Prescription Drug Program Summary Plan Description Supplement for the Hitachi Health and Welfare Plan

For Hitachi Vantara Employees

January 1, 2021

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Introduction

About This Document

Some terms are defined within the text. Others, initial capitalized throughout, are defined in the **Terms to Know** section at the end of this SPD Supplement. It is important that you familiarize yourself with these terms as they help describe the benefits that are available to you.

Hitachi America, Ltd ("Hitachi" or the "company") offers coverage to eligible employees and their Dependents under the outpatient Prescription Drug Program ("Program") through the Hitachi America, Ltd. Health and Welfare Plan ("Plan"). Benefits are only available under the Program to individuals enrolled in a major medical plan (the "Medical Plan") offered under the Plan.

This document is the Prescription Drug Program Summary Plan Description ("SPD") Supplement, which describes the prescription drug coverage available under the Plan effective January 1, 2021. Together with the Medical SPD (sometimes called the Medical Benefit Booklet) it is intended to comply with U.S. Department of Labor requirements. Keep this information with your important papers for future reference.

The Plan, including the Prescription Drug Program described in this SPD Supplement, is intended to conform to all applicable legal requirements including, but not limited to, the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and the Internal Revenue Code of 1986, as amended (the "Code"), and all regulations issued thereunder.

Important Notice

The company reserves the right, by action of its Board of Directors or its delegate pursuant to its normal administrative procedures, to amend, modify, or terminate the Plan or any part of the Plan or Program, or the amount of required Participant contributions, at any time and for any reason, retroactively or otherwise. No amendment will reduce any benefit payable for claims that are incurred before the date of any amendment.

The terms of the Plan or Program document(s) can only be modified by a written amendment adopted in accordance with the Plan's or Program's amendment procedures. The Plan or Program cannot be modified by written or verbal statements of representatives of the company, a Claims Administrator, or the Plan Administrator. In the event of an inconsistency between any such statement and the terms of the Plan or Program document, the Plan or Program document will control.

No provision of this SPD Supplement, the Medical Benefit Booklet, the Plan or Program document(s), or any document incorporated by reference is intended to vest any Employee, former Employee, or Dependent to any such class in any benefit under the Plan or Program unless specifically required under applicable law.

This SPD Supplement describes the Program and also constitutes part of the Medical Plan document. In the event of a conflict between this SPD Supplement and the Plan or Program document(s), the applicable Plan or Program document(s) will govern.

If you have questions concerning the benefits outlined in this SPD Supplement, contact CVS Caremark, Inc. (“CVS Caremark”), who administers the Prescription Drug Program at 1-855-311-3078. The CVS Caremark member service team is available 24 hours a day, seven days a week. (Telephonic emergency pharmacist services are also available 24 hours a day, seven days a week.) Information is also available on CVS Caremark’ web site at www.Caremark.com.

In addition to the above documents, as part of the Affordable Care Act, the company also provides you with concise statements of your Medical Plan options (including prescription drug coverage information) in Summaries of Benefits and Coverage (“SBCs”). The SBCs are provided to you during annual enrollment each year and also are available at www.benefitsolver.com. You can use these documents to compare the company’s coverage to other employer coverage that you may have access to as you make your enrollment decisions for the coming year. You may request copies of the SBCs, at no cost to you, by calling 1-844-318-3274.

Medicare Part D

If you are a participant in a company-sponsored Medical Plan option, you have prescription drug coverage. For most individuals, the company expenses that the coverage provided through the Program is, on average, at least as good as the Medicare prescription drug coverage available through Medicare Part D. Therefore, if you are eligible for Medicare Part D, it is likely to be to your advantage to remain in the Medical Plan and receive prescription drug benefits as you always have.

A “Creditable Prescription Drug Coverage Notice” will be distributed to all Medicare-eligible participants in Hitachi’s Medical Plan each year. The purpose of the notice is to inform you about whether or not coverage under the Hitachi Prescription Drug Program is, on average, at least as good as the Medicare prescription drug coverage. To request a copy, contact Hitachi America, Ltd. – Hitachi Benefit Pool (HBP), 50 Prospect Avenue, Tarrytown, NY 10591, or (914) 332-5800.

Retroactive Termination of Coverage

The Plan may rescind (i.e., cancel or discontinue on a retroactive basis) coverage if you or your dependents perform an act, practice, or omission that constitutes fraud or makes an intentional misrepresentation of material fact, as determined at the discretion of the Plan Administrator. This would include, for example you’re intentionally enrolling an individual whom you know is not an eligible dependent. If the Plan Administrator believes a rescission of coverage is appropriate, you will receive a notice of rescission of coverage at least 30 days before coverage is rescinded. You will also be provided the opportunity to appeal the Plan Administrator’s action under the Plan’s claims and appeals procedures. If a rescission of coverage occurs, no COBRA coverage will be available.

