SUMMARY PLAN DESCRIPTION

FOR THE

VMWARE, INC. GROUP HEALTH AND WELFARE PLAN AND CAFETERIA PLAN

January 2021

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VMWARE INC. SPD FOR THE GROUP HEALTH AND WELFARE PLAN AND CAFETERIA PLAN

I. INTRODUCTION

VMware sponsors and maintains the VMware Group Health and Welfare Plan ("Welfare Plan") and the VMware Cafeteria Plan ("Cafeteria Plan"). The Plans are maintained for the benefit of eligible employees and their eligible family members, and the purpose is to provide the benefits listed in Section XIII (Benefits, Third Party Administrators and Insurers) and described in the enrollment materials. The Cafeteria Plan permits eligible employees to make pre-tax contributions to one of two types of health care flexible spending accounts ("Health FSA") and/or dependent care flexible spending account ("Dependent Care FSA"). VMware also makes contributions to a health savings account ("HSA") on behalf of eligible employees who are enrolled in a high deductible health plan and the Cafeteria Plan permits employees to make pre-tax contributions towards their own HSA. Please note that the Cafeteria Plan, Dependent Care FSA and the HSA are not subject to ERISA.

This summary, together with the summaries (including documents called SPDs), booklets, certificates, EOCs or other materials describing the benefits, which are provided by the third party administrators for the self-insured programs or insurance companies or HMOs (the "Program Materials") is your Summary Plan Description or SPD for the Welfare Plan and the Cafeteria Plan. The SPD is provided to explain to you, in easy to understand language, how these Plans work. It describes your benefits and rights as well as your obligations under these Plans. It is important for you to understand that because this is only a summary, it cannot cover all the details of the Plans or how the rules will apply to every person in every situation. All of the specific rules governing the Welfare Plan and the Cafeteria Plan are contained in the official "plan documents." You can obtain copies of the Plan documents from your Plan Administrator.

Every effort has been made to accurately describe the complicated provisions of the Welfare Plan and the Cafeteria Plan. In the event there is any conflict between the SPD and the Plan documents, the Plan documents will always be followed in the actual determination of your benefits or rights.

If you have any questions concerning your benefits, you should contact the Plan Administrator.

II. PARTICIPATION

Employee Eligibility to Participate

You will be notified of your eligibility for benefits through enrollment materials. Generally, you are eligible to participate in the Plans if you are a regular employee on the U.S. payroll who works 20 or more hours per week. You are not eligible if you are an independent contractor or consultant, a leased, staffing or temporary agency employee. With respect to eligibility, to the extent applicable the Plans will comply with all requirements of the Patient Protection and Affordable Care Act of 2010.

Dependent Eligibility to Participate

In addition to yourself, you also may enroll your eligible dependents (e.g. spouse, domestic partner, and children as specified in the enrollment materials) for coverage. See the Program Materials for a description of who qualifies as an eligible dependent.

Enrolling for Coverage

When you first become eligible for coverage under the Plans, you will be provided enrollment information from the Plan Administrator and you must follow the enrollment procedures specified by the Plan Administrator within 30 days of when you become eligible. If you are an eligible employee, you will be automatically covered under certain benefit programs (e.g. EAP, business travel accident, basic life, AD&D, short and long term disability). Other benefit programs (e.g. medical and prescription drug, dental, vision, supplemental life, Health FSA, Dependent Care FSA, HSA, and group legal) require that you elect to participate. To enroll for coverage, you must follow the enrollment procedures specified by the Plan Administrator.

Each fall, VMware will have an open enrollment period. During this time, you may elect coverage for the first time under the Plans, may discontinue coverage under the Plans, may enroll or discontinue coverage for your eligible family members, and may switch between the different benefit programs that are available to you.

Once you make an election, it is irrevocable for the rest of the Plan Year. You cannot change your elections until a later open enrollment period or special enrollment period or until an event occurs that allows you to change your election (for example, you have a qualified change of status, your dependent changes his or her coverage under his or her employer's plan, or a Qualified Medical Child Support Order ("QMCSO") is issued).

Special Enrollment

If you initially declined to enroll in an underlying health benefit component because you had other coverage and later lose that coverage, you may be able to enroll yourself or your dependents in the health care components. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself or your dependents. A new election must be submitted within 30 days of these special enrollment events, or 60 days in the event of a birth or adoption.

You and your dependents may also enroll in health benefits if you or your dependents have coverage through Medicaid or a State Children's Health Insurance Program ("CHIP") and you or your dependents lose eligibility for that coverage or you become eligible for a premium assistance program through Medicaid or CHIP. See the Special Provisions Regarding Health Benefits section below for additional information about CHIP. If you believe you are eligible for such special enrollment you must request enrollment or de-enrollment within 60 days.

You may prospectively revoke coverage under an underlying group medical plan (but not the Health FSA) and make corresponding changes to your salary reduction contribution if you are eligible for a special enrollment period to enroll in a qualified health plan through a federal or state

exchange or enrollment during the exchange's annual open enrollment period. For more information about special enrollment periods in the Exchanges, see https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/

Mid-Year Changes

You may revoke your pre-tax election under the Cafeteria Plan and make a new election for the rest of the Plan Year if both the revocation and the new election are on account of and correspond with a "change in status" or other permitted mid-year election change described below (in addition to the special enrollment rights described above) that affects eligibility for coverage or other change as permitted by IRS rules. An election change must be submitted within 30 days of the permitted mid-year election change, or 60 days in the event of a birth or adoption.

A. **Change in Status.** The following events are changes in status:

- A change in legal marital status, including marriage, death of a spouse, divorce, legal separation, and annulment of a marriage.
- A change in number of dependents, including birth, death, adoption, and placement for adoption.
- A change in employment status that effects eligibility of the employee, spouse, or child, including commencement of employment, termination of employment, strike or lockout, commencement of an unpaid leave of absence, return from an unpaid leave of absence, or a change in worksite.
- Child satisfies or ceases to satisfy eligibility requirements as a dependent, including attainment of a particular age, loss of disability status, or similar circumstance.
- A change in place of residence of the employee, spouse, or child that affects eligibility for the availability of benefits.
- A reduction in hours of service of an employee who has been in an employment status under which the employee was reasonably expected to work at least 30 hours per week, results in a change in that employee's status so that employee will reasonably be expected to average less than 30 hours per week after the change, even if that reduction in hours does not result in the employee ceasing to be eligible under the group health components.

B. **Judgment, Decree or Order.** If a judgment, decree or order from a court requires your dependent child to be covered under a health component, you may change your election to provide coverage for the child. Conversely, if the order requires another individual to provide coverage (and such coverage is provided) you may change your election to revoke coverage for your child. A new election must be submitted within 30 days. This does not apply to the Dependent Care FSA.

C. **Entitlement to, or Loss of, Medicare or Medicaid.** If you, your spouse and/or a dependent who is enrolled in health coverage becomes enrolled in Medicare or Medicaid, you may cancel or reduce coverage for the person who becomes enrolled in Medicare or Medicaid. Conversely, if you, your spouse and/or a dependent who was covered under Medicare or Medicaid loses

this coverage, you are allowed to make an election to commence or increase coverage for the person who loses Medicare or Medicaid coverage. If there is a loss in Medicaid coverage, the new election must be submitted within 60 days. This does not apply to the Dependent Care FSA.

D. **Significant/Insignificant Changes in Cost.** If the cost of coverage under an underlying accident or health program significantly increases, you are allowed to increase contributions prospectively or elect similar coverage (if available) or revoke coverage if similar coverage is not available. If the cost of coverage under an underlying accident or health program significantly decreases, you are allowed to decrease your contributions prospectively or commence participation in the option with the decrease in cost. The basis of whether a change in cost is significant or insignificant is determined on a group level, not on an individual level. *Insignificant* cost increases or decreases (determined on a group level) will automatically apply. Regarding the Dependent Care FSA, you may choose to increase your contributions in the event that the provider of services increases their fees during the Plan Year, as long as the provider of services is not a relative. Conversely, should you remove your dependent from child care or the need for child care decreases, you are allowed to decrease your Dependent Care FSA election accordingly. This does not apply to the Health FSA.

E. **Significant Curtailment of Coverage/Addition, Significant Improvement or Drop of Benefit Package Option.** If coverage under an underlying accident or health plan is significantly curtailed, you may revoke your election and elect another option with similar coverage. If a new benefit is added or significantly improved during the Plan Year, you may elect the newly added option. Conversely, if an existing benefit is dropped, you are allowed to choose another benefit that provides similar coverage. This does not apply to the Health FSA.

F. **Change in Coverage under another Group Health Plan.** You are allowed to make an election change that is on account of or corresponds with a change made under the cafeteria plan of your spouse, former spouse, or dependent's employer, provided the employer permits participants to make an election change that would be permitted under the status change rules contained in this Cafeteria Plan or this Cafeteria Plan permits you to make an election for a period of coverage that is different from the period of coverage under the plan of your spouse, former spouse, or dependent. This does not apply to the Health FSA.

G. **Loss of Coverage under Other Group Health Coverage.** You may add coverage for you, your spouse, or your dependent if coverage is lost under any group health plan sponsored by a governmental or educational institution. This does not apply to the Health FSA or the Dependent Care FSA.

