Disabled Again?

1. If your current disability is related or due to the same cause(s) as your prior disability for which you received a payment:

   Your current disability will be treated as part of your prior claim, and you will not have to complete another elimination period if you return to active employment for your Employer on a full-time basis for 60 consecutive days or less. Your disability will be subject to the same terms of the plan as your prior claim.

2. If your current disability is unrelated to your prior disability for which you received a payment:

   Your current disability will be treated as a new claim, and you will have to complete another elimination period. Your disability will be subject to all of the plan provisions.

If you become covered under any other group short term disability plan, you will not be eligible for payments under this plan.

How Can TRISTAR Help You and Your Employer Prevent a Disability or Help You Return to Work?

TRISTAR has rehabilitation services available. As these services are designed to coordinate with your long-term disability coverage, please see the Other Services section in your long-term disability plan.

Paid Family Leave Benefits

An eligible employee may request up to sixteen (16) weeks of Paid Family Leave in order to care for a seriously ill Family Member, bond with his or her new Child, or Military Assist provided that the employee furnish the following documentation as appropriate to his or her request:

1. A certificate from the Family Member's Physician stating the Serious Health Condition of the Care Recipient which requires the employee's presence, and the Physician's opinion as to the probable duration of the Family Member's condition, and acknowledgement, in writing, from the employee that he or she is the only Family Member available to provide the necessary care or comfort to the Care Recipient.
2. A certificate for a leave of absence taken for reason of the birth of a Child of the employee or the employee's Domestic Partner, or the placement of a minor Child with the employee in connection with the adoption or foster care of the Child by the employee or Domestic Partner.
3. When taking bonding leave, you must be an active, regular-status employee at the time of birth or custody of the child.
4. The minimum increment allowed for bonding leave is 1 week.
5. Military Assist certification supporting military documentation and documentation of the qualifying event.

Periods of Paid Family Leave for the same Care Recipient within a Twelve-Month Period shall be considered one Disability Benefit Period. Periods of disability for pregnancy and periods of family care leave for bonding associated with the birth of that Child shall be considered one Disability Benefit Period.

Amount of Benefit

The weekly benefit payable hereunder, for an employee's Paid Family Leave, will be equal to 100% of his or her weekly Earnings but not more than $4,800 for sixteen (16) weeks of Paid Family Leave. The weekly minimum amount is $50.

For each day of any period of disability for which benefits are payable, and which is less than a full week, the amount of benefit payable will be one-seventh (1/7) of the amount of the weekly benefit.

The maximum benefit payable during an employee's Paid Family Leave will be sixteen (16) times 100% of his or her weekly benefit payable not to exceed the benefit maximum of $4,800 during the twelve-month period that begins with the first day that a valid claim is established for Paid Family Leave.

Short Term Disability Coverage

CLAIM INFORMATION

When Do You Notify TRISTAR (as the Claims Administrator) of a Claim?

Your Employer has arranged to have TRISTAR (as the claims administrator) determine the benefits for which you qualify under the plan. You are encouraged to notify TRISTAR of your claim as soon as possible, so that a claim decision can be made in a timely manner. Notice of a claim must be provided within 20 days after the date your disability begins. If it is not possible to give notice within 20 days, it must be given as soon as it is reasonably possible. If you are filing a claim for bonding, a 30-day advance notice is required.

How Do You File a Claim?

To apply for benefits, you will need to complete a Claim Form, provided by TRISTAR or your Human Resources Department. For disability or for care of a family member, your doctor must complete the Attending Physician's Statement and send or fax the completed form to TRISTAR for processing. It is important for you to notify TRISTAR as soon as you are released by your doctor to return to work, or when you recover from your disability.

What Information Is Needed as Proof of Your Claim?

You must send TRISTAR written proof of your claim no later than 15 days from the time TRISTAR requested the documentation. If it is not possible to give proof within 15 days, you will be provided additional 15 days to secure proof of claim. If no proof is provided after 30 days your claim will be denied, and no benefits will be provided to you.