Coverage may be retroactively terminated due to administrative delays in processing or due to a failure to timely pay required premiums or contributions toward the cost of coverage. Except where required by law, coverage may be terminated for these reasons without advance notice. Any such retroactive cancellation is not considered a rescission.

Contact Information

The following provides contact information for answers to your Prescription Drug Program questions.

Contact	With Questions About…	Contact Information…
CVS Caremark	Prescription Drug Coverage	**Member Services** 1-855-311-3078 www.caremark.com **Mobile App Go to** cvs.com/mobile-cvs/apps or call 1-800-ShopCVS **Mail Service thru Mail Order Pharmacy or Mail Service** 1-855-311-3078 To order online, sign in at www.Caremark.com and follow the prompts. **CVS Specialty Pharmacy** 1-800-237-2767 CVSspecialty.com

Eligibility

Employees and dependents who are eligible for medical coverage under the Medical Plan are eligible for the prescription drug coverage described in this SPD Supplement and only employees and dependents who are enrolled in that medical coverage may receive prescription drug benefits. For a description of the eligibility terms for the Medical Plan, see the applicable Medical Benefits Booklet.

Enrollment

Each year during annual enrollment, you have the opportunity to review and change your Medical Plan election. (The Program is included in each Medical Plan option, but benefits are paid differently.) Any changes you make during annual enrollment will become effective the following January 1.

You may also be required to provide certain Eligibility Verification Documentation when enrolling a Dependent. Please contact Benefitsolver at 1-844-318-3274 if you have questions about eligibility or the process to submit supporting documentation that your Dependent(s) meet the definition of eligibility for Hitachi Medical Plan coverage.

You must enroll in a Medical Plan option to have coverage under the Prescription Drug program. See your Medical Benefit Booklet and/or other enrollment materials for more information about enrollment provisions, such as:

- How to enroll;
- Late enrollees;
- Special enrollment periods;
- Changing coverage;
- Qualified Medical Child Support Orders (QMCSO);
- Coverage during a Family and Medical Leave (FMLA);
- When coverage begins;
- Paying for coverage; and
- Continuing coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Prescription Drug Program at a Glance

As part of your Medical Plan option election, outpatient prescription drug coverage through CVS Caremark automatically is included for medications that are approved by the U.S. Food and Drug Administration ("FDA") and prescribed by a Physician. (Inpatient prescription drugs are covered under the medical portion of the Medical Plan.) The following chart provides a high-level summary of your prescription drug coverage under each Medical Plan option. For additional information, contact CVS Caremark.

Silver HDHP and Bronze HDHP Options

	Silver HDHP[1]	Bronze HDHP
Annual Prescription Drug Deductible	Included in the Silver HDHP Medical Plan option's annual medical Deductible	Included in the Bronze HDHP Medical Plan option's annual medical Deductible
Annual Prescription Drug Out-of-Pocket Maximum	Included in the Medical Plan option's out-of-pocket maximum	Included in the Medical Plan option's out-of- pocket maximum
Generic Drugs	You pay 20% Coinsurance	You pay 20% Coinsurance
Preferred Brand-Name Drugs	You pay 20% Coinsurance	You pay 20% Coinsurance
Non-Preferred Brand-Name Drugs	You pay 20% Coinsurance	You pay 20% Coinsurance
Specialty Drugs (pills or injectables)	You pay 20% Coinsurance	You pay 20% Coinsurance
Diabetes and Asthma Drugs and Supplies	Covered at applicable generic or brand-name drug copay	Covered at applicable generic or brand-name drug copay
Tobacco Cessation Products (prescription and over-the-counter products)[2]	You pay $0	You pay $0
Certain Preventive Medications	You pay $0	You pay $0

Please note: if a brand-name drug is received when a generic is available, you will pay the difference in cost between the two. Also, certain drugs require pre-authorization. If pre-authorization is not obtained, the drug will not be covered

[1] "HDHP" stands for High Deductible Health Plan.
[2] Must have a prescription from your Physician.

How the Prescription Drug Program Works

In addition to your medical coverage, the Plan offers outpatient prescription drug coverage through the Prescription Drug Program. CVS Caremark administers this Program, which consists of two parts, a:

- Retail pharmacy network for short-term medications; and
- Mail OrderMail Service pharmacy for long-term maintenance medications.