H. **FMLA.** You may revoke an existing health plan (including the Health FSA) election and make a new election if you take an FMLA leave.

I. Change in Contributions to Health Savings Account. You may change or revoke your contributions to your HSA prospectively at any time. The change will be effective only after a valid election change has been received and processed by the administrator.

You must request the enrollment change within 30 days of the change in status (60 days in the case of losing/gaining eligibility for Medicaid or CHIP or the birth or adoption of a child) through Workday Benefits (www.myworkday.com/vmware). The change is effective as soon as administratively feasible after receiving and approving the request (except for newborn or adopted children, who are covered back to the date of birth, adoption, or placement for adoption). Changes to pre-tax contributions will be prospective.

Termination of Coverage

Unless your coverage is extended or continued as permitted under the Plan, your coverage ends at the times specified in the Program Materials.

III. COST OF COVERAGE

VMware pays the entire cost for certain benefits. You and VMware share the cost of the coverage for certain benefits and you pay the full cost for other benefits. VMware will provide you with information showing the current costs for your benefits during enrollment. VMware may change the amounts that it contributes toward benefits under the Plans at any time and for any reason. VMware will periodically provide you with information showing the current costs for your benefits.

Your contributions for your portion of the cost of benefits and your tax dependents (e.g. dependent children) may be deducted from your regular paycheck ("salary reduction contributions") on a pre-tax basis through the Cafeteria Plan. That means you will most likely pay less in taxes since part of your pay is being deducted for the cost of your coverage before the whole paycheck is taxed.

Please note that the health care programs may also have deductibles, co-payments, co-insurance and maximum out-of-pocket amounts that you must pay. Deductibles, co-payments, co-insurance and out-of-pocket limits may vary among the coverage options available under the component benefit programs, among the different features of a single coverage option, among covered groups, or in any other manner described in the health care benefit Program Materials.

IV. BENEFITS

Information regarding the benefits available under the Plans is described in the Program Materials which are included with and made a part of this SPD. This information is important. You should read it and make sure you understand it. The Program Materials contain a description of the circumstances that may result in disqualification, ineligibility, or the denial, loss, forfeiture, suspension, offset, reduction, or subrogation of benefits. For example, the Program Materials contain information regarding what is covered and not covered, when you must get approval before obtaining medical care, deductibles, copayments, coinsurance, annual out-of-pocket maximums, the lifetime maximum and other limits on specific benefits. The Program Materials also contain information on subrogation and rights of recovery when third parties have caused injuries or illnesses, coordination of benefits or there are other individuals, entities, plans, programs or insurance that may be responsible for providing you benefits.

V. FLEXIBLE SPENDING ACCOUNTS

VMware offers two types of flexible spending accounts: Health Care Flexible Spending Accounts (General Purpose Health FSA or Limited Purpose Health FSA) and Dependent Care Flexible Spending Accounts. The General Purpose Health FSA or Limited Purpose Health FSA cover eligible health care expenses for you and your tax dependents (e.g. your spouse, children, and domestic partner if s/he qualifies as a tax dependent). If you are enrolled in the VMware high deductible health plan and make or receive contributions to an HSA you may only enroll in the Limited Purpose Health FSA. The Cafeteria Plan also offers a Dependent Care FSA to help you cover out of pocket eligible dependent care expenses.

Health Care Flexible Spending Account

If you are an eligible employee you may elect to enroll in either the General Purpose Health FSA or the Limited Purpose Health FSA. You may not enroll in the General Purpose Health FSA if you are enrolled in a high deductible health plan and make, or receive contributions to a health savings account. If you elect to contribute to either of the Health FSAs you may contribute up to a maximum of $2,750 (adjusted for inflation) per year on a pre-tax basis. You will then be entitled to receive reimbursement for eligible health care expenses which are incurred while you are a participant in the Cafeteria Plan by you and your "eligible family members" up to the total dollar amount you elected for the Plan Year, less any prior reimbursements made for that Plan Year. The expense must be incurred and the services performed before you may submit the expense for reimbursement. Note: "incurred" means an expense is incurred when you are provided with the health care that gives rise to the health expenses, and not when you are formally billed or charged for, or pay for the health care.

Eligible Health Care Expenses. With respect to the General Purpose Health FSA, eligible health care expenses include deductibles, copayments, dental and orthodontia expenses, prescription and over the counter drugs and medications, insulin, eye care, hearing care, menstrual care products, routine physical examinations, and any other medical care item which constitutes "medical care" under Section 213(d) of the Internal Revenue Code. With respect to the Limited Purpose Health FSA, eligible health care expenses include dental and vision care. Expenses reimbursed from your General Purpose Health FSA or Limited Purpose Health FSA cannot be deducted on your income tax return, and you cannot be reimbursed for expenses for which you have been reimbursed or which are reimbursable under any other health program.

In all instances, the health care expenses must be primarily to alleviate or prevent a physical or mental defect or illness. It can include amounts for cosmetic surgery only if it is necessary to improve a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. Eligible health care expenses can include products as well as services.

Medications, products and services for cosmetic purposes, even if prescribed by a doctor (such as hair growth and wrinkle treatments) are not eligible expenses. In addition, an expense is not eligible if it is not for health care, or if it is merely for the beneficial health of you and your "eligible family members" (for example, vitamins or nutritional

supplements that are not taken to treat a specific medical condition). Per IRS regulations, health insurance premiums of any kind are not reimbursable under the Health FSA. For a list of eligible health care expenses, go to Publication 502 at https://www.irs.gov/pub/irs-pdf/p502.pdf.

Whether an expense is for health care as defined by Code Section 213(d) and 223(d)(2) is within the sole discretion of the Administrator.

Timing for Incurring Expenses. Eligible health care expenses must be incurred during the Plan Year.

Reimbursement Procedures. Your claims for reimbursement will be made online or on forms provided by the Contract Administrator (listed at the end of this SPD or by using your debit card, in accordance with procedures established by the Contract Administrator). Claims incurred during the Plan Year should be submitted within a reasonable time of incurring the expense, but in no event later than March 31st after the end of the Plan Year. If you fail to submit a claim within the period specified above, the claim shall not be considered for reimbursement by the Contract Administrator.

Debit Card. When you enroll, you will automatically be sent a debit card by the Contract Administrator within a few weeks. You may request additional cards for use by your spouse or eligible dependents (check with the Contract Administrator for details). Use of the card verifies your acceptance of the "terms & conditions" for use as specified by the Contract Administrator. You will be provided with instructions on how to activate and use your card. Be sure to keep your receipts for any services or products purchased with each card issued for your General Purpose Health FSA or Limited Purpose Health FSA.

You may be required to submit a detailed receipt (not the credit card like receipt, but one that describes the product or service paid for to show that the card was used for eligible expenses). If you are not able to show the card was used for eligible expenses, you will be required to repay the Cafeteria Plan in the amount of the card transaction. If you fail to repay the Cafeteria Plan, collection of past due amounts will be deducted from future reimbursement checks and/or be subject to other collection policies. Card privileges may be revoked at any time. Use of the card that exceeds the amount elected less amounts previously paid is your responsibility and must be paid back to the Cafeteria Plan.

Carryover. If you were a Participant on the last day of the preceding Plan Year and have unused amounts in your General Purpose Health FSA or Limited Purpose Health FSA from the immediately preceding Plan Year, you may carryover unused amounts up to a maximum of $550.00 (indexed for inflation). Any unused amounts in excess of the $550.00 (indexed for inflation) carryover will be forfeited.

If you will have a Health Savings Account for the upcoming year and have unused amounts (as of December 31st of the year prior) in your General Purpose Health FSA from the immediately preceding Plan Year, those unused amounts will automatically (up to the maximum carryover for that year ($550 in 2021)) carryover from the General Purpose Health FSA and transfer to a Limited Purpose Health FSA. Only expenses that constitute

eligible health care expenses with respect to the Limited Purpose Health FSA (dental and vision expenses) will be paid or reimbursed from such unused amounts carried over from your prior year General Purpose Health FSA.

Forfeiture. If there is money in your Health FSA that exceeds the maximum carryover amount ($550 in 2021) at the end of the Plan Year, IRS rules require that the money in your account be forfeited. In general, forfeited amounts will be used to pay Plan administrative costs. For this reason, you need to make careful estimates of your reimbursable expenses for the coming Plan Year when you make your Health FSA election. As noted above, you have until March 31st after the end of the Plan Year in which to file claims for expenses incurred during the Plan Year. If you terminate during the year or lose eligibility, you will have 90 days after your date of termination (or loss of eligibility) in which to file claims for expenses incurred prior to your termination.

