VMware, Inc.

SHORT TERM DISABILITY PLAN

PLAN DOCUMENT

VMware, Inc.

VMware, Inc.

SHORT TERM DISABILITY PLAN

PLAN DOCUMENT

TABLE OF CONTENTS

VMware, Inc.

SHORT TERM DISABILITY PLAN

PLAN DOCUMENT

TABLE OF CONTENTS
(Continued)

VMware, Inc.

SHORT TERM DISABILITY PLAN

PLAN DOCUMENT

TABLE OF CONTENTS
(Continued)

VMware, Inc.

SHORT TERM DISABILITY PLAN

PLAN DOCUMENT

INTRODUCTION

The principal purpose of this Plan is to aid Employees in the establishment of financial security for themselves in the event of short-term disability. This Plan does not replace other disability benefits sources which are available to an Employee such as Workers' Compensation, Social Security or State mandated Plans. This Plan provides a benefit supplement, if necessary, to such other benefit sources, in order to assist an Employee in meeting his or her reasonable income needs while disabled.

VMware, Inc.

SHORT TERM DISABILITY PLAN

PLAN DOCUMENT

Effective with respect to Disabilities commencing on or after January 1, 2020, VMware, Inc. hereby amends and restates, in its entirety, the VMware, Inc. Short Term Disability Plan Document, so as to read as set forth below:

ARTICLE I

DEFINITIONS

GENERAL

Wherever the following terms are used in this Plan, they will have the meaning specified below unless the context clearly indicates to the contrary.

1.01 ACTIVELY AT WORK

"Actively at Work" means Employee is working at least twenty (20) hours per week for VMware, Inc. performing the Essential Functions of Employee's Regular Occupation and receiving Regular Wages.

1.02 CLAIMS ADMINISTRATOR

"Claims Administrator" means Sedgwick an independent Claims Administrator.

1.03 COMPANY

"Company" means VMware, Inc. and its U.S subsidiaries except as specified otherwise.

1.04 CONTRACTOR

"Contractor" means a person hired through their own firm or any consulting or staffing company, such as those hired for a prescribed period of time to assist with a specific project or complete a limited work assignment.

1.05 DISABILITY

"Disability" means a Disability as defined in Section 3.02.

1.06 EFFECTIVE DATE

"Effective Date of the Plan" means January 1, 2009; amended terms of the Plan are effective as of the effective date of the change.

1.07 EMPLOYEE

"Employee" means an individual who, on or after the Effective Date of the Plan, is a regular employee on the Company's U.S. payroll who is "Actively at Work" working at least twenty (20) hours per week. "Employee" does not include Interns, Contractors, and those not classified as employees of the Company for income tax withholding purposes are excluded from eligibility. If during any period, VMware, Inc. has not treated an individual as an Employee and, for that reason, has not withheld employment taxes with respect to that individual, then that individual will not be eligible to participate in the Plan for that period, even in the event that the individual is determined, retroactively, to have been an Employee during all or any portion of that period. An individual's status as an Employee and eligibility for plan participation will be determined by VMware, Inc. and any such determination will be conclusive and binding on all persons.

1.08 ESSENTIAL FUNCTIONS

"Essential Functions" means functions which are normally required for the performance of an occupation and which cannot be reasonably omitted or modified.

1.09 FUNDING AND SOURCES OF CONTRIBUTIONS

"Funding and Sources of Contributions" means the STD Plan is self-funded by VMware, Inc. with benefits paid through contributions made solely by VMware, Inc. out of its general assets. The Company allows a Participant to elect to have the cost of the Company-paid coverage included in the Participant's taxable income. Such an election made with respect to the Short-Term Disability Plan #567675 001 will remain in force until changed in accordance with the procedures approved by the Company.

1.10 HEALTH CARE PROVIDER

"Health Care Provider" means any physician, surgeon, or qualified licensed psychologist who is duly licensed and acting within the scope of his/her practice or Nurse Practitioners and Nurse-midwives who are licensed to practice under State law and who are performing within the scope of their practice as defined under State law. A Health Care Provider cannot be the Company, Employee; his/her spouse, daughter, son, mother, father, sister or brother by marriage, blood or adoption, or registered domestic partner.

"Psychologist" means a psychologist licensed in the state of practice, with a doctorate degree in psychology.

1.11 INTERN

"Intern" means a student working for the Company in a professional field gaining supervised practical experience.

1.12 OBJECTIVE MEDICAL EVIDENCE

“Objective Medical Evidence” means medical demonstration of anatomical, physiological, or psychological abnormalities manifested by signs or laboratory findings, apart from Participant’s perception of mental or physical impairments. These signs are observed through medically acceptable clinical techniques such as medical history, physical examination, and laboratory tests.