Prescription Drug ID Card

Employees who elect to participate in a Hitachi Medical Plan option administered by Anthem BCBS, are enrolled in the Prescription Drug Coverage program. You will receive a Health Plan ID card from Anthem BCBS that will be used for medical benefit services. You will receive a separate CVS Caremark ID card for pharmacy benefit services.

Formulary Drugs

Frequently, several drugs work equally well for a specific medical condition. CVS Caremark uses medical literature to verify that the drugs CVS Caremark chooses for its formulary are clinically effective and safe. Through the use of a formulary, companies like CVS Caremark can maximize treatment quality while managing prescription drug costs.

You can ask your Physician which drugs work for your medical condition. Then, check to see which ones are on the formulary. Your Coinsurance for drugs on the formulary is considerably less than your Coinsurance for drugs not on the formulary. Because the formulary may change throughout the year, you may request a current and up-to-date listing directly from CVS Caremark, or go to CVS Caremark' web site at **www.Caremark.com**.

If your medication no longer appears on the formulary, your Physician can review the formulary to find an alternative (or even a generic). If a generic or preferred brand-name drug on the formulary is not an alternative for you, you will pay the higher non-preferred brand-name cost.

Process for Adding a Drug to the Formulary

Once a drug is approved by the FDA, the clinicians of the CVS Caremark Drug Evaluation Unit evaluate it. The clinicians apply a three-step process when deciding whether or not to add a drug to the CVS Caremark formulary. The process involves the work of the following committees:

- Therapeutic Assessment Committee: This committee determines the clinical appropriateness and develops the criteria and guidelines for the drug's use.
- Value Assessment Committee: This committee adds cost and contracting considerations to the recommendations of the Therapeutic Assessment Committee.
- National Pharmacy and Therapeutics Committee: This is an independent committee that makes the final decision of whether or not to include a new drug on the CVS Caremark formulary.

Prior Authorization Process

How to Obtain Prior Authorization

When your pharmacist tries to fill your prescription and the computer system indicates “prior authorization required,” more information is needed to determine if the Program covers the drug.

Ask your Physician to either contact the CVS Caremark Coverage Review Department or to prescribe another medication that’s covered by the Program. (The preferred method to request prior authorization is electronically, but your Physician may contact the CVS Caremark Coverage Review Department **at** 1 800-294-5979.) Only your doctor can give CVS Caremark the information needed to see if your drug can be covered. CVS Caremark’s prior authorization phone lines are open 24 hours a day, seven days a week, so a determination can be made right away. If the information provided meets the Program's requirements, you pay your coinsurance at the pharmacy.

Appealing Authorization Decisions

If your authorization for benefits is denied, you can appeal the decision by writing to:

Caremark, Inc
Appeals Department MC 109
PO Box 52084
Phoenix, AZ 85072-2084

Also see the **Claims and Appeals Procedures** section.

Network Pharmacies

CVS Caremark has contracted with a network of pharmacies to help control the costs of prescriptions——for both you and Hitachi. While the directory of network pharmacies may change from time to time, CVS Caremark continues to select pharmacies based on their range of services, geographic location, and cost-effectiveness. Use your prescription ID card at participating retail pharmacies near you. CVS Caremark will list the names of three pharmacies closest to your zip code or you can log on to www.CVS.com to view the pharmacy listing. You also can check with your pharmacist before you fill your prescription to make sure that the pharmacy is still participating in CVS Caremark’ network.

The Retail Pharmacy Network

Coverage for short-term prescriptions is available through the retail pharmacy network. The amount you pay depends on whether you receive:

- In-network or out-of-network services[3]; and
- Generic, preferred brand-name, or non-preferred brand-name drugs.

[3] Out-of-network prescription drugs are covered at the same benefit level as in-network prescription drugs; however, your share of the cost of out-of-network prescription drugs may be higher as out-of-network pharmacies are not under contract with CVS Caremark.

See the **Prescription Drug Program at a Glance** section details regarding your Coinsurance (your share of costs) under each Medical Plan option.

Please note: If there is a generic (chemical) equivalent for your prescription, it will automatically be dispensed unless your Physician writes your prescription as "dispense as written" (DAW). If you prefer the brand-name drug, you will pay the difference in cost.

How to Use Participating Pharmacies

To fill a prescription through the retail pharmacy network:

- Go to a network pharmacy.
- Present your prescription and your prescription ID card to the pharmacist.
- Make sure that your pharmacist has complete and correct information about you and your covered dependents.
- Sign for and receive your prescription. You can receive up to a 30-day supply of prescribed medication.

In most cases, your cost is lower if you have your prescription filled with a generic drug. You might ask your Physician (or pharmacist) if your prescription may be filled with a generic instead of a brand-name drug.