Dependent Care Flexible Spending Account

If you are eligible, you may elect to contribute up to the lesser of your "earned income" or $5,000 ($2,500 if you are married and filing separately) on a pre-tax basis to a Dependent Care FSA. (Your "earned income" is the lesser of your earnings or your spouse's actual or deemed earnings.) You will then be entitled to receive reimbursement for employment-related dependent care expenses, which enable you and your spouse, if applicable, to work (or to actively seek work) or your spouse to attend school full-time, and which are incurred after your election date, but during the Plan Year, up to the current balance in your Dependent Care FSA. **Note: "incurred" means an expense is incurred when you are provided with the dependent care services and not when you are formally billed or charged for the dependent care services.**

Eligible Participants. You must either be a single parent, or if you are married, your spouse must work or be a full-time student for at least 5 months during the year while you are working, or be physically or mentally unable to care for him or herself. If you are divorced or legally separated, you must have custody of your child most of the time even though your former spouse may claim the child for income tax purposes. If your spouse is a full-time student or is physically or mentally incapable of caring for himself or herself, he or she will be deemed to be earning $250 per month (if you receive care for one dependent) or $500 per month (for two or more dependents).

Qualifying Dependents. You may receive reimbursement for employment-related dependent care expenses for the care of "qualifying dependents." Qualifying dependents are children under age 13 whom you claim as dependents for income tax purposes, or your spouse or other dependent who is physically or mentally unable to care for himself or herself (even if you cannot claim an exemption for the person for income tax purposes) and who lives with you for at least half of the year. You may also claim dependent care expenses for the care of an elderly parent who spends at least 8 hours a day in your home and whom you can claim as a tax dependent.

Eligible Dependent Care Expenses. You may be reimbursed for care provided inside or outside your home by anyone **other than** your spouse, your child under age 19, and/or any person you claim as a dependent for income tax purposes. If the care is outside your home,

it must be provided for your dependent who is under age 13 and whom you claim as a dependent on your tax return or for another "qualifying dependent" that regularly spends at least 8 hours per day in your household. If the expenses are incurred for services provided by a dependent care center (a facility that provides care for a fee and cares for more than 6 individuals not residing at the facility), the center must comply with all applicable state and local licensing and other legal requirements.

Reimbursement Procedures. Your claims for reimbursement will be made online or on forms provided by the Contract Administrator or by using your debit card in accordance with procedures established by the Contract Administrator. Claims should be submitted within a reasonable time of incurring the expense, but in no event later than March 31st after the end of the Plan Year. If you fail to submit a claim within the period specified above, the claim shall not be considered for reimbursement by the Contract Administrator. No reimbursement will be made for amounts that exceed the balance in your Dependent Care FSA at the time reimbursement is requested. The amount of any eligible expenses not reimbursed will be carried over to subsequent months during the same Plan Year and reimbursed when the balance in your account permits.

Forfeiture. If there is money in your account at the end of the Plan Year, and you have no more reimbursable expenses, IRS rules require that the money in your account be forfeited. In general, forfeited amounts will be used to pay Cafeteria Plan administrative costs or returned to VMware. For this reason, **you need to make careful estimates of your reimbursable expenses for the coming Plan Year when you make your Dependent Care FSA election**. If you terminate during the year you will have 90 days after your date of termination in which to file claims for expenses incurred prior to your termination.

Dependent Care FSA v. Tax Credit. Your individual circumstances and income will determine whether the federal, state (where eligible) and Social Security tax savings under the Dependent Care FSA provide greater tax benefits than using the federal tax credit. Contributions to the Dependent Care FSA reduce your federal tax credit availability. Since individual tax situations vary, it is important for you to select which approach offers more favorable tax savings. Regardless of whether you choose to enroll in the Dependent Care FSA or claim the federal tax credit, you must submit IRS Form 2441 along with your personal annual income tax filing. Please seek professional tax advice with any questions you may have regarding your individual tax situation.

Termination of Employment or Loss of Eligibility. If you terminate employment or cease to be an eligible employee (for instance, due to a reduction of hours), you may receive reimbursement for any allowable employment-related dependent care expenses incurred through the date of your termination or the date you cease to be an eligible employee, up to the amount in your Dependent Care FSA as of the date you ceased to participate.

VI. HEALTH SAVINGS ACCOUNT

If you enroll in the VMware high deductible health plan and do not have coverage under another "impermissible plan" (e.g., a traditional plan of your spouse, individual health insurance,

Medicare, or a general purpose health care flexible spending account) you are eligible to establish a Health Savings Account (HSA). An HSA is a custodial account, in your name, set up at the financial institution listed at the end of this SPD. VMware will make contributions to your HSA in an amount that will be communicated to you with your enrollment materials, and which will vary depending on whether you have high deductible single coverage or have high deductible family coverage.

You can make pre-tax payroll contributions to your HSA, which when combined with the VMware contributions do not exceed the maximum statutory limits. If you will be at least 55 before December 31st you may contribute an additional catch up contribution. The amount of the annual limits will be provided to you during enrollment. You may also find information at https://www.treasury.gov/resource-center/faqs/Taxes/Pages/Health-Savings-Accounts.aspx

Your HSA account can be invested and grow (once you reach a certain balance) or can be used, tax-free, for out-of-pocket eligible medical expenses (such as copays and deductibles). If you are enrolled in a high deductible health plan and establish an HSA you may not enroll in the General Purpose Health FSA but you may enroll in the Limited Purpose Health FSA.

Your HSA (which is separate from the Cafeteria Plan) belongs to you and cannot be forfeited, although there may be adverse tax consequences if contributions to your HSA or distributions from your HSA do not comply with IRS requirements. Check with your personal tax advisor if you have questions about your personal situation.

VII. SPECIAL PROVISIONS REGARDING HEALTH BENEFITS

Newborn's and Mother's Health Protection Act

The underlying medical care programs may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarean section. However, this does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

Women's Health and Cancer Rights Act

For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

Plan limits, deductibles, copayments, and coinsurance apply to these benefits.

Mental Health Parity and Addiction Equity Act

Any underlying medical care programs which provides both medical/surgical benefits and mental health or substance use disorder benefits, shall provide parity between the medical/surgical benefits and the mental health or substance use disorder benefits. This means that the same financial requirements (e.g. deductibles, co-payments, co-insurance, out-of-pocket maximums and any annual or lifetime limits) as well as quantitative treatment limitations (such as the number of treatments, visits or days of coverage) will be the same for medical/surgical benefits and mental health or substance use disorder benefits. Non-quantitative treatment limits, such as medical management standards, are also the same. For more information see the Program Materials.

Genetic Information Nondiscrimination Act

The underlying health care programs are prohibited from (i) adjusting group premiums or contribution amounts based on genetic information; (ii) requesting or requiring an individual or an individual's family members to undergo genetic testing; or (iii) requesting, requiring or purchasing genetic information for underwriting purposes. The HIPAA privacy rules (described below) also prohibit the use or disclosure of genetic information for underwriting purposes. The health care components are designed to meet these requirements. For more information see the Program Materials.

Medicaid and the Children's Health Insurance Program (CHIP)

If you are eligible for health care coverage but are unable to afford the premiums, some States have premium assistance programs that can help pay for the coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you, your spouse, children or dependents are already enrolled in Medicaid or CHIP, you can contact your State Medicaid or CHIP office to find out if premium assistance is available. You can contact the U.S. Department of Labor, Employee Benefits Security Administration at www.dol.gov/ebsa or 1-866-444-EBSA (3272), or the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services at www.cms.gov or 1-877-267-2323 to get a list of States that provide premium assistance (you are also provided this notice annually). If you, your spouse, children or dependents are not currently enrolled in Medicaid or CHIP and you think you might be eligible, you can contact your State Medicaid or CHIP office or call 1-877-KIDS-NOW (1-877-543-7669) or go to www.insurekidsnow.gov for further information.

If you, your spouse, children or dependents are eligible for premium assistance under Medicaid or CHIP, and if you are not already enrolled, you are entitled special enrollment rights described in the Special Enrollment section above.

Affordable Care Act

This section describes some of the applicable provisions of the Federal health care reform laws (known as the "Affordable Care Act") that apply to the medical care components of the Welfare Plan. You can cover your adult children to age 26. You do not need prior authorization to obtain

in network OB/GYN services. If your medical coverage requires you to designate a primary care physician you have the right to designate any in-network primary care physician accepting new patients and may designate an in-network pediatrician for your children. You may seek emergency medical services at an in-network or out-of-network provider without having to obtain prior authorization and with the same co-payments and deductibles; however the out-of-network provider may balance bill you for the difference between its charge and the amount paid by the medical care program you are enrolled in. Your medical coverage cannot be retroactively cancelled, unless you fail to timely pay premiums, or commit intentional misrepresentation or fraud. In other circumstances, you will generally be provided advance notice of cancellation. There are no pre-existing condition exclusions and no annual or lifetime limits. You are not required to pay a co-payment or other cost-sharing for in-network preventive and wellness services, such as routine exams, immunizations, mammograms, and routine baby care (see www.healthcare.gov for more information). The VMware medical coverage options provide minimum value and affordable coverage as required under the Affordable Care Act. You may be entitled to external review of certain health care claims. More detailed information may be found in the Program Materials.

Grandfathered Medical Plans

As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the healthcare components may not include certain consumer protections of the Affordable Care Act that apply to other health plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Qualified Medical Child Support Orders (QMCSO)

The health care components will provide benefits as required by any qualified medical child support order, as defined in ERISA Section 609(a) or National Medical Support Notice. For a copy QMCSO procedures, please contact the Plan Administrator. The health care components will also provide benefits to dependent children placed with you for adoption under the same terms and conditions as apply in the case of dependent children who are your natural children, in accordance with ERISA Section 609(c).