1.13 ORGAN DONATION

"Organ Donation" means the donation of an organ from an individual from whom an organ is taken for transplantation.

1.14 PARTICIPANT

"Participant" means an Employee who satisfies the eligibility requirements of Section 2.01.

1.15 PARTIAL DISABILITY

“Partial Disability” means a Partial Disability as defined in Section 3.02.

1.16 PLAN

“Plan” means the VMware, Inc. Short Term Disability Plan.

1.17 PLAN ADMINISTRATOR

“Plan Administrator” is VMware, Inc.

1.18 PLAN NUMBER

“Plan Number” for the VMware, Inc. Health and Welfare Benefits Plan is 503.

1.19 PLAN SPONSOR

“Plan Sponsor” means “VMware, Inc.” and refers to VMware, Inc. and its US subsidiaries except where specified otherwise.

1.20 PLAN YEAR

“Plan Year” begins on January 1 and ends on the following December 31. The financial records of the Plan are kept on a Plan Year basis.

1.21 REGULAR OCCUPATION

“Regular Occupation” means the activity which, immediately prior to the start of the disability for which the Employee is applying for benefits (1) the Employee was regularly performing, and (2) was the source of the Employee’s income from VMware, Inc.

1.22 REGULAR WAGES

"Regular Wages**"**, means:

1. For *non-commissioned Employees*, the Employee's Base Salary, which is the rate of pay paid to the Employee by the Employer (excluding overtime, shift differential pay, bonuses, etc.) during the last pay period immediately prior to the date of Disability or Partial Disability.

2. For *all other Employees* whose compensation is determined in whole or in part on a commission or other sales related basis, Regular Wages will be determined by the Employee's On-Target Earnings (OTE) (On-Target Earnings equal Base Salary and target incentive, as determined by the Company.)

1.23 SICK TIME

"Sick Time" means Company granted time off from work to care for an Employee's own illness/injury.

1.24 TRANSITIONAL RETURN TO WORK

"Transition Return to Work**"** means work defined in Section 3.05.

1.25 WAITING PERIOD

"Waiting Period" means a period of continuous Disability which must be satisfied before the Participant is eligible to receive benefits under the Plan**.**

ARTICLE II

PARTICIPATION

2.01 ELIGIBILITY FOR PARTICIPATION

An Employee's eligibility for benefits under the VMware Short Term Disability (STD) plan begins on the first day the employee is actively at work. STD Plan coverage is provided automatically to employees without the need to enroll. STD coverage continues for employees who are on an approved leave provided under the company leave of absence policies, as specified in those policies. Short term disability benefits for California-based employees are provided under a different program – either the California Voluntary Disability Plan or California State Disability Plan.

Interns and Contractors, and those not classified as employees by VMware, Inc. for income tax purposes are excluded from eligibility.

If during any period, VMware, Inc. has not treated an individual as an Employee and, for that reason, has not withheld employment taxes with respect to that individual, then that individual will not be eligible to participate in the Plan for that period, even in the event that the individual is determined, retroactively, to have been an Employee during all or any portion of that period. An individual's status as an Employee and eligibility for plan participation [like above] will be determined by VMware, Inc. and any such determination will be conclusive and binding on all persons.

If an Employee is not Actively at Work due to disability on the date his/her participation would otherwise have been effective, his/her participation date will be deferred until the first day upon which he/she returns to active work as an Employee of the Company

2.02 CESSATION OF PARTICIPATION

A Participant's coverage will end on the earliest of the following:

A. on the date the Participant begins an unauthorized unpaid leave of absence;

B. at midnight on the date the Participant's employment with VMware, Inc. terminates;

C. on the date the Participant is no longer eligible to participate in the Plan;

D. on the date the Participant retires;

E. on the date the Participant dies; or

F. on the date VMware, Inc. discontinues the Plan.

ARTICLE III

DISABILITY BENEFIT

3.01 WAITING PERIOD

A Participant who sustains a Disability or Partial Disability will, subject to the provisions of the Plan, become eligible to receive the benefit described in Section 3.05 on the eighth (8^{th}) consecutive day of Disability. Any partial day of Disability during the Waiting Period will be counted as a full day for purposes of fulfilling the Waiting Period requirement.

During the Waiting Period, 5 business days of accrued Sick Time must be used. Any days that the Participant does not have Sick Time available will be unpaid.

3.02 DISABILITY and PARTIAL DISABILITY DEFINED

A. "Disability" means an Employee will be considered disabled under the Plan if Sedgwick, the Claims Administrator, determines that as a result of sickness, injury, or pregnancy, and all of the following three conditions are met:

- the Employee is unable to perform with reasonable continuity the Essential Functions of the Employee's Regular Occupation;

- the Employee is under the regular and continuous care and treatment by a Health Care Provider or by a nurse or physician's assistant under direct supervision of a Health Care Provider, unless such regular and continuous care and treatment are not medically necessary given the condition; and
- the Disability is supported by Objective Medical Evidence provided by a Health Care Provider.