Participants enrolled in the Silver or Bronze High Deductible Health Plan ("HDHP") Medical Plan option, must pay the full cost for prescription(s) until you meet your medical Deductible. Eligible prescription drug expenses apply to the Medical Plan options annual out-of-pocket maximum combined.

As long as you go to a network pharmacy, you do not have to file a claim for the Program to pay benefits. If you go outside of the network, you pay 100% of the cost at the time of your purchase. You then must submit a claim form to be reimbursed according to Program provisions.

Refills

From time to time you may need to have your prescription refilled. If your Physician authorizes a prescription refill, bring the prescription bottle or package to the network pharmacy. You may also use the pharmacy's automated refill system (if available).

Under the retail pharmacy network, the Program limits refills to a 30-day supply. In addition, the Program does not allow you to refill your prescription until a 10-day supply of your prescription remains (based on the quantity and day supply prescribed by your Physician).

The Mail Service Mail Order Pharmacy

For long-term maintenance medications, you may use the Mail Service pharmacy. With this service, you can receive up to a 90-day supply of your medicine delivered to your home through the mail with free standard shipping. You also have the option of automatic refills.

Your share of cost depends on whether you receive a generic, preferred brand-name, or non-preferred brand-name drug. See the **Prescription Drug Program at a Glance** section for details.

Please note: If there is a generic equivalent for your prescription, it will automatically be dispensed unless your Physician writes your prescription as "dispense as written" (DAW). If you prefer the brand-name drug, you will pay the difference in cost.

Hitachi has selected Mail Service as the preferred way to fill maintenance medications. Each year, you must notify CVS Caremark of your preference for retail versus Mail Service of maintenance medications for you and your family members. There is no penalty to select retail; however, **if you do not notify CVS Caremark of your preference**, you will pay the full cost of those medications at retail beginning with the third fill.

How to Use the Mail Service Pharmacy

To fill a prescription through Mail Service :

- Complete an order form and mail it, along with your original prescription, in the envelope provided. You can request an order form by calling CVS Caremark or you can go online to **www.Caremark.com** . A new order form and envelope are also sent to you with each delivery.
- Have your Physician write a new original prescription so that you can submit it directly to the Mail Service pharmacy. If you need medication immediately, ask your Physician for two prescriptions:
  - One for an immediate supply (you can then take this to your local retail network pharmacy); and
  - A second one for the extended supply (you can then submit this one to the Mail Service pharmacy). Be sure to tell your Physician that you are eligible for a 90-day supply, with three refills, which equals a one-year supply of medication.
- You can pay by credit card, or you can contact CVS Caremark to find out the exact cost of your prescription and submit a check. Do not submit cash with your order. See the **Prescription Drug Program at a Glance** section for your share of prescription drug costs.
- Participants enrolled in the Silver or Bronze High Deductible Health Plan ("HDHP") Medical Plan option, must pay the full cost for prescription(s) until you meet your medical Deductible. Eligible prescription drug expenses apply to the Medical Plan options annual out-of-pocket maximum combined.
- Mail your completed order form and payment to:

CVS Caremark Mail Service
PO Box 94467
Palatine, IL 60094-4467

You will receive your Mail Service prescription at your home approximately 10 to 14 business days from the date Mail Service receives your order.

Refills

Because CVS Caremark will have your initial prescription on file, you can refill your long-term maintenance medication using one of two options:

- Call CVS Caremark to request the refill; or
- Log onto the CVS Caremark web site to request a refill.

Under the Mail Service pharmacy, the Prescription Drug Program limits refills to a 90-day supply. If a prescription is rejected for refill too soon, CVS Caremark will hold the request on file if the refill is due within 30 days. If the request cannot be filled within 30 days, CVS Caremark will cancel the order, and

you will need to request a refill within the filling time limit. If you are refilling using the web site, you will get a message right away stating that you cannot fill the medication yet. The web site will tell you the day you can order a refill. If you are requesting a refill by phone, you will also be told if the request for a refill can be filled, if not now, by what date.

When the number of refills on the prescription has been exhausted, you will need to provide a new prescription from your Physician. The 30-day rule for filling the new prescription for the same long-term maintenance medication will apply. If the new prescription for the same medication can be filled within 30 days, CVS Caremark will hold onto the prescription. If the new prescription cannot be filled within 30 days, the prescription will be returned to you along with a letter explaining why it is being returned. You will need to resubmit the prescription within the filling time limit.