Continuation of Benefits During Leave

If you go on a leave of absence and are receiving pay directly from VMware (e.g. paid time off or vacation time), your elections and salary reduction contributions shall continue in the normal course in accordance with the elections you made.

If you go on a leave where you are not receiving pay directly from VMware (e.g. unpaid leave or you are receiving disability benefit payments from a third party payor) VMware will continue your health coverage for the time period required under the Family and Medical Leave Act (FMLA) or for such longer period as provided in VMware's leave of absence policy (as amended from time

to time). Subject to any rights under the FMLA or other applicable law, you are responsible for paying your portion of salary reduction contributions. You may "catch-up" any missed salary reduction contributions on a pre-tax basis via payroll withholding.

Should you fail to pay your portion of the salary reduction contributions or not return to employment, VMware is entitled to recover any contributions which VMware has paid on your behalf while you were on an unpaid leave.

While on leave, you have the same rights regarding open enrollment and status change election modifications as those employees participating in the Cafeteria Plan who are not on leave.

Continuation of Benefits for Military Leave

You have certain rights and obligations under a Federal law commonly known as USERRA when you go on a military leave that is subject to USERRA. This includes the right to continue health care coverage for up to 24 months. You also have certain reinstatement rights upon your return from a military leave covered by USERRA. VMware will continue your underlying health program coverage for up to the first 548 days of qualified military leave. After that you may continue your underlying health coverage for up to a total of 24 months. You are responsible for making benefit elections during open enrollments that occur while you are on military leave. For more information about your rights and obligations under USERRA see VMware Benefits.

COBRA Continuation Coverage

Continuation of Coverage

COBRA requires eligible employees and dependents enrolled in the health care components to be permitted to continue their health plan coverage (medical and prescription drug, dental, vision, EAP and Health FSA) on a temporary basis in certain instances where coverage would otherwise end. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage is lost because of the qualifying event. With respect to the General Purpose Health FSA or Limited Purpose Health FSA you are only entitled to elect COBRA continuation coverage if you have a positive balance in your General Purpose Health FSA or Limited Purpose Health FSA at the time you have a qualifying event and lose coverage (after calculating expenses up to that point) and such coverage will only continue until the end of the year.

Qualified Beneficiaries

If you are an employee, you will become a qualified beneficiary if you lose your coverage because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage.

Domestic partners are not qualified beneficiaries under Federal law. Therefore, domestic partners are not individually entitled to elect COBRA continuation coverage. However, the VMware health care programs extend COBRA like coverage to domestic partners. See the Program Materials for more information.

Duration of Continuation Coverage

The following events will create a right to elect continued coverage under COBRA for the period indicated if the event causes the person to lose coverage:

18-month events. The following events will entitle you, your covered spouse, and your covered dependents to 18 months of continued coverage:

- Any voluntary or involuntary termination of employment other than for gross misconduct.
- Reduction in hours to below the hours required for participation in the health care components.

29-month event. If you or your covered dependent is disabled (according to Social Security) at the time of or within 60 days after the COBRA qualifying event (termination of employment or reduction in hours) and if notice of the Social Security disability award is provided in writing to the Plan Administrator within 18 months of the qualifying event and within 60 days of the date of the award, then you and your covered dependents are

entitled to 29 months of coverage. If you don't give this notice, you will lose your right to continued coverage.

36-month events. The following events will entitle your covered dependent(s) to 36 months of continued coverage:

- Divorce or legal separation, if you notify the Plan Administrator in writing within 60 days of the later of the event or the date coverage ends due to the event.
- Dependent child no longer eligible, if you notify the Plan Administrator in writing within 60 days of the later of the event or the date coverage ends due to the event.
- Employee dies.
- Employee enrolls in Medicare.

When a 36-month event occurs during the period of continuation coverage for an 18-month event (or a 29-month event), your dependents coverage will be extended to 36 months from the original qualifying event date. If this happens (you have a second "qualifying event"), you must notify the Plan Administrator in writing within 60 days of the second event, or your covered dependents will not be entitled to COBRA beyond the initial 18 (or 29) month period.

Also, if you enroll in Medicare while an active employee and then you have an 18-month qualifying event (you terminate employment or reduce your hours) within 18 months after enrolling in Medicare, your covered dependents are entitled to 36 months of continued coverage measured from the date you enrolled in Medicare.

Note: With respect to the General Purpose Health FSA or Limited Purpose Health FSA COBRA coverage continues until the end of the year in which you had a qualifying event.

Cal-COBRA and EOB. If you are eligible for Cal-COBRA (e.g. because you are on COBRA and covered by a Kaiser California plan) coverage may be continued for up to a total of 36 months, subject to paying 110% of the applicable premium. You will receive information about Cal-COBRA directly from Kaiser.

Children Born or Acquired During COBRA Continuation Coverage

If you acquire a new dependent by birth, adoption, or placement for adoption during your COBRA continuation period, the child may be enrolled immediately for COBRA continuation coverage and the child has the same rights during the open enrollment period as any other person in the family who has COBRA continuation coverage. The maximum COBRA continuation coverage period for the child is the same as the maximum period that applies to other members of the family. It is not measured from the date of the birth, adoption, or placement for adoption. You must notify the COBRA Administrator within 31 days of the birth, adoption or placement for adoption.

Termination of COBRA Continuation Coverage

Your COBRA continuation coverage will terminate on the earliest of the following:

- The last day of the last month of the applicable 18, 29, or 36 month period (or end of the year for a Health FSA).
- The last day of the month for which timely payment is made (non-payment).
- The date the person continuing coverage first becomes covered under another group health plan after electing COBRA continuation coverage. You must notify the COBRA Administrator in writing within 31 days of becoming covered under the other plan.
- The date the person continuing coverage first enrolls in Medicare after electing COBRA continuation coverage. You must notify the COBRA Administrator in writing within 31 days of becoming covered under Medicare.
- The date VMware (and its related companies) discontinues all group health plans offered to any similarly situated active employees.
- If coverage is being continued due to disability (months 19 through 29), the first day of the month that is more than 30 days following the date the Social Security Administration determines that the person is no longer disabled. For example, if the Social Security Administration determines you stopped being disabled on January 15, your disability extension will end on March 1. If the Social Security Administration determines that the disability has stopped, you must notify the COBRA Administrator in writing within 31 days of the date of the determination.

Cost of COBRA Continuation Coverage

If you or your dependents choose to continue coverage, you will be required to pay the full cost of the coverage, plus 2% for administration. However, if you or your covered dependent is entitled to 29 months of extended coverage due to disability, you may be required to pay 150% of the designated cost after the first 18 months of coverage. The COBRA Administrator can provide you with information on the cost of continuation coverage.

How to Apply for COBRA Continuation Coverage

It is VMware's responsibility to notify the COBRA Administrator of an employee's termination, reduction in work hours, or death, or the employee becoming eligible for Medicare. However, you are responsible for notifying VMware in writing within 60 days in the event of a divorce, legal separation, or your child's loss of dependent status, using the procedures specified below.

NOTICE PROCEDURES:

Any notice that you provide must be provided through Workday Benefits (www.myworkday.com/vmware). Oral notice, including notice by telephone, is not acceptable.

Once the COBRA Administrator receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each qualified beneficiary. The

COBRA Administrator will provide the eligible person with the necessary application and information to enroll for continued coverage through COBRA. The eligible person will have 60 days from the time coverage stops or the date a COBRA notice is sent (whichever is later) to enroll for COBRA coverage.

Each qualified beneficiary has the right to make a separate, individual election. The covered employee may elect COBRA continuation coverage for his or her spouse and a parent may elect COBRA continuation coverage on behalf of his or her children. For each qualified beneficiary who elects continuation coverage, coverage will begin on the date the health care coverage would otherwise have been lost. If you, your spouse, or your dependents do not enroll for continuation of coverage within the 60 days, you lose the opportunity to do so.

Paying for COBRA Continuation Coverage

If you or your dependent elect continued coverage, payment of all contributions due must be made within 45 days of the date the election form was signed to continue coverage. Subsequent COBRA payments will be due on a monthly basis on the first day of the month of coverage. However, you will be given a grace period until the 30th day of the month for which it is due to make each periodic payment. If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the health care components.

Applying for the Disability Extension

To extend your coverage beyond the 18-month period, you must provide a letter of determination to the COBRA Administrator showing that you are entitled to Social Security disability benefits. You must provide this information in writing within 60 days of its receipt and before the end of the 18-month COBRA continuation period or you will not be allowed to extend your COBRA coverage.

If the Social Security Administration determines that the disability has stopped, you must notify the COBRA Administrator in writing within 30 days of the date of the determination.

Privacy of Health Information

HIPAA requires the group health benefit components to safeguard the privacy of your "Protected Health Information." HIPAA applies to the group health benefit components (i.e. medical and prescription drug, dental, vision, EAP and the General Purpose Health FSA or Limited Purpose Health FSA). However, as explained below, the health care components may use and disclose Protected Health Information, including your Protected Health Information, in some cases.