B. "Partial Disability" means an Employee will be considered Partially Disabled under the Plan if Sedgwick, the Claims Administrator, determines that as a result of sickness, injury, or pregnancy, and all of the following three conditions are met:

- the Employee is able to: 1) perform all of the Essential Functions his/her Regular Occupation but only at a reduced work schedule: or 2) is able to perform a type of work other than his/her Regular Occupation only at a reduced work schedule;

- the Employee is under the regular and continuous care and treatment by a Health Care Provider or by a nurse or physician's assistant under direct supervision of a Health Care Provider, unless such regular and continuous care and treatment are not medically necessary given the condition; and

- the Partial Disability is supported by Objective Medical Evidence provided by a Health Care Provider.

However, an Employee will not be considered to have a Disability or a Partial Disability if the Employer can provide alternative employment that is within the capabilities of the

Employee and that has compensation comparable to the Employee's Regular Occupation, as determined solely by the Employer.

3.03 LIMITATIONS AND EXCLUSIONS

No Participant will be entitled to benefits with respect to a Disability which arises out of, relates to, is caused by, or results from:

A. an injury, sickness, mental illness, substance abuse, or pregnancy not being treated by a Health Care Provider;

B an illness or injury due to active participation in an unlawful act, including a riot or fight (unless the Participant was defending oneself against an unprovoked assault);

C. a loss of professional license, occupational license or certification;

D. an illness or injury to which a contributing cause was the Participant's commission or attempted commission of a crime;

E. an illness or injury due to the Participant's active participation in war or any act of war, declared or undeclared;

F. an illness or injury sustained while the Participant was not covered under the Plan;

G. a vague or undefinable condition such as "tiredness" or "pain" for which his/her doctor cannot provide Objective Medical Evidence;

H. cosmetic surgery - except surgery made necessary by a medical condition or accidental injury incurred while covered under the Plan; or

I. working for oneself (in an income-producing capacity) or an employer other than VMware, Inc.

No Benefits Are Payable:

A. to an individual who is a) incarcerated, in any federal, state or municipal penal institution, jail, medical facility, public or private hospital or in any other place because of a criminal conviction of a federal, state or municipal law or ordinance, or b) who commits a crime and is disabled due to an illness or injury, caused by, or arising out of the commission of, arrest, investigation, prosecution of any crime that results in a felony conviction,

B. to any Employee who willfully, for the purpose of obtaining benefits, either makes a false statement or representation, with actual knowledge of the falsity thereof, or withholds a material fact in order to obtain benefits under this Plan, or

C. during any period of Disability for which benefits are paid or payable under any Unemployment Compensation Act of the United States or of any state.

3.04 SUCCESSIVE PERIODS OF DISABILITY

Successive periods of Disability will be determined as follows:

A. Two consecutive periods of Disability, due to the same cause or condition and separated by 14 calendar days or less of return to work at the Participant's normal work schedule with the Company, will be considered the same period of Disability. A new waiting period will not be required and the first and second portions of the period of Disability will be counted toward the benefit maximum.

B. Two consecutive periods of Disability, due to the same cause or condition and separated by more than 14 calendar days of return to work at the Participant's normal work schedule with the Company, will be considered two separate periods of Disability. A new elimination period and new benefit maximum will be applied.

C. If a second period of Disability is found to be unrelated to the cause or condition of a previous Disability and the second disability starts after the Participant returns to his/her normal work schedule with the Company for at least one day, it will be considered as separate period of Disability. A new elimination period and new benefit maximum will be applied.

3.05 AMOUNT OF PLAN BENEFITS

Subject to Section 3.07 and other provisions of the Plan:

An Employee filing a claim for disability benefits as a result of an Organ Donation will receive a weekly benefit amount equal to 100% of Regular Wages (as defined in Section 1.21) for the first thirty (30) days of leave, and 70% of Regular Wages (as defined in Section 1.21) for the remainder of the disability period, not to exceed the Maximum Benefits payable under the Plan.

For all other Disabilities, the amount of weekly benefit for which a Participant is covered under the Plan will be 70% of Regular Wages, as defined in Section 1.21.
For each period of Disability for which benefits are paid and which is less than a full week, the amount of benefit payable will be one-fifth (1/5) of the weekly benefit.

A. Partial Disability Benefits

During a period of Partial Disability, benefits will be calculated by prorating the weekly disability benefit for the hours not worked due to disability as follows:

a. Determine the amount of the weekly benefit.

b. Determine the amount of the hourly benefit by dividing the weekly benefit by the number of hours regularly worked in a week.

c. Determine the number of hours not worked due to disability during the week.

d. Multiply the number of hours not worked due to disability during the week by the Employee's hourly benefit rate.