Prescription Drugs and Supplies

Preventive Medications

Certain preventive drugs purchased in-network are covered at 100% without your having to pay any copays or Coinsurance. If you are enrolled in the Silver or Bronze HDHP Medical Plan option, you do not have to satisfy the Medical Plan annual Deductible first.

The following are some examples of these preventive drugs. A complete list can be found at https://www.healthcare.gov/preventive-care-benefits or **www.Caremark.com** or by calling CVS Caremark Member Services at 1-855-311-3078.

- Barrier contraception devices for women such as Femcap and the Today Contraceptive Sponge;
- Generic hormonal contraceptives for women;
- Emergency contraceptive medications for women;
- Risk-reducing medications, such as tamoxifen or raloxifene, for women with an increased risk for breast cancer and at low risk for adverse medication effects;
- Aspirin and various forms of aspirin for men ages 45 through 79 and women ages 55 through 79 (must have a prescription);
- Certain folic acid supplements for pregnant women;
- Certain smoking cessation products; and
- Certain pediatric multivitamins for children ages six months through six years.

Specialty Pharmacy

All prescriptions for specialty medications must go through CVS Specialty Pharmacy—the specialty pharmacy for CVS Caremark offers many products and services that you won't get from other pharmacies, such as:

- Providing a Patient Care Coordinator who serves as your personal advocate and your point of contact. This highly trained individual works closely with your Physician and the Program to obtain prior authorizations, coordinate billing, and will even contact you when it's time to refill your prescription.
- Offering a complete specialty pharmacy inventory with many specialty medications that are not readily available at a local pharmacy.
- Delivering your specialty medications directly to you or your Physician.
- Providing you with the necessary supplies you need to administer your medications—at no additional cost.
- Offering clinically based care management programs which include consultations with your Physician to help you get the most benefit from the specialty medication that the Physician has prescribed for you.

Step Therapy

"Step therapy" is designed to help you get the best results and save money.

Certain conditions and specialty medications fall under the Step Therapy program. If your Physician prescribes medication to treat a health condition such as Multiple Sclerosis, or Rheumatoid Arthritis, you will be required to try a lower-cost (but equally safe and effective) drug first—before the Program will pay benefits for a higher-cost, brand-name drug.

Quantity Limits for Certain Prescription Drugs

To ensure the proper use of certain prescription drugs, quantity limits are placed on a few generic and brand-name drugs as a result of manufacturing or FDA guidelines. This means that quantity limits are placed on specific medications, unless your Physician or health care provider contacts CVS Caremark to authorize continued use based on medical necessity.

Listed below are some of the following classes of drugs affected by these limits:

- Compound medications;
- Migraine drugs;
- Proton Pump Inhibitors (PPI), used in the treatment of acid reflux disease; and
- Impotence drugs.

If you purchase a drug that falls into one of the classes above, CVS Caremark will notify you of the limits that apply. These limits only affect the amount of the drug that the Prescription Drug Program will pay for, not whether you can obtain greater quantities.

If you exceed a drug's limit and your Physician has determined that continued use of the drug is medically necessary, he or she may call CVS Caremark at 1-855-311-3078 to request prior authorization of a higher limit.

Medications Not Covered

The Program does not pay benefits for all types of prescription drug medications and medical devices, including the following:

- Appetite suppressants;
- Legend homeopathic medications;
- Durable and disposable medical supplies;
- Medications used for experimental purposes and/or dosage regimens determined to be experimental;
- Medications not approved by the FDA;

and

Certain drugs that have limited clinical value and which have clinically appropriate, lower-cost alternatives (e.g., brand name or generic drugs that are combinations of existing generic or over-the-counter drugs, new formulations of existing drugs).

Please note: Contact CVS Caremark to find out if a prescribed medication is covered.

When Coverage Ends / Continuation Coverage

Your entitlement to Program benefits automatically ends on the same date that Medical Plan coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, Hitachi will still pay claims for covered prescription drug expenses that you incurred before your coverage ended. However, benefits are not paid for prescription drugs that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended.

For a description of when your coverage ends, and applicable opportunities to continue coverage, consult the applicable Medical Benefit Booklet.

Administrative Information

This section contains important information about how your prescription drug benefits are administered and steps you can take if certain situations arise. For information about how your benefits are funded, your rights and responsibilities as a participant, and other conditions and limitations applicable to your prescription drug benefits, please consult the Medical Benefit Booklet.

Claims and Appeals Procedures

This section provides a high-level explanation of the claims and appeals procedures. For claims and appeals procedures, time frames, and requirements specific to the Prescription Drug Program, contact

CVS Caremark at the phone number listed on the back of your prescription drug card or go to **www.Caremark.com**.