Protected Health Information is data about a past, present or future physical or medical condition, treatment received, or payment for health care that also identifies the person it relates to. The health care components are allowed to use or disclose Protected Health Information for a variety of reasons, including, but not limited to, for treatment, payment and health care operations, pursuant to your authorization, for public health purposes, to VMware as the Plan Administrator

and sponsor for its health care benefit program administrative purposes, as required by law, and as described in the HIPAA privacy notice.

Participants and their covered eligible dependents will have the rights set forth in the *HIPAA Notice of Privacy Rights* and any other rights and protections required under HIPAA. The Notice may periodically be revised. To receive more information about the privacy practices or your rights, or to request a copy of the *HIPAA Notice of Privacy Rights*, you may contact:

HIPAA Privacy Officer
c/o VMware, Inc.
3401 Hillview Avenue
Palo Alto, CA 94304
(650) 427-5000

The *HIPAA Notice of Privacy Rights* is also available by e-mail. You may contact the Privacy Officer or send an e-mail to a member of the benefits department to request an electronic copy of this Notice.

The health care components have established a complaint procedure concerning the handling of Protected Health Information. The HIPAA privacy notice explains the complaint procedure. All complaints or issues raised by participants or their covered eligible dependents with respect to the use of their PHI must be submitted in writing to the Privacy Officer at:

HIPAA Privacy Officer
c/o VMware, Inc.
3401 Hillview Avenue
Palo Alto, CA 94304

A response will be made within a reasonable period of time, including time to investigate and resolve any issues, after the receipt of the written complaint. The Privacy Officer shall have full discretion in resolving the complaint and making any required interpretations and factual determinations. The decision of the Privacy Officer shall be final and be given full deference by all parties.

VIII. AMENDMENT OR TERMINATION OF THE PLANS

VMware reserves the right to amend the Plans, any component benefit program, in whole or in part at any time. VMware reserves the right to change or cancel the Plans, any component benefit program, or any benefits under the Plans, at any time. If VMware cancels the Plans, any component benefit program or any benefits under the Plans, participation in the canceled benefits terminates on the date of cancellation. However, no amendment or termination will affect your right to any unpaid benefit under the Plans or component benefit program, if you have satisfied all the requirements to receive a benefit under the Plans or component benefit program. Participation in the Plans or component benefit program does not give you any rights to continuing employment.

IX. COST OF COVERAGE AND FUNDING

Cost of Coverage and Payment for Coverage

You and VMware (or your VMware related employer) share the cost of coverage for the Benefits Programs that you select. The amount of employer contributions and employee contributions are determined by VMware in its sole and absolute discretion. Employer contributions may be paid directly to the insurance company or other provider and shall be applied toward the cost of benefits. With respect to any self-funded benefits, which are payable out of VMware's (or related employer's) general assets, VMware will use employee and employer contributions to pay such benefits directly on behalf of participants and their covered family members.

The dollar amount of the required employee contributions is determined from time to time by VMware, in its sole discretion, and is set forth in the latest enrollment materials provided to you. VMware may require different contribution levels for different classes of employees and may increase or decrease the amount of required contributions. Employee contributions are collected through payroll deductions through the Cafeteria Plan or applied directly to the payment of premiums. Employee contributions for your share of the cost of benefits may be made on a pre-tax basis for you, your spouse and eligible dependents through the Cafeteria Plan. Coverage for individuals who are not your tax dependents is paid on an after-tax and the VMware contribution towards the cost of coverage is reported as imputed income to you.

Please note that VMware also establishes (i) any amount that must be paid by you as a deductible before benefit programs will reimburse you for expenses that otherwise would be eligible for benefits, (ii) any co-payment which must be paid by you to a provider at the time services are received under a coverage option, and (iii) any maximum out-of-pocket amount that you must pay during any one plan year. Deductibles, co-payments and out-of-pocket limits may vary among the coverage options available under the component benefit programs, among the different features of a single coverage option, among covered groups, or in any other manner determined in the discretion of the Employer and described in the Program Materials.

Source of Benefit Payments

The source of funding for the payment of benefits are determined by VMware in its sole and absolute discretion. The funding policy for any particular benefit program may call for VMware to purchase and hold insurance contracts and policies to provide some or all of the benefits, for all or a part of the benefits provided to be paid from the general assets of VMware (or related employer), or for all or part of the benefits provided to be funded by participant contributions. The funding policy of any particular benefit program may be amended in writing by VMware or its authorized delegate from time to time.

Insured and Contractual Benefits

With regard to the insured and contractual benefits, nothing obligates VMware (or any related employer) beyond the obligation to make premium payments as provided by the applicable contracts. VMware (or any related employer) does not guarantee benefits payable under any insurance policy or other contract, and any benefits under an insurance

policy or other contract will be the exclusive responsibility of the insurer or other entity that is required to provide benefits under that policy or contract.

Self-Funded Benefits

With regard to unfunded benefits, which are payable out of the general assets of VMware (or related employer), nothing will be construed to require VMware, any related employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any participant (or covered family member) and, no participant, covered family member or other person has any claim against, right to, or security or other interest in, any fund, account or asset of the Employer.

No Rights to Assets

No employee, participant or covered family member shall have any right to, interests in or claim for any particular assets of VMware, any related employer, the Plans, any benefit program or any underlying contract, trust or other vehicle.

Payment of Administrative Expenses

All reasonable expenses incurred in administering the Plans, including, but not limited to, administrative fees and expenses owing to any administrative service provider, actuary, consultant, accountant, specialist or other person or organization that may be employed by the Plan Administrator in connection with Plans administration, shall be paid by the Plans, including, to the extent permitted by applicable law, by any forfeitures, unless paid by VMware or a related employer.

X. CLAIMS PROCEDURE

Filing Claims

The claims procedures described below are representative of the actual claims procedures followed by the applicable Claims Administrator. We are required to describe the ERISA required claims procedures which apply to the Welfare Plan (including the Health FSA) in this SPD. The Program Materials explain the specific procedures you must follow in claiming benefits under the respective program. The third party administrators listed at the end of the SPD are the Claims Administrators for the self-insured health plans, and the HMO or insurance Companies are the Claims Administrators with respect to the insured benefits. They are referred to as the "Claims Administrator" in this section. You must follow the claims procedures of the Claims Administrators, which may require you to complete, sign and submit a written claim on the Claims Administrator's form. You should consult the Program Materials for the details on filing a claim and appealing claims that are denied.

Eligible employees who elect to participate in a Health FSA may submit claims for the reimbursement of eligible health care expenses from their General Purpose or Limited Purpose Health FSA, as applicable. Eligible Employees who elect to participate in a Dependent Care FSA

may submit claims for the reimbursement of eligible dependent care expenses. Distributions from a Participants' Health Savings Account (whether before or after cessation of participation) and all other matters relating to the Participant's HSA are outside of the Cafeteria Plan and are governed by the agreement between you and the HSA custodian. The Dependent Care FSA and the Health Savings Account are not subject to ERISA. However, for administrative convenience the Dependent Care FSA administrator generally follows the "post-service" claims procedures time frame that apply to the General Purpose Health FSA and Limited Purpose Health FSA (i.e. the post-service medical claims procedures), which is described below. Even if the Claims Administrator follows the procedures set forth below, no one (not you, your spouse, dependents or other party) may rely on, or assert a violation based on the Claims Administrator's failure to follow the claims procedures set forth below, with respect to the Dependent Care FSA

For purposes of determining the entitlement to benefits under each benefit program, the respective Claims Administrator is the "named fiduciary" (with respect to the benefits subject to ERISA) with the full power and authority to interpret and apply the terms of the Plans as they relate to the benefits provided under the applicable insurance contract or benefit program. The decisions of the Claims Administrator are binding.

A "claim" is defined as any request for a benefit made by you, a covered spouse or dependent, or a beneficiary (a "claimant"), or by an authorized representative of a claimant, that complies with the procedures for making a benefit claim. There are different types of claims (health, disability and other benefits) and each one has a specific timetable for approval, payment, request for further information, or denial of the claim.

With respect to those benefits that are subject to ERISA, the Claims Administrator will decide the claim in accordance with its reasonable claims procedures, as required by ERISA. If the Claims Administrator denies a claim in whole or in part, you will receive a written notification setting forth the reasons for the denial and describing your rights, including your right to appeal the denial. You must appeal the denial within certain timeframes. The Claims Administrator will decide the appeal in accordance with its reasonable claims procedures, as required by ERISA, and provide you written notification of its decision. There may be voluntary levels of appeal and for medical benefits, and under certain circumstances, you may have the right to obtain external review (that is, review outside the Welfare Plan).

Disability, Business Travel Accident, Life and AD&D Claims

The claims procedures outlined below are representative of the actual claims procedures followed by the Claims Administrator of the disability, business travel accident, life and AD&D benefit components.

Filing a Claim

You must follow the claims procedures established by the applicable Claims Administrator. If you are required to file an initial claim for benefits, you must do so within the time specified in the Program Materials. See Section XIII for contact information for the Claims Administrators.