Your proof of claim, provided at your expense, must show:

1. That you are under the ***regular care*** of a ***doctor***.
2. The appropriate documentation of your weekly earnings.
3. The date your disability began.
4. Appropriate documentation of the disabling disorder.
5. The extent of your disability, including restrictions and limitations preventing you from performing your usual occupation.
6. The name and address of any ***hospital or institution*** where you received treatment for your disability, including all attending doctors.
7. The name and address of any doctor you have seen regarding your disability.

TRISTAR may request that you send satisfactory proof of continuing disability, indicating that you are under the regular care of a doctor. This proof, provided at your expense, must be received no later than 30 days after the end of each extension of leave.

If necessary to determine your eligibility for benefits, you will be required to give TRISTAR authorization to obtain additional medical information, and to provide non-medical information as part of your proof of claim, or proof of continuing disability. Your claim may be denied, or payments may stop if the required information is not submitted and such failure to submit the required information is unreasonable.

Regular care means:

- you personally visit a doctor as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and
- you are receiving appropriate treatment and care, which conforms with generally accepted medical standards, for your disabling condition(s) by a doctor whose specialty or experience is appropriate for your disabling condition(s), according to generally accepted medical standards.

Doctor means:

a person who is performing tasks that are within the limits of his or her medical license; and

- is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- has a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
- is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

Any relative including, but not limited to, you, your spouse, or a child, brother, sister, or parent of you or your spouse will not be recognized as a doctor for a claim that you send to TRISTAR.

Hospital or institution means an accredited facility licensed to provide care and treatment for the condition causing your disability.

Who Will Payments Be Made To?

Payments will be made to you.

What Happens If Your Claim is Overpaid?

Any overpayments due to any of the following reasons may be recovered:

- fraud;
- any error TRISTAR makes in processing a claim; and
- your receipt of deductible sources of income.

You must reimburse the overpayment in full. You will be told the method by which you must repay the overpaid amount.

You will not be required to repay more money than the amount you were paid.

Glossary

Active employment means you are working for your Employer for earnings that are paid regularly and that you are performing with reasonable continuity the substantial and material acts necessary to pursue your usual occupation. You must be working at least 20 hours per week.

Your worksite must be:

- your Employer's usual place of business;
- an alternate work site at the direction of your Employer other than your home unless clear specific expectations and duties are documented; or
- a location to which your job requires you to travel.

Normal vacation is considered active employment.

Temporary and seasonal workers are excluded from coverage.

Individuals whose employment status is being continued under a severance or termination agreement will not be considered in active employment.

Deductible sources of income means income from deductible sources listed in the plan that you receive while you are disabled. This income will be subtracted from your gross disability payment.

Deployment is means as covered active duty, a call or notice of impending covered active duty, or a rest and recuperation leave from covered active duty.

Disability earnings means the earnings which you receive for work performed while you are disabled and working for:

- your Employer; or
- another employer, but only if you became employed after your disability began.

Salary continuance will not be included as disability earnings since it is not payment for work performed.

Doctor means:

a person who is performing tasks that are within the limits of his or her medical license; and

- is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- has a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
- is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

Any relative, including but not limited to, you, your spouse, or a child, brother, sister, or parent of you or your spouse will not be recognized as a doctor for a claim that you send to TRISTAR.

Elimination period means a period of continuous disability which must be satisfied before you are eligible to receive benefits under the plan.

Employee means a person who is in active employment with the Employer for the minimum hours' requirement.

Employer means Lam Research Corporation, and includes any division, subsidiary or affiliate.

Evidence that you qualify for coverage means a statement of your medical history which will be used to determine if you are approved for coverage. This evidence will be provided at your own expense.

Gross disability payment means the benefit amount before any deductible sources of income and disability earnings are subtracted.

Hospital or institution means an accredited facility licensed to provide care and treatment for the condition causing your disability.

Injury means physical harm or damage to the body. Injury which occurs before you are covered under the plan will be treated as a sickness. Disability must begin while you are covered under the plan.