Please note: Under the Affordable Care Act ("ACA"), medical benefit claims (not eligibility claims) are eligible for an external review by an independent review organization (IRO). To be eligible for the external review, the medical benefit claim must involve medical judgment,[4] excluding claims that involve only contractual or legal interpretation without any use of medical judgment as determined by the external reviewer. You will be provided with information regarding this external review if you receive a final internal adverse benefit determination (that is, your claim is denied after the claims and appeals procedures have been followed). You cannot request an external review unless you have exhausted the internal claims and appeals procedures and receive a final adverse benefit determination.

About Claims

A "claim" is a request by you or your authorized representative for an eligibility determination or a Plan benefit. Any claim must be filed by you or your authorized representative.

The claims and appeals procedures are slightly different, depending on whether you have an "eligibility" claim or a "benefit" claim.

A claim that does not relate to a specific benefit (for example, a claim regarding eligibility) must be filed initially with Hitachi. (See "Eligibility Claims and Appeals" below.) CVS Caremark handles all claims related to benefits.

Please note: International claims must be submitted via paper claims to the CVS Caremark paper claims department.

The following information must be included:

- Medicine strength /or NDC Number;
- Total charge (foreign currency and U.S. dollar equivalent);
- Original pharmacy receipts. If not available:
  - Pharmacist's signature;
- Prescription number;
- Date of purchase;
- Medicine name (foreign and U.S. equivalent); and
- Metric quantity/days' supply.

[4] An adverse benefit determination is eligible for the external review if it involves medical judgment (that is, the Medical Plan's (or Program's) requirements for medical necessity, health care setting, level of care, or effectiveness of a covered benefit), or involves a determination that a treatment is experimental, investigational, or unproven. It also includes rescissions (a retroactive termination) of coverage.

Contact the number on the back of your prescription ID card for further detail.

Eligibility Claims and Appeals

An "eligibility claim" is a claim to participate in a benefit plan or plan option or to change an election to participate during the Plan Year. If a Claims Administrator denies your, your Spouse's, or your child's participation in a benefit plan, you may request that the decision be reviewed.

Requests for an eligibility claim must be in writing and submitted either via paper or electronically to Hitachi at:

Hitachi America, Ltd.
Corporate Benefits
50 Prospect Avenue
Tarrytown, New York 10591

You may also submit a request for an eligibility claim electronically to HAL.Benefits@hal.hitachi.com

The chart below applies to the procedure you must follow for **eligibility claims**.

	Eligibility Claims Procedure
When you will be notified of the claim decision or if you do not provide sufficient information	You will be notified of the decision within 90 days of receipt of your claim (180 days when special circumstances apply) by the Hitachi Corporate Benefits Department. You will also be notified if you do not provide sufficient information. The notification will include the deadline to submit additional information, if applicable.
If your claim is approved **If your claim is denied**	You will be notified in writing. If your claim is denied, in whole or in part, you will be notified in writing. The written denial notice will include: ▪ The specific reason(s) for the denial; ▪ The Plan provisions upon which the denial was based; ▪ Any additional material or information you may need to submit to complete the claim; and ▪ The Plan's appeal procedures.
What you can do if your claim is denied	Before you can bring any action at law or in equity to recover benefits, you must exhaust this process. Specifically, you must file an appeal as explained below and the appeal must be finally decided by the Sr. Director of the Hitachi Benefits Department. This individual is authorized to determine eligibility appeals and interpret the terms of the Plan in his or her sole discretion. All decisions by the Sr. Director of the Hitachi Benefits Department are final and binding on all parties.

	Eligibility Claims Procedure
How to file an appeal	If your eligibility claim is denied and you want to appeal it, you must file your appeal within 60 days from the date you receive written notice of your denied claim. You may request access, free of charge, to all documents relating to your appeal. To file your appeal, write to the address specified on your claim denial notice. You should include: ▪ A copy of your claim denial notice; ▪ The reason(s) for the appeal; and ▪ Relevant documentation.
The Sr. Director of the Hitachi Benefits Department will notify you in writing if your appeal is approved or denied	You will be notified of the decision within 60 days of the Sr. Director of the Hitachi Benefits Department's receipt of your appeal (120 days, when special circumstances apply). If your appeal is denied, in whole or in part, your written denial notice will include: ▪ The specific reason(s) for denial; ▪ A statement regarding the documents to which you are entitled to receive access and copies; and ▪ The Plan provisions upon which the denial was based. ▪ The decision on your appeal is final.