Decision on a Claim

Disability Programs. In the case of a claim for disability benefits under the Welfare Plan, the Claims Administrator will notify the claimant or claimant's authorized representative of its benefit determination not later than 45 days after receipt of the claim. This period may be extended by the Claims Administrator for up to 30 days, provided that (i) the Claims Administrator determines that the extension is necessary due to matters beyond the control of the Claims Administrator, and (ii) the Claims Administrator notifies the claimant or authorized representative, before the end of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to make its determination. This 75-day period (original 45-day period plus first 30-day extension) for making the benefit determination may be extended for up to an additional 30 days, provided that the Claims Administrator notifies the claimant or authorized representative (before the end of the first 30-day extension period) of the circumstances requiring the additional extension and the date by which the Claims Administrator expects to make its benefit determination. If the extension is necessary because of the failure of the claimant or authorized representative to submit information necessary to decide the claim, the notice of extension will specifically describe the required information. The claimant or authorized representative will have 45 days from receipt of the notice to provide the specified information.

Business Travel Accident, Life and AD&D Programs. In the case of a claim for business travel accident, life or AD&D benefits, the Claims Administrator will notify the claimant or claimant's authorized representative of the Claims Administrator's benefit determination not later than 90 days after receipt of the claim. This period may be extended one time only by the Claims Administrator for up to 90 days, provided that (i) the Claims Administrator determines that special circumstances require an extension of time for processing the claim, and (ii) written notice of the extension is furnished to the claimant or authorized representative before the end of the initial 90-day period. The notice of extension will indicate the special circumstances requiring the extension of time and the date by which the Claims Administrator expects to make its determination.

With respect to disability, business travel accident, life and AD&D claims, if the claim is denied (in whole or in part), the Claims Administrator will provide the claimant or authorized representative with written notification of the adverse benefit determination. The notification will set forth, in a manner calculated to be understood by the claimant or authorized representative (and for disability claims, in a culturally and linguistically appropriate manner:

- The specific reason or reasons for the adverse benefit determination;
- Reference to the specific Welfare Plan provisions on which the determination is based;
- A description of any additional material or information necessary for the claimant or authorized representative to perfect the claim, and an explanation of why such material or information is necessary;

- A description of the Claims Administrator's review procedures and the time limits applicable to such procedures (including a statement of the claimant's right to bring a civil action following an adverse benefit determination on review); and

With respect to disability claims, the notification will also set forth:

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views of health care professionals treating the claimant and vocational professionals who evaluated the claimant, presented by the claimant; (ii) the views of medical or vocational experts whose advice was obtained in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination regarding the claimant made by the Social Security Administration and presented by the claimant to the Claims Administrator.
- If the adverse benefit determination is based on medical necessity or experimental treatment, or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Welfare Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Welfare Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Welfare Plan do not exist; and
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all document, records, and other information relevant to the claimant's claim for benefits.

Appeal of Adverse Decision

If you disagree with the decision on your claims, you or your authorized representative may file a written appeal with the applicable Claims Administrator. For a list of Claims Administrators see the end of this SPD.

With respect to disability claims, you must submit an appeal, in writing, to the Claims Administrator within 180 days following receipt by the claimant or authorized representative of an adverse benefit determination.

With respect to business travel accident, life and AD&D claims, you must submit an appeal, in writing, to the Claims Administrator within 60 days following receipt by the claimant or authorized representative of an adverse benefit determination.

With respect to disability, business travel accident, life and AD&D claims, the claimant or authorized representative may submit written comments, documents, records, and/or other information relating to the claim for benefits, as part of the appeal. The Claims Administrator will provide the claimant or authorized representative, upon request and free of charge, with reasonable access to (and copies of) all documents, records, and other information relevant to the claim for benefits. The Claims Administrator's review of the

adverse benefit determination on a timely appeal will take into account all comments, documents, records, and other information submitted by the claimant or authorized representative relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination.

With respect to disability claims, the Claims Administrator's review will not give any deference to the initial adverse benefit determination, and will be conducted by an individual (i) who is not the individual who made the initial adverse benefit determination that is the subject of the appeal, and (ii) who is not the subordinate of such individual. The Claims Administrator will identify any medical or vocational expert whose advice was obtained in connection with the initial adverse benefit determination, without regard to whether the expert's advice was relied upon in making the earlier determination. In the Claims Administrator's review on appeal of an initial adverse benefit determination that is based (in whole or in part) on a medical judgment, the individual conducting the Claims Administrator's review will consult with a health care professional who has the appropriate training and experience in the field of medicine involved in the medical judgment, and (i) who is not the individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, and (ii) who is not the subordinate of any such individual.

Before issuing an adverse benefit determination the Claims Administrator has to provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan, insurer, or other person making the benefit determination in connection with the claim as soon as possible and sufficiently in advance of the date on which the adverse benefit determination is required to be provided, to give the claimant a reasonable opportunity to respond. Before issuing an adverse benefit determination on a new or additional rationale, the Claims Administrator also has to provide the claimant, free of charge, with the rationale, and sufficiently in advance of the date on which the adverse benefit determination is required to be provided to give the claimant a reasonable opportunity to respond.

Notification on Appeal

The Claims Administrator will notify the claimant or authorized representative of its decision on appeal in writing in accordance with the time frames and procedures described below.

With respect to disability claims, the Claims Administrator will notify the claimant or authorized representative of the Claims Administrator's benefit determination on review within 45 days after receipt of a timely appeal, unless the Claims Administrator determines that special circumstances require an extension of time for processing the appeal. If the Claims Administrator determines that an extension of time for processing the appeal is required, written notice of the extension will be sent to the claimant or authorized representative before the end of the initial 45-day period. In no event will the extension exceed a period of 45 days from the end of the initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Claims Administrator expects to make its benefit determination on review.

With respect to business travel accident, life and AD&D claims, the Claims Administrator will notify the claimant or authorized representative of the Claims Administrator's benefit determination on review within 60 days after receipt of a timely appeal, unless the Claims Administrator determines that special circumstances require an extension of time for processing the appeal. If the Claims Administrator determines that an extension of time for processing the appeal is required, written notice of the extension will be sent to the claimant or authorized representative before the end of the initial 60-day period. In no event will the extension exceed a period of 60 days from the end of the initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Claims Administrator expects to make its benefit determination on review.

With respect to disability, business travel accident, life and AD&D claims, the Claims Administrator's benefit determination on review will be provided in writing to the claimant or authorized representative. In the case of an adverse benefit determination on review, the notification will set forth, in a manner calculated to be understood by the claimant or authorized representative:

- The specific reason or reasons for the adverse benefit determination on review;
- Reference to the specific Welfare Plan provisions on which the determination is based;
- A statement that the claimant or authorized representative is entitled to receive, upon request and free of charge, reasonable access to (and copies of) all documents, records, and other information relevant to the claim for benefits;
- A statement describing any voluntary appeal procedures offered by the Welfare Plan, and a statement of the claimant's right to bring a civil action following an adverse benefit determination on review; and
- With respect to disability claims, if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination on review, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination on review and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant or authorized representative upon request.

With respect to disability claims, the notification will also set forth a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views of health care professionals treating the claimant and vocational professionals who evaluated the claimant, presented by the claimant to the Claims Administrator; (ii) the views of medical or vocational experts whose advice was obtained in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination regarding the claimant made by the Social Security Administration and presented by the claimant to the Claims Administrator.

Health Care Claims

The claims procedures described in this section are representative of the actual claims procedures followed by the Claims Administrators for the health benefit programs (medical, prescription drug, vision, dental, General Purpose Health FSA or Limited Purpose Health FSA, and EAP). The Affordable Care Act added additional requirements related to internal claims and appeals as well as an external review process, which apply to the medical benefits under the Welfare Plan. *This section does not describe all of the procedures applicable to claims under the medical benefits; see the Program Materials for more details*. This section describes the procedures that apply to dental, vision and General Purpose Health FSA or Limited Purpose Health FSA. Because the EAP provides services rather than reimbursement, there is no need to submit claims under the EAP. However, if you need to contact the EAP Administrator, see Section XIII. Although the Dependent Care FSA is not subject to ERISA or the ERISA required claims procedures, the third party administrator uses similar procedures for Dependent Care FSA claims as it does for General Purpose Health FSA or Limited Purpose Health FSA claims. Both claims under the General Purpose Health FSA or Limited Purpose Health FSA and Dependent Care FSA are subject to the post-service claims procedures.

Pre-Service and Post-Service Claims

A *pre-service claim* is any claim for a benefit that requires Claims Administrator approval in advance of obtaining medical care. A *post-service claim* is any claim for a benefit in which the medical care or treatment has already occurred.

In the case of a pre-service claim, the Claims Administrator will notify the claimant or claimant's authorized representative of the Claims Administrator's benefit determination not later than 15 days after the Claims Administrator's receipt of the claim. This period may be extended one time only by the Claims Administrator for up to 15 days, provided that (i) the Claims Administrator determines that the extension is necessary due to matters beyond the control of the Claims Administrator, and (ii) the Claims Administrator notifies the claimant or authorized representative, before the end of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to make its determination. If the extension is necessary because of the failure of the claimant or authorized representative to submit information necessary to decide the claim, the notice of extension will specifically describe the required information. The claimant or authorized representative will have 45 days from receipt of the notice to provide the specified information.