Law, plan or act means the original enactment of the law, plan or act and all amendments.

Layoff or leave of absence means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by your Employer, other than for reasons in connection with any severance or termination agreement. Your normal vacation time, any period of disability or FMLA leave is not considered a temporary layoff or leave of absence.

Maximum period of payment means the longest period of time payments will be made to you for any one period of disability.

Military Assist means to participate in a qualifying event because of a family member's military deployment.

Payable claim means a claim for which Lam Research Corporation is liable under the terms of the Program.

Plan means a line of coverage under the Program.

Pre-existing condition means a condition for which you received medical treatment, consultation, care or services including diagnostic measures, took prescribed drugs or medicines or followed treatment recommendation for your condition during the given period of time as stated in the plan.

Qualifying Event means any military event or an essential need resulting from the family member's deployment.

Regular care means:

- you personally visit a doctor as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and
- you are receiving appropriate treatment and care, which conforms with generally accepted medical standards, for your disabling condition(s) by a doctor whose specialty or experience is appropriate for your disabling condition(s), according to generally accepted medical standards.

Sickness means any disorder of your body or mind, but not an injury; pregnancy including abortion, miscarriage or childbirth. Disability must begin while you are covered under the plan.

Substantial and material acts means the important tasks, functions and operations generally required by employers from those engaged in your usual occupation that cannot be reasonably omitted or modified. In determining what substantial and material acts are necessary to pursue your usual occupation, the specific duties required by your Employer or job will be looked at first. If you are unable to perform one or more of these duties with reasonable continuity, then it will be determined whether those duties are customarily required of other employees or individuals engaged in your usual occupation. If any specific, material duties required of you by your Employer or job differ from the material duties customarily required of other employees or individuals engaged in your usual occupation, then those duties will not be considered in determining what substantial and material acts are necessary to pursue your usual occupation.

Usual occupation means any employment, business, trade or profession and the substantial and material acts of the occupation you were regularly performing for your Employer when the disability began. Usual occupation is not necessarily limited to the specific job you performed for your Employer.

Weekly benefit means the total benefit amount for which an employee is covered under this plan.

Weekly earnings means your gross weekly income from your Employer as defined in the plan.

Weekly payment means your payment after any deductible sources of income have been subtracted from your gross disability payment.

You means a person who is eligible for coverage under the Program.

SUMMARY PLAN DESCRIPTION

This booklet is intended to comply with the disclosure requirements of the regulations issued by the U.S. Department of Labor under the Employee Retirement Income Security Act (ERISA) of 1974. ERISA requires that you be given a "Summary Plan Description" which describes the plan and informs you of your rights under it.

Plan Name

Short Term Disability Coverage for all United States employees of Lam Research, excluding employees working in California.

Plan Number

505

Type of Plan

Employee Welfare Benefit Plan

Plan Sponsor

Lam Research Corporation
4650 Cushing Parkway
Fremont, California 94538

Employer Identification Number

94-2634797

Plan Administrator

Lam Research Corporation
Attention: Human Resources Department
4650 Cushing Parkway
Fremont, California 94538

Agent for Service of Legal Process

Lam Research Corporation
Attention: Human Resources Department
4650 Cushing Parkway
Fremont, California 94538

Plan Year Ends

December 31

Claims Administration provided by

TRISTAR
2835 Temple Avenue
Signal Hill, CA 90755

Your Employer retains complete authority and responsibility for your Employer's Plan(s), its operation, and the benefits provided thereunder. TRISTAR has been delegated the responsibility to act on behalf of your Employer in connection with the Plan only as expressly stated in the Administrative Services Agreement between your Employer and TRISTAR (the "ASA") or as agreed to in writing by TRISTAR and your Employer.