Benefits Claims and Appeals

Network Benefits

In general, if you receive prescription drugs through CVS Caremark (in-network), CVS Caremark will pay Hitachi's share of the cost to the pharmacy directly. If a pharmacy bills you for any covered prescription drugs other than your Coinsurance, contact the provider or call CVS Caremark at the phone number on the back of your prescription drug ID card for assistance.

Please note: Keep in mind that, participants enrolled in the Silver HDHP or Bronze HDHP option, are responsible for meeting the annual medical Deductible before any prescription drug benefits are payable.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting Caremark.com or by calling the toll-free number on the back of your prescription drug ID card. Mail your completed claim form along with your receipt(s), to the address on your prescription drug ID card.

If you do not have a claim form, attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- Your name and address;
- The patient's name, age, and relationship to you;
- The Id Number as shown on your Health Plan ID card;

- The name, address and tax identification number of the provider of the prescription drug(s);
- A diagnosis from the Physician;
- The date of the prescription drug purchase;
- An itemized receipt/bill from the pharmacy that includes:
  - Patient name,
  - Prescription number,
  - Total charge,
  - Date filled,
  - Quantity,
  - Day supply,
  - NDC codes,
  - NABP/NPI of the pharmacy that filled each prescription and the pharmacy name and address,
  - The name of the prescription drug,
  - The dose of the medication being prescribed; and
  - The charge for the prescription drug.

Any reimbursement to you may be delayed if all of the information listed above is not provided.

After CVS Caremark has processed your claim, you will receive payment for benefits that the Prescription Drug Program allows. It is your responsibility to pay the pharmacy the charges you incurred, including the difference between what you were billed and what the Prescription Drug Program paid.

Please note: All claim forms for out-of-network prescription drugs must be submitted within 12 months after the date of purchase. Otherwise, the Prescription Drug Program will not pay any benefits for that prescription drug, or benefits will be reduced, as determined by CVS Caremark. This 12-month requirement does not apply if you are legally incapacitated.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for benefits is denied in part or in whole, you may call CVS Caremark at the number listed on the back of your prescription drug ID card before requesting a formal appeal. If CVS Caremark cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for benefits, post-service claim, or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit urgent care appeals in writing. This communication should include:

- The patient's name and prescription drug ID number as shown on the prescription drug ID card;
- The patient's date of birth;
- Drug name(s) being appealed;
- The pharmacy's name;
- The date of purchase;
- The reason you disagree with the denial; and
- Any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to the address listed on the denial letter from CVS Caremark.

For urgent care requests for benefits that have been denied, your provider can call CVS Caremark at 1-855-311-3078

Review of an Appeal

CVS Caremark will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- An appropriate individual(s) who did not make the initial benefit determination; and
- A health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if CVS Caremark upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

The Program offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from CVS Caremark within 60 days from receipt of the first level appeal determination.

Please note*:* Upon written request and free of charge, any Covered Person may examine documents relevant to their claims and/or appeals and submit opinions and comments. CVS Caremark will review all claims in accordance with the rules established by the U.S. Department of Labor.

Timing of Appeals Determinations

The timing of the claims appeal process is based on the type of claim you are appealing. If you want to appeal a claim, it is important to understand whether it is:

- An urgent care request for benefits;

- A pre-service request for benefits;
- A post-service request for benefits; or
- A concurrent claim for benefits.

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent care request for benefits: a request for benefits provided in connection with urgent care services;
- Pre-service request for benefits: a request for benefits which the Program must approve or in which you must notify CVS Caremark before a prescription drug requiring prior authorization is provided; and
- Post-service request for benefits: a claim for reimbursement of the cost of a non-urgent prescription drug that has already been provided.

Please Note: CVS Caremark's decision is based only on whether or not benefits are available under the Program for the proposed prescription drug. The determination as to whether the pending prescription drug is necessary or appropriate is between you and your Physician.

The tables below describe the time frames which you and CVS Caremark are required to follow.

Urgent Care Request for Benefits[5]	
Type of Request for Benefits or Appeal	**Timing**
If your request for benefits is incomplete, CVS Caremark must notify you within:	**24 hours**
You must then provide completed request for benefits to CVS Caremark within:	**48 hours** after receiving notice of additional information required
CVS Caremark must notify you of the benefit determination within:	**72 hours**
If CVS Caremark denies your request for benefits, you must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
CVS Caremark must notify you of the appeal decision within:	**72 hours** after receiving the appeal

[5] You do not need to submit urgent care appeals in writing. You should call CVS Caremark as soon as possible to appeal an urgent care request for benefits.