B. Transitional Return to Work

With the consent of the Claims Administrator, an Employee may engage in transitional return to work for up to ninety (90) days without jeopardizing the Employee's eligibility for benefits. Transitional return to work on a part-time work scheduled will not be considered unless the part-time work schedule is a minimum of four (4) hours per day.

During a period of Transitional Return to Work benefits will be calculated as Partial Disability benefits are calculated above in Section 3.05A.

C. Recovery of Overpayment

In the event that an overpayment exists any overpayment will become payable by the Participant, immediately upon request.

D. Benefit Integration

In the event that a Participant either fails to apply for, elects to defer, or fails to request any of the benefits set forth in Section 3.07, the Claim Administrator will consider, for the purpose of determining the reduction in payments under this Plan, the benefit that would have been paid had the Participant made application for, and received such benefits on the earliest date he or she was eligible.

3.06 MAXIMUM BENEFIT

The Claims Administrator will determine the start of a period of Disability or Partial Disability for which Plan benefits are payable. A period of Disability will end and in no event, will benefits continue beyond the occurrence of any of the following:

A. The date following 180 days of Disability or Partial Disability;

B. The death of the Participant;

C. The Participant is no longer under the care of a Health Care Provider;

D. The refusal by the Participant to be examined by an independent physician or refusal of recommended treatment that is generally acknowledged by Health Care Providers to cure, correct or limit the disabling condition;

E. An independent medical exam report, fails to confirm his/her Disability or Partial Disability;

F. Disability or Partial Disability cannot be confirmed because the Claims Administrator has not received the appropriate medical evidence; or

G. Participant is not undergoing effective treatment for alcoholism or drug abuse, if his/her Disability or Partial Disability is due to any extent by alcoholism or drug abuse.

3.07 REDUCTION OF BENEFITS

Plan benefits will be reduced by other income the Participant receives or is eligible to receive as a result of the Disability or Partial Disability for which the Participant is claiming benefits under this Plan whether such other benefits are applied for or not. Other sources of income include:

A. State disability benefits: Disability benefits received or entitled to receive under any state or municipal compulsory benefit act or law.

B. Benefits paid pursuant to any state or federal workers' compensation or disability law or other law of similar purpose; such benefits will include, but will not be limited to, temporary disability and permanent disability payments (whether total or partial), vocational rehabilitation indemnity benefits, attorney's fees and any amounts awarded or allocated for future medical expenses. Any amount awarded or paid in a lump sum for income replacement for Disability or Partial Disability in accordance with a workers' compensation plan, whether voluntarily or by operation of law, will be deducted from the Plan benefit payable commencing from the date of the award or settlement and continuing for as many future weeks as is necessary to equal the amount of such lump sum or, if it results in over- compensation, must be repaid to the Plan;

C. Remuneration, income, salary or sick pay received from any employer or from the Participant's self-employment, unless such remuneration is for Transitional Return to Work as described in Section 3.05B;

D. Any Federal Social Security or Supplemental Security Income for which the Participant and his or her dependents are eligible because of the Participant's Disability or retirement under Social Security (Old Age, Survivors, Disability and Health Insurance) [OASDHI] of the United States. Dependent benefits are not included if the Participant is divorced and benefits are being paid to the divorced spouse or child(ren) instead of to the Participant. For purposes of computing this offset, any statutory cost of living increases awarded after the initial Social Security Award date, will not be used. However, if the initial award is subsequently adjusted for any other reason, other than a statutory cost of living increase, the new award will be offset;

E. Compulsory "no-fault" automobile insurance;

F. Any Company-sponsored or Company-funded pension plan, government pension or railroad (RRA) pension;

G. Recoveries resulting from Acts of Third Party (see section 3.08);

H. The portion of a settlement or judgment, minus associated costs, of a lawsuit that represents or compensates for his/her loss of earnings;

I. Any amount provided under federal maritime law; and

J. Veteran's Administration benefits.

No offsets will be taken from the retirement or disability benefits the Participant is receiving from a military or government pension, veteran's benefits, Social Security or another employer's retirement plan if such benefits were awarded prior to the onset of the Disability or Partial Disability claimed under the VMware, Inc. STD Plan.