In the case of a post-service claim, the Claims Administrator will notify the claimant or claimant's authorized representative of the Claims Administrator's benefit determination not later than 30 days after the Claims Administrator's receipt of the claim. This period may be extended one time only by the Claims Administrator for up to 15 days, provided that (i) the Claims Administrator determines that the extension is necessary due to matters beyond the control of the Claims Administrator, and (ii) the Claims Administrator notifies the claimant or authorized representative, before the end of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to make its determination. If the extension is necessary because of

the failure of the claimant or authorized representative to submit information necessary to decide the claim, the notice of extension will specifically describe the required information. The claimant or authorized representative will have 45 days from receipt of the notice to provide the specified information.

If the pre-service or post-service claim is denied (in whole or in part), the Claims Administrator will provide the claimant or authorized representative with written notification of the adverse benefit determination. A *written notification of an adverse benefit determination* will set forth, in a manner calculated to be understood by the claimant or authorized representative:

- The specific reason or reasons for the adverse benefit determination;
- Reference to the specific Welfare Plan provisions on which the determination is based;
- A description of any additional material or information necessary for the claimant or authorized representative to perfect the claim, and an explanation of why such material or information is necessary;
- A description of the Welfare Plan's review procedures and the time limits applicable to such procedures;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant or authorized representative upon request; and
- If the adverse benefit determination is based on medical necessity or experimental treatment or a similar exclusion or limitation, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Welfare Plan to the claimant's medical circumstances) or a statement that such an explanation will be provided free of charge upon request.

The claimant or authorized representative may obtain a full and fair internal review by the Claims Administrator of the claim and adverse benefit determination by submitting an appeal to the Claims Administrator within 180 days following receipt by the claimant or authorized representative of an adverse benefit determination (whether the claim is a pre-service claim or post-service claim). The claimant or authorized representative may submit written comments, documents, records, and/or other information relating to the claim for benefits, as part of the appeal. The Claims Administrator will provide the claimant or authorized representative, upon request and free of charge, with reasonable access to (and copies of) all documents, records, and other information relevant to the claim for benefits.

The Claims Administrator's review of the adverse benefit determination on a timely appeal will take into account all comments, documents, records, and other information submitted by the claimant or authorized representative relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination. The

Claims Administrator's review will not give any deference to the initial adverse benefit determination, and will be conducted by an individual (i) who is not the individual who made the initial adverse benefit determination that is the subject of the appeal, and (ii) who is not the subordinate of such individual. The Claims Administrator will identify any medical or vocational expert whose advice was obtained in connection with the initial adverse benefit determination, without regard to whether the expert's advice was relied upon in making the earlier determination.

In the Claims Administrator's review on appeal of an initial adverse benefit determination that is based (in whole or in part) on a medical judgment (including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate), the individual conducting the Claims Administrator's review will consult with a health care professional who has the appropriate training and experience in the field of medicine involved in the medical judgment, and (i) who is not the individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, and (ii) who is not the subordinate of any such individual.

In the case of a pre-service claim, the Claims Administrator will notify the claimant or authorized representative of the Claims Administrator's final internal benefit determination within 30 days after receipt of a timely appeal. In the case of a post-service claim, the Claims Administrator will notify the claimant or authorized representative of the Claims Administrator's final internal benefit determination within 60 days (30 and another 30 days if there are two levels of appeal) after receipt of a timely appeal. The Claims Administrator's final internal benefit determination (for pre-service or post-service claims) will be provided in writing to the claimant or authorized representative. In the case of a *final internal adverse benefit determination*, the notification will set forth, in a manner calculated to be understood by the claimant or authorized representative:

- The specific reason or reasons for the final internal adverse benefit determination;
- Reference to the specific Welfare Plan provisions on which the determination is based;
- A statement that the claimant or authorized representative is entitled to receive, upon request and free of charge, reasonable access to (and copies of) all documents, records, and other information relevant to the claim for benefits;
- A statement describing the external appeal procedures offered by the Welfare Plan;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the final internal adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the final internal adverse benefit determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant or authorized representative upon request; and
- If the final internal adverse benefit determination is based on medical necessity or experimental treatment or a similar exclusion or limitation, either an explanation of the

scientific or clinical judgment for the determination (applying the terms of the Welfare Plan to the claimant's medical circumstances) or a statement that such an explanation will be provided free of charge upon request.

Concurrent Claims

A *concurrent care claim* relates to the Claims Administrator's previous approval for an ongoing course of treatment to be provided over a period of time or number of treatments. The claims procedures for concurrent care claims are identical to the claims procedures set forth above for urgent care claims, pre-service claims, or post-service claims (whichever is appropriate in the circumstances), except as follows:

In the case of a concurrent care claim involving a reduction or termination by the Claims Administrator of a previously approved ongoing course of treatment (other than by amendment or termination of the Welfare Plan) before the end of the previously approved period of time or number of treatments, the reduction or termination will constitute an adverse benefit determination. The Claims Administrator will notify the claimant or claimant's authorized representative of this determination at a time sufficiently in advance of the reduction or termination to allow the claimant or authorized representative to file an appeal and obtain a review by the Claims Administrator of the adverse benefit determination before the benefit is reduced or terminated.

In the case of a concurrent care claim involving a request by a claimant or authorized representative to extend a previously approved ongoing course of treatment beyond the approved period of time or number of treatments, and that involves urgent care, the Claims Administrator will notify the claimant or authorized representative of the benefit determination within 24 hours after the Claims Administrator's receipt of the claim, provided that the claim is made to the Claims Administrator at least 24 hours before the end of the previously approved period of time or number of treatments.

Urgent Care Claims

An *urgent care claim* is an oral or written request for medical care or treatment where a delay in the Claims Administrator's benefit determination could seriously jeopardize the claimant's life or health, or the claimant's ability to regain maximum function, or (in the opinion of a physician with knowledge of the claimant's medical condition) would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Whether a claim is an urgent care claim will be determined by an individual acting on behalf of the Welfare Plan, applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine. However, if a physician with knowledge of the claimant's medical condition determines that the claim is an urgent care claim as described above, then it will be treated as an urgent care claim.

In the case of an urgent care claim, the Claims Administrator will notify the claimant or claimant's authorized representative of the Claims Administrator's benefit determination not later than 72 hours after the Claims Administrator's receipt of the claim, unless the claimant or authorized representative fails to provide sufficient information to determine

whether (or to what extent) benefits are covered or payable under the Welfare Plan. In the case of such a failure, the Claims Administrator will notify the claimant or authorized representative not later than 24 hours after the Claims Administrator's receipt of the claim, regarding the specific information necessary to complete the claim. The claimant or authorized representative will have 48 hours to provide the specified information. The Claims Administrator will notify the claimant or authorized representative of the Claims Administrator's benefit determination not later than 48 hours after the earlier of (i) the Claims Administrator's receipt of the specified information, or (ii) the end of the period given to the claimant or authorized representative to provide the specified additional information.

The Claims Administrator will provide the initial benefit determination to the claimant or authorized representative in writing or orally. If the determination is provided orally, written notification will be sent no later than 3 days after the oral notification. Written notice of an initial benefit determination will include a description of the expedited review procedure applicable to urgent care claims (including the fact that all necessary information will be transmitted between the Claims Administrator and the claimant or authorized representative by telephone, facsimile, or other similarly expeditious method that is available).

The claimant or authorized representative may obtain a full and fair review by the Claims Administrator of the claim and adverse benefit determination by submitting an appeal (either orally or in writing) to the Claims Administrator on an expedited basis following receipt by the claimant or authorized representative of an adverse benefit determination. The claimant or authorized representative may submit written comments, documents, records, and/or other information relating to the claim for benefits, as part of the appeal. The Claims Administrator will provide the claimant or authorized representative, upon request and free of charge, with reasonable access to (and copies of) all documents, records, and other information relevant to the claim for benefits.

The Claims Administrator's review of the adverse benefit determination on a timely appeal will take into account all comments, documents, records, and other information submitted by the claimant or authorized representative relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination. The Claims Administrator's review will not give any deference to the initial adverse benefit determination, and will be conducted by an individual (i) who is not the individual who made the initial adverse benefit determination that is the subject of the appeal, and (ii) who is not the subordinate of such individual. The Claims Administrator will identify any medical or vocational expert whose advice was obtained in connection with the initial adverse benefit determination, without regard to whether the expert's advice was relied upon in making the earlier determination.

In the Claims Administrator's review on appeal of an initial adverse benefit determination that is based (in whole or in part) on a medical judgment (including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate), the individual conducting the Claims Administrator's review will consult with a health care professional who has the

appropriate training and experience in the field of medicine involved in the medical judgment, and (i) who is not the individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, and (ii) who is not the subordinate of any such individual.

The Claims Administrator will notify the claimant or authorized representative of the Claims Administrator's final internal benefit determination within 72 hours after receipt of a timely appeal. The Claims Administrator's final internal benefit determination will be provided in writing to the claimant or authorized representative.