The Plan Administrator and TRISTAR agree that, with respect to Section 503 of the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, TRISTAR will be the "appropriate named fiduciary" to the extent set forth in the ASA, for purposes of denial and/or review of denied claims under the Plan. In exercising its fiduciary responsibility, TRISTAR will have discretionary authority to determine eligibility for benefits as described in the Claim Services section of Exhibit B of the ASA; to determine the amount of benefits for each claim received; to handle any appeal of a denied claim; and to interpret and construe the terms of the Plan. However, the Plan Administrator will have the sole and complete authority to determine eligibility of persons to participate in the Plan. TRISTAR will have no other fiduciary duties under the Plan.

Subject to the terms of the ASA, claims administration for benefits under your Employer's Plan is provided by TRISTAR. For all purposes of the Plan, the Employer acts on its own behalf or as an agent of its employees. Under no circumstances will the Employer be deemed the agent of TRISTAR, absent a written authorization of such status executed between the Employer and TRISTAR. Nothing in these documents shall, of themselves, be deemed to be such written execution.

Claim Procedures

1. Determination of Benefits

TRISTAR shall notify you of the claim determination within 45 days of the receipt of your claim. This period may be extended by 30 days if such an extension is necessary due to matters beyond the control of the Plan. A written notice of the extension, the reason for the extension and the date by which the Plan expects to decide your claim, shall be furnished to you within the initial 45-day period. This period may be extended for an additional 30 days beyond the original 30-day extension if necessary due to matters beyond the control of the Plan. A written notice of the additional extension, the reason for the additional extension and the date by which the Plan expects to decide on your claim, shall be furnished to you within the first 30-day extension period if an additional extension of time is needed. However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination by TRISTAR will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If your claim for benefits is denied, in whole or in part, you or your authorized representative will receive a written notice from TRISTAR of your denial. The notice will be written in a manner calculated to be understood by you and shall include:

(a) the specific reason(s) for the denial,

(b) references to the specific Plan provisions on which the benefit determination was based,

(c) a description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary,

(d) a description of the Plan's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following your appeals, and

(e) if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request.

2. Appeals of Adverse Determination

If your claim for benefits is denied or if you do not receive a response to your claim within the appropriate time frame (in which case the claim for benefits is deemed to have been denied), you or your representative may appeal your denied claim in writing to TRISTAR within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. You may submit with your appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted by TRISTAR, utilizing individuals not involved in the initial benefit determination. This review will not afford any deference to the initial benefit determination.

TRISTAR shall make a determination on your claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if TRISTAR determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that TRISTAR expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If the claim on appeal is denied in whole or in part, you will receive a written notification from TRISTAR of the denial. The notice will be written in a manner calculated to be understood by the applicant and shall include:

(a) the specific reason(s) for the adverse determination,

(b) references to the specific Plan provisions on which the determination was based,

(c) a statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to your benefit claim upon request,

(d) a description of the Plan's review procedures and applicable time limits,

(e) a statement that you have the right to obtain upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination, and

(f) a statement describing any appeals procedures offered by the Plan, and your right to bring a civil suit under ERISA.

If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

If the appeal of your benefit claim is denied or if you do not receive a response to your appeal within the appropriate time frame (in which case the appeal is deemed to have been denied), you or your representative may make a second, voluntary appeal of your denial in writing to TRISTAR within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. You may submit with your second appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

TRISTAR shall make a determination on your second claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if TRISTAR determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date by which TRISTAR expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Your decision to submit a benefit dispute to this voluntary second level of appeal has no effect on your right to any other benefits under this Plan. If you elect to initiate a lawsuit without submitting to a second level of appeal, the Plan waives any right to assert that you failed to exhaust administrative remedies. If you elect to submit the dispute to the second level of appeal, the Plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that the appeal is pending.

If the claim on appeal is denied in whole or in part for a second time, you will receive a written notification from TRISTAR of the denial. The notice will be written in a manner calculated to be understood by the applicant and shall include the same information that was included in the first adverse determination letter. If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied upon appeal.

Rights and Protections

As a participant in this Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary Plan description. The Plan Administrator may make a reasonable charge for the copies.

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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