3.08 ACTS OF THIRD PARTIES

In the event that a Participant is injured through the acts or omissions of another person or organization:

A. This Plan will be subrogated to all rights of recovery that the Participant, his/her heirs, guardians, executors, agents or other representatives (hereafter individually and collectively "Participant") may have as a result of the injury, including, without limitation rights to recovery pursuant to:

1. any legal action initiated by this Plan;

2. any action in intervention;

3. any action, at law or in equity, legally permissible to enforce this Plan's rights of recovery against any person or entity that caused, contributed to or is in any way responsible for the injury;

4. any action, at law or in equity, legally permissible to enforce this Plan's rights of recovery against any person, insurance Company, health care provider or other entity that is in any way responsible for providing indemnification, coverage, compensation or other payment as a result of the injury;

5. any action, at law or in equity, legally permissible to enforce this Plan's rights of recovery against any person who received payment of funds from either (a) a person or entity that caused, contributed to or is in any way responsible for the injury; or (b) any insurance Company, health care provider or other entity that is in any way responsible for providing indemnification, coverage, compensation or other payment as a result of the injury;

6. any suit to impose a constructive trust on funds paid by any source as a result of the injury;

7. any suit to enforce an equitable lien on funds paid by any source as a result of the injury;

8. under no fault, personal injury protection, financial responsibility, uninsured motorist and underinsured motorist insurance;

9. under motor vehicle medical and wage loss reimbursement insurance;

10. under homeowners, renters, premises and owners, landlords and tenant's insurance including medical reimbursement coverages; and

11. under group accident and health insurance, and athletic team, sporting event, school, club and other specific risk insurance coverages or accident benefit Plans.

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

C. The Participant shall agree to provide the Plan Administrator with a lien on the proceeds described above, to the extent of the full amount of payments made under the terms of this Plan; said lien may be filed with the person or organization whose act or omission injured the Participant, with his, her or its agents, or may be filed with the Court; when this Plan provides a Notice of Lien regarding a subrogation claim to any person, insurer, attorney or other responsible party, the notice is sufficient to protect the Plan's subrogation rights and the Plan may not be compelled to initiate or to intervene in any legal action in order to establish or maintain its right of subrogation;

D. The Participant shall provide the Plan Administrator with a credit against payments to be made in the future under this Plan; said credit to be equal to the proceeds above described, less any amount paid to the Plan by the way of reimbursement.

E. The amount of this Plan's subrogation interest will be deducted first from any recovery by or on behalf of the Participant. This Plan reserves the right to reduce the amount of its recoverable subrogation interest where in the discretion of the Plan a reduction is in the best interests of this Plan and its Participants and warranted by the circumstances. This Plan will not be responsible for expenses or attorney's fees incurred by a Participant in connection with any recovery unless the Plan has agreed in writing to pay those expenses or fees. This Plan also reserves the right to initiate an action in the name of the Plan or in the name of the Participant to recover its subrogation interest. With respect to the Participant, in no instance will the recoverable subrogation interest exceed total Plan benefits paid with respect to the injury.

ARTICLE IV

PAYMENT OF BENEFITS

4.01 APPLICATION FOR BENEFITS

To be entitled to any Plan benefits for which a Participant is otherwise eligible under the Plan, a Participant must be in compliance with such procedures and requirements as the Plan Administrator has prescribed, with respect to the completion and filing of an application for such benefits, and submission of evidence that such Participant is entitled to such benefits.

The Plan Administrator, in accordance with applicable law, will have the right to:

A. Require proof of Disability or Partial Disability, at the Participant's expense during the pendency of a claim, except as provided in Section 4.03;

B. Require information with respect to the Participant's age, address, marital status, dependents, employment record, and medical history;

C. Require evidence that such Participant has applied for Social Security benefits or other benefits as outlined in Section 3.07;

D. Personally contact and interview the Participant, the Participant's Physician, employer or any other persons who can provide relevant information regarding the Participant's Disability or Partial Disability. Failure to cooperate with the Plan Administrator in a reasonable investigation or processing of a claim may result in benefits being denied, or terminated; or

E. Require any other information reasonably relevant to a determination of whether such Participant is eligible to receive Plan benefits.

The Plan Administrator may also require written authorization to:

1. Obtain information from all the Physicians of a Participant applying for Plan benefits, with respect to such Participant's physical condition, diagnosis, prognosis, date of expected return to work and related matters;

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

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

4.02 TIME LIMIT FOR APPLICATION FOR BENEFITS

Application for benefits, in accordance with the procedures and requirements prescribed by the Plan Administrator, must be made within forty-five (45) days following the date of Disability. Failure to make application within this time limit without just cause, may result in

denial of benefits, in whole or in part, if it was not reasonably possible to do so, provided such application was made as soon as was reasonably possible.