External Review Program for Medical Benefits. If, after exhausting your internal appeals (or as otherwise specifically noted below for expedited external reviews) you are not satisfied with the Claims Administrator's determination of your claim for medical benefits, you may be entitled to request an external review of the Claims Administrator's determination at no charge. You may request the external review by an independent review organization (IRO) based on (i) medical judgment (including, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or exclusions for treatments that are experimental or investigational); (ii) rescission of coverage (coverage that was cancelled or discontinued retroactively); or (iii) as otherwise required by applicable law.

To request a *standard external review*, you or your representative should send a written request to the address set out in the adverse benefit determination letter. In urgent situations as detailed below, you or your representative should request an expedited external review at the number provided by the Claims Administrator or by sending a written request to the address set out in the adverse benefit determination letter. A request must be made within four months after the date you receive the Claims Administrator's final adverse decision on your internal claim/appeal. An external review request should include all of the following:

- a specific request for external review;
- your name, address, and insurance ID number;
- your designated representative's name and address, when applicable;
- the service that was denied; and
- any new, relevant information that was not provided during the internal appeal.

Within five business days after receipt of the request, the Claims Administrator will complete a preliminary review to determine whether the individual for whom the request was submitted was covered under the Welfare Plan at the time the health care service or procedure that is at issue in the request was provided, has exhausted the applicable internal appeals process, and has provided all the information and forms required so that the Claims Administrator may process the request. The Claims Administrator will notify you within one day of completing your preliminary review whether the request is eligible for external review by an IRO.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You should submit in writing any additional information that the IRO will consider

when conducting the external review within ten business days following the date of receipt of the notice. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days. The Claims Administrator will provide to the assigned IRO all medical records, other documents, and other information or evidence that you or your physician submitted that the Claims Administrator considered in making its determination.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by the Claims Administrator. The IRO will provide written notice of its Final External Review Decision within 45 days after it receives the request for external review (unless the IRO requests additional time and you agree). This notice will be delivered to you and the Claims Administrator and include the clinical basis for the determination. If the decision reverses the Claims Administrator's determination, the Welfare Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Welfare Plan.

An *expedited external review* is similar to a standard external review, except the time periods for completing certain portions of the review process are much shorter, and in some instances you have the right to file an expedited external review before completing the internal appeals process. You have the right to make a written or verbal request for an expedited external review if you receive: (1) an adverse benefit determination for a claim or appeal involving a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize your life or health or the ability to regain maximum function and you have filed a request for an expedited internal appeal; or (2) a final appeal decision for a determination involving a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which you received emergency services, but you have not been discharged from a facility.

The Claims Administrator will determine immediately upon receipt of the request whether you were covered under the Welfare Plan at the time of the services or procedure at issue and provided all required information and forms. The Claims Administrator will immediately send a notice in writing to you upon completion of this review and follow the same procedures as with a standard external review. The IRO will provide notice of the final external review decision for an expedited external review, as expeditiously as required, but in no event more than 72 hours after receiving the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide confirmation of the decision to you and the Claims Administrator.

Discretionary Authority

The Plan Administrator and Claims Administrator (with respect to the benefit program they insure and/or administer) have full discretionary authority to determine eligibility, status, and rights of all individuals under the Plans and to construe any and all terms of the Plans.

No Transfer of Benefits or Rights

None of the benefits, payments, proceeds, claims or any other rights afforded to you, a covered spouse or dependent or beneficiary under the Plans shall be subject to any claim or any creditor. In addition, you, your covered spouse or dependent, or beneficiary may not assign, alienate, anticipate, commute, pledge or encumber any benefits, payments, proceeds, claims or other rights which any of you may be entitled to receive or assert under the Plans, other than with the express written consent of the Plan Administrator (or third party administrator responsible for claims adjudication of a benefit program) or as expressly required by law. Payment of benefits to a third party does not in any way constitute an assignment.

Legal Action

Because the Welfare Plan is governed by ERISA, you have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the final appeal. However, you generally must first exhaust the claims and appeals procedures. In addition, you must bring a civil action within two years or a shorter period set forth in the Program Materials.

XI. YOUR ERISA RIGHTS

As a participant in the Welfare Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Welfare 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 Welfare Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Welfare 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 Welfare 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 Welfare Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You may be entitled to continue health care coverage for yourself, your spouse or your dependents if there is a loss of coverage under a group health care component as a result of a qualifying event.

You or your dependents may have to pay for such coverage. You should review this SPD and the Program Materials for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Welfare Plan documents or the latest annual report from the Welfare 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 after you have exhausted the Welfare Plan's claims and appeals procedures. In addition, if you disagree with the Welfare Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Welfare Plan fiduciaries misuse the Welfare 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 Welfare Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

XII. GENERAL PLAN INFORMATION

Plan Sponsor:	VMware, Inc. 3401 Hillview Avenue Palo Alto, CA 94304 (650) 427-5000
Employer Identification Number:	94-3292913
Name of Plan:	VMware Group Health and Welfare Plan
Plan Number:	503
Plan Year:	January 1 through December 31
Type of Plan:	Health and welfare benefits
Source of Contributions:	Employer and employee contributions
Funding Medium:	Self-insurance and insurance
Type of Administration:	Fully insured benefits are administered by insurance companies which are responsible for all claims and discretionary determinations, and for making payments under the portions of the Welfare Plan which they insure. The self-insured benefits are administered by third party administrators. The table at the end provides contact information for each third party administrator and insurance company.
Plan Administrator:	Health & Welfare Plan Committee c/o VMware Benefits Department 3401 Hillview Avenue Palo Alto, CA 94304 (650) 427-5000
Agent for Service of Process:	VMware, Inc. Attention: legal department 3401 Hillview Avenue Palo Alto, CA 94304 (650) 427-5000 Legal process also may be served on the Plan Administrator.

XIII. BENEFITS, THIRD PARTY ADMINISTRATORS AND INSURERS

Type of Benefit:

The Third Party Administrator and Insurance Companies are responsible for making all discretionary determinations and for making payments under the portions of the Plans which they administer or insure.

Medical and Prescription Drug (including Expert Opinions)

United Healthcare
PO Box 30555
Salt Lake City, UT 84130-0555
844-562-6290
www.myuhc.com
Group # 915259

CVS Caremark
PO Box 52136
Phoenix, AZ 85072-2136
844-257-4616
www.caremark.com
Group # RX2769

Kaiser Northern California HMO
PO Box 23448
San Diego, CA 92193
1-800-464-4000
www.kaiserpermanente.org
Group # 39501-0000

Kaiser Hawaii HMO
Kaiser Foundation Health Plan, Inc.
PO Box 378021
Denver, CO 80237
1-800-432-5955
www.kp.org
Group # 09549-001-10

Grand Rounds
360 3rd Street, Ste. #425
San Francisco, CA 94107
1-800-929-0926
www.grandrounds.com

Dental	Delta Dental PPO PO Box 997330 Sacramento, CA 95899-7330 1-800-765-6003 www.deltadentalins.com Group # 00422
Vision	Vision Service Plan PO Box 997105 Sacramento, CA 95899-7105 1-800-877-7195 www.vsp.com Group # 12122074
Life (including Supplemental Life) and Accidental Death and Dismemberment	CIGNA PO Box 15050 Wilmington, DE 19850 www.cigna.com Group Basic Life # FLX 962455 AD&D # OK 964094 1-800-362-4462 Supp # FLX 962456 1-800-362-4462
Business Travel	Gerber Life 1311 Mamaroneck Avenue White Plains, NY 10605 1-800-704-2180 Group # BTA-119785
Long Term Disability	CIGNA OR Life Insurance Co. of N. America One Front Street, 7th Floor San Francisco, CA 94111 **OR** PO Box 15050 Wilmington, DE 19850 1-800-362-4462 www.cigna.com Group # LK 961804
Short Term Disability	Sedgwick PO Box 171816 1-866-251-1749

Employee Assistance Program	Lyra Health 287 Lorton Ave Burlingame, CA 94010 844-377-7481 vmware.lyrahealth.com
Group Legal	ARAG Insurance Company 400 Locust Street, Suite 480 Des Moines, IA 50309 1-800-247-4184 ARAGLegalCenter.com Group # 16121
International Health Plan	Geoblue OR 4 Ever Life Insurance Company administered by Worldwide Insurance Services, LLC 933 First Avenue King of Prussia, PA 19406 1-855-682-7965 Policy # 4EL-8165-16
Health FSAs **General Purpose Health FSA & Limited Purpose Health FSA**	TRI-AD 221 West Crest Street Escondido, CA 92025 1-888-844-1372 www.tri-ad.com
Dependent Care FSA (not subject to ERISA)	TRI-AD 221 West Crest Street Escondido, CA 92025 1-888-844-1372 www.tri-ad.com
Health Savings Account (not subject to ERISA)	Health Equity 15 West Scenic Pointe Drive Draper, Utah 84020 1-866-296-2857 www.healthequity.com/ed/vmware Policy #29020
COBRA Administrator	Accrue CMS PO Box 53525 Bellevue, WA 98015 1-866-517-7580

Voluntary Hospitalization, Critical Illness & Accident	Voya Financial 20 Washington Ave South Minneapolis, MN 55401 877-236-7564 https://presents.voya.com/EBRC/VMwareInc Group# 708348