4.03 MEDICAL EXAMINATIONS

The Plan Administrator may require that a Participant applying for Disability or Partial Disability benefits, or appealing an adverse benefit determination, submit to an examination by one or more Physicians or vocational experts designated by the Plan Administrator, for a medical or vocational opinion, as to whether such Participant is disabled so as to meet the eligibility requirements under the Plan for Plan benefits, and whether the Disability or Partial Disability has existed for the prerequisite Elimination Period. Reexaminations of a Participant receiving Plan benefits may be directed by the Plan Administrator from time to time for the purpose of assisting the Plan Administrator in determining whether continued eligibility for such benefits exists. The fees of such Physicians or vocational experts and the expenses of such examinations will be paid by the Plan.

4.04 CLAIM DETERMINATION

An application for benefits will be submitted to the Claims Administrator. The Participant or the Participant's representative will provide an Employee/Claimant's Statement, an authorization for release of medical information and a Physician's Statement. The Physician's Statement will be from a Physician attending the Participant for the illness or injury, which is the basis of the Full or Partial Disability claim.

Following receipt of a claim by the Claims Administrator, the Plan will provide the Participant, within a reasonable period of time, but no more than forty-five days (45) days, with a written determination of whether the claim qualifies for benefits under the Plan. However, this period of time may be extended as follows:

i. If there are unresolved issues that prevent a decision on the claim, and additional information is needed from the Participant or his/her Physician, the time period is tolled from the date on which the notice of additional information required is sent until the date the Participant responds to the notice. In each instance, the notice to the Participant will specify the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. The Participant will be given at least forty-five (45) days from receipt of the notice to provide such information.

ii. If matters beyond the control of the Plan require an extension of the time for determination more than forty-five (45) days after receipt by the Claims Administrator of the claim, written notice indicating the reasons for an extension of up to thirty (30) days will be given to the Participant within the initial forty-five (45) day period. The notice will specify the circumstances requiring the extension of time and the date by which the Claims Administrator expects to render a decision.

iii. If an additional thirty (30) day extension is required, then Participant will be notified in writing within the first thirty (30) day extension period.

If it is determined that the Participant is entitled to benefits, the written notice will specify the amount of the benefit payment to be provided under this Plan. The notice will include the method by which the amount of the benefit payment was computed.

If it is determined that a Participant is not entitled to benefits, the written notice will set forth the specific reasons for the determination, specify the Plan provisions upon which the denial was based, describe any additional material or information deemed necessary in order to perfect the claim, and explain why this information or material is necessary. If the Claims Administrator or any representative thereof relied on an internal rule, guideline, protocol or other similar criterion in making the determination, the Claims Administrator or representative will inform the Participant and will offer, at the Participant's request and at no cost, a copy of the rule, guideline, protocol or other similar criterion.

4.05 CLAIM REVIEW PROCEDURE

A Participant whose claim has been denied, in whole or in part, may, within one hundred and eighty (180) days after receipt of notice of such denial, make written request for review of the claim to the Claims Administrator. The Participant will have the right to review, on written request, and free of charge, all documents pertinent to his or her claim. The Participant will have the opportunity to submit written comments, documents, records and other information relating to the claim for benefits. The review will take into account all comments, documents, records, and other information the Participant submits, without regard to whether such information was submitted or considered in the initial benefit determination. In connection with the review procedure, the Claims Administrator or its representative will have discretionary authority to interpret the Plan, including any ambiguous provisions, and to determine eligibility for benefits.

The appeal will not defer to the initial adverse determination, and it will be conducted by a fiduciary who is neither the individual who made such initial determination, nor the subordinate of such individual. The appeal of a claim that was denied based on a medical judgment will be reviewed by the Claims Administrator or its representative in consultation with a qualified health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional cannot be an individual who was consulted in connection with the adverse determination that is the subject of the appeal, nor the subordinate of such individual. The Claims Administrator or its representative must identify for the Participant medical or vocational experts whose advice was obtained by it in connection with an adverse determination, without regard to whether the advice was relied upon in making the benefit determination.

The Claims Administrator or its representative will provide the Participant with a written decision. In the case of an adverse benefit determination, the notice will include the specific reasons for the adverse determination, reference to the specific plan provisions on which the determination is based, and a statement that the Participant is entitled to receive, upon request and free of charge, documents, records and other information relevant to the claim for benefits. If the Claims Administrator or the representative relied on an internal rule, guideline, protocol or other similar criterion in making the determination, the Claims Administrator or representative will inform the Participant and

will offer, at the Participant's request and free of charge, a copy of the rule, guideline, protocol or similar criterion.

This decision will be provided within a reasonable period of time, but no more than forty-five (45) days after receipt of the request for review. If special circumstances require an extension of the time for review, written notice indicating the reason for such extension will be given to the Participant within such forty-five (45) day period. In case of an extension, the decision will be provided within a reasonable period of time but no more than ninety (90) days after receipt of the request for review.

No action for benefits may be commenced against the Plan Sponsor, Plan Administrator, or designated representative of the Plan prior to the completion of this Claims Review Procedure, except as permitted by law.

4.06 LIMITATION IN ACTIONS

Effective for claims and actions filed on or after the Effective Date of the Plan, any claim filed under Article IV and any action filed in state or federal court by or on behalf of a Participant for the alleged wrongful denial of the Plan benefits or for the alleged interference with ERISA protected rights, must be brought within two years of the date the participant's cause of action first accrues. For the purposes of this Section, a cause of action with respect to a Participant's benefits under the Plan will be deemed to accrue when the Participant has received the initial calculation of his benefits that are the subject of the claim or legal action, or the initial notice of denial, termination or other adverse action. For the purposes of this Section, a cause of action with respect to the alleged interference with ERISA-protected rights will be deemed to accrue when the claimant has actual or constructive knowledge of the acts that are alleged to interfere with ERISA protected rights. Failure to bring any such claim or cause of action within the two-year time frame will preclude a participant, or any representative of the Participant, from filing the claim or cause of action. Correspondence or other communications following the mandatory appeals process will have no effect on this two-year time frame.

4.07 NON-ALIENATION OF BENEFITS

To the extent permitted by law, no benefit payable at any time under the Plan will be assignable or transferable, or subject to any lien, in whole or in part, either directly or by operation of law, or otherwise, including, but not by way of limitation, execution, levy, garnishment, attachment, pledge, bankruptcy, or in any other manner, and no benefit payable under the Plan will be liable for, or be subject to, any obligation or liability of any Participant. If any Participant entitled to a benefit under the Plan will attempt to, or will alienate, sell, transfer, assign, pledge or otherwise encumber such benefit, or any part thereof, or if by reason of his or her bankruptcy, or other event happening at any time, such benefit would devolve upon anyone else or would not be enjoyed by him or her, then the Plan Administrator, in its discretion, which will be exercised uniformly by treating individuals in similar circumstances alike, may terminate the Participant's interest in any such benefit, and hold or apply it to or for his or her benefit, or the benefit of his or her spouse, children or other dependents, or any of them, in such manner as the Plan Administrator may deem proper and in accordance with law.

4.08 PAYMENT TO REPRESENTATIVE

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

4.09 PAYMENT IN THE EVENT OF DEATH

In the event that the final payment of Disability income is payable as the result of the death of a Participant, such payment will be paid to the Participant's estate. Any such payment will fulfill the Plan's responsibility for the amount paid.

4.10 OVERPAYMENT

In the event that the Participant receives an overpayment from the Plan (including any overpayment caused by his/her receipt of income from other sources that should have reduced Plan benefits that were paid to him/her), the Participant must reimburse the Plan for the overpayment. The Plan will have an equitable lien on any overpayment that the Participant receives from the Plan and any payment the Participant receives (or are entitled to receive) from a third party that is owed to the Plan because it should have reduced Plan benefits that have already been paid. If Participant receives money from a third party for which the Plan is entitled to reimbursement, Participant or his/her attorney (if the attorney is holding the money), will hold the money in constructive trust for repayment to the Plan, and will promptly repay the Plan for the amount of the overpayment. Participant or his/her attorney (if the attorney is holding the money), will be considered a fiduciary with respect to the monies held in constructive trust. The Plan will have first priority in any amounts received from a third party that are owed to the Plan, regardless of the manner in which the terms of the payment are structured or worded. The Plan's reimbursement will not be reduced by attorney's fees.

Participants are legally obligated to avoid doing anything that would prejudice the Plan's rights of reimbursement. However, the Plan will be entitled to recover in accordance with these rules, even if Participant does not sign or return any forms required by the Plan. Failure to cooperate may result in Participants disqualification from receipt of further benefits from the Plan.

Until arrangement are made to repay an overpayment, any VMware, Inc. disability benefits that become payable may be reduced to offset the overpayment.

ARTICLE V

CONTRIBUTIONS TO THE PLAN

5.01 COMPANY CONTRIBUTIONS

The Company pays the entire cost of the Plan.

5.02 THE COMPANY'S LIABILITY IN THE EVENT OF AMENDMENT, SUSPENSION OR TERMINATION OF THE PLAN

No amendment, suspension or termination will occur that would (a) cause or permit the Plan assets to be used for any purpose other than the defrayal of administrative expenses and for payment to Participants of benefits provided herein, (b) cause or permit Plan assets to inure (other than through payments made pursuant to the Plan) to the benefit of any private shareholder or individual or (c) except as may otherwise be required by law, impair the right of a Participant upon the adoption of such amendment to receive benefits provided for herein to which he or she already became entitled prior to such amendment. Upon termination of the Plan, the Company will make provision for the payment of benefits hereunder to each Participant to whom benefits are payable on the date of termination and all expenses and charges properly payable hereunder, including all expenses incurred and to be incurred in the liquidation and distribution of the Plan assets.

ARTICLE VI

ADMINISTRATION OF THE PLAN

6.01 APPOINTMENT OF PLAN ADMINISTRATOR

The Company will appoint a Plan Administrator, which administrator may be the Company or any Employee of the Company, or such other person as the Company may select.

6.02 DUTIES OF PLAN ADMINISTRATOR

The Plan Administrator is responsible for the administration of this Plan in accordance with the provisions of the Plan. The Plan Administrator will have such powers and perform such duties as are necessary for the proper operation of the Plan. The Plan Administrator will have discretionary authority to construe the terms of the Plan, including any ambiguous terms and to determine eligibility for benefits. The Plan Administrator may, from time to time, designate representatives who will carry out the delegated responsibilities on behalf of the Plan Administrator. Contemplated designees include, but are not limited to, a Claims Administrator. All such designees will serve at the pleasure of the Plan Administrator and, if Employees, will serve without compensation.

6.03 LIMITATION OF LIABILITY

The Plan Administrator and any representative thereof will be entitled to rely upon any information from any source assumed in good faith to be correct. Neither the Plan Administrator nor any of its representatives, nor the Company, nor any officer or other representative of the Company will be liable because of any act or failure to act on the part of the Plan Administrator or any of its Employees, to any person whomsoever except that nothing herein will be deemed to relieve any individual from liability for his/her own fraud, bad faith, or gross negligence.

ARTICLE VII

DURATION AND AMENDMENT OF THE PLAN

7.01 PERMANENCE OF THE PLAN

Although the Company has established the Plan with the bona fide intention and expectation that it will be able to continue the Plan indefinitely, nevertheless, the Company is not, and will not be under any obligation or liability whatsoever to continue or to maintain the Plan for any given length of time. The Company, through the actions of its Board of Directors or the Board's authorized representative may, in its sole and absolute discretion, terminate the Plan in accordance with its provisions at any time without any liability whatsoever for such discontinuance or termination. In the event that the Plan is terminated, the Plan will continue to pay all benefits then due and payable to Participants.

7.02 RIGHT TO AMEND

The Company reserves the right, any time and from time to time, to modify, alter, or amend, in whole or in part, any or all of the provisions of the Plan, provided, however, that no such modification, alteration, or amendment which increases the duties, obligations or liabilities of the Plan Administrator will be made without the consent of the Plan Administrator. Modification, alteration, or amendment will be accomplished through action of the Board of Directors or the Board's authorized representative.

No modification, alteration or amendment will have any retroactive effect so as to deprive any Participant of any benefit then payable. Notwithstanding the foregoing, any modification, alteration or amendment of the Plan may be made retroactive to the extent necessary for the Plan to comply with applicable law.

ARTICLE VIII

GENERAL PROVISIONS

8.01 NO LIMITATION OF MANAGEMENT RIGHTS

Participation in the Plan will not lessen or otherwise affect the responsibility of an Employee to perform fully his/her duties in a satisfactory and worker like manner, nor will it affect the Company's right to discipline, discharge, or take any other action with respect to an Employee.

8.02 PARTICIPANT'S RESPONSIBILITIES

Each Participant will be responsible for providing the Plan Administrator with his/her current address. Any notices required or permitted to be given hereunder will be deemed given if directed to such address and mailed by regular United States mail. Neither the Plan Administrator nor the Company will have any obligation or duty to locate a Participant. In the event a Participant becomes entitled to a payment under the Plan and such payment cannot then be made (i) because the current address referred to above is incorrect, (ii) because such Participant fails to respond to the notice sent to the current address referred to above, (iii) because of conflicting claims to such payment, or (iv) because of any other reason, the amount of such payment, if and when made, will be that determined under the provisions of Article III hereof, without interest thereon.

8.03 GOVERNING LAW

The Plan will be governed by and construed in accordance with the Federal laws governing Employee benefit plans.

8.04 MISSING PERSONS

If, within one year after any amount, whether a distribution, income or other increment, becomes payable hereunder to a Participant, said amount will not have been claimed by the Participant, provided due and proper care will have been exercised by the Plan Administrator in attempting to make such payment, the amount thereof will be forfeited to and become the property of the Plan and will cease to be a liability of the Plan.

ARTICLE IX

ERISA RIGHTS

As a Participant in the VMware Inc. Short Term Disability Plan, you are entitled to certain rights and protections. The Employee Retirement Income Security Act of 1974 (ERISA) provides that all Plan Participants will be entitled to:

9.01 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 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.

9.02 PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty of do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your employer, union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

9.03 ENFORCE YOUR RIGHTS

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or 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.

9.04 ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Plan Administrator. If you have 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 of the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.