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	**Timing**
If your request for benefits is filed improperly, CVS Caremark must notify you within:	**5 days**
If your request for benefits is incomplete, CVS Caremark must notify you within:	**15 days**
You must then provide completed request for benefits information to CVS Caremark within:	**45 days**
CVS Caremark must notify you of the benefit determination:	
If the initial request for benefits is complete, within:	**15 days**
After receiving the completed request for benefits (if the initial request for benefits is incomplete), within:	**15 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
CVS Caremark must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
CVS Caremark must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, CVS Caremark must notify you within:	**30 days**
You must then provide completed claim information to CVS Caremark within:	**45 days**
CVS Caremark must notify you of the benefit determination:	
If the initial claim is complete, within:	**30 days**
After receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
CVS Caremark must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal

Post-Service Claims	
Type of Claim or Appeal	**Timing**
You must appeal the first level appeal (file a second level appeal) within:	**30 days** after receiving the first level appeal decision
CVS Caremark must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

Concurrent Care Claims

If a long-term prescription drug was previously approved for a specific period of time and your request to extend the usage of the prescription drug is an urgent care request for benefits as described above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved prescription. CVS Caremark will make a determination on your request for the extended prescription within 24 hours from receipt of your request.

If your request for an extension of the prescription drug is not made at least 24 hours prior to the end of the approved prescription, the request will be treated as an urgent care request for benefits and decided according to the timeframes described above. If a prescription was previously approved for a specific period of time or number of pills, etc. and you request to extend the prescription in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by CVS Caremark, or if CVS Caremark does not respond to your appeal in accordance with applicable regulations regarding timing, you may have the right to external review through an Independent Review Organization (IRO) upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in CVS Caremark' decision letter to you. (The process is available at no charge to you.)

If you have depleted all levels of appeals and are still not satisfied with the final internal determination of a benefit claim, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons;
- The exclusions for experimental or investigational services or unproven services;
- Rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on the back of your

prescription drug ID card or by sending a written request to the address listed in the determination letter. A request must be made within four months after the date you received CVS Caremark decision.

An external review request should include all of the following:

- A specific request for an external review;
- The Covered Person's name, address, and CVS Caremark ID number;
- The Covered Person's date of birth;
- Your designated representative's name and address, when applicable;
- The prescription drug that was denied; and
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). CVS Caremark has entered into an agreement with UM Company to perform such reviews. There are two types of external reviews available:

- A standard external review; and
- An expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- A preliminary review by CVS Caremark of the request;
- A referral of the request by CVS Caremark to the IRO; and
- A decision by the IRO.

Within the applicable timeframe after receipt of the request, CVS Caremark will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Program at the time the prescription drug 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 CVS Caremark may process the request.

After CVS Caremark completes the preliminary review, CVS Caremark will issue a notification in writing to you. If the request is eligible for external review, CVS Caremark will request that the IRO conduct such review.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within 10 business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after 10 business days.

CVS Caremark will provide to the IRO the documents and information considered in making CVS Caremark' determination. The documents include:

- All relevant medical records;
- All other documents relied upon by CVS Caremark; and
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and CVS Caremark will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by CVS Caremark. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and CVS Caremark, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing CVS Caremark' determination, the Program will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Program and any applicable law regarding Plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Program will not be obligated to provide benefits for the prescription drug(s).

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter and, in some instances, you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function.

Immediately upon receipt of the request, CVS Caremark will determine whether the individual meets both of the following:

- Is or was covered under the Program at the time the prescription drug that is at issue in the request was prescribed; and
- Has provided all the information and forms required so that CVS Caremark may process the request.

After CVS Caremark completes the review, CVS Caremark will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, CVS Caremark will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by CVS Caremark. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the IRO will provide written confirmation of the decision to you and to CVS Caremark.

You may contact CVS Caremark at the toll-free number on the back of your prescription drug ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Limitation of Action

You cannot bring any legal action against Hitachi or CVS Caremark to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed and until after exhausting the Plan’s administrative remedies. If your claim for benefits is denied, in whole or in part, (or in the unlikely event that you do not receive a response to your claims for benefits), and you want to bring a legal action against the company or CVS Caremark, you must do so within twenty-four months after your claim is incurred or you lose any rights to bring such an action against the company or CVS Caremark.

You cannot bring any legal action against Hitachi or CVS Caremark for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against the company or CVS Caremark, you must do so within twenty-four months after your claim is incurred or you lose any rights to bring such an action against the company or CVS Caremark.

HIPAA Privacy

Federal privacy laws require employer-sponsored group health plans to develop privacy policies and disclose them to their employees. For more information about the HIPAA privacy procedures applicable to the prescription drug benefits, consult the Medical Benefit Booklet.

Unclaimed Prescription Drug Benefit Funds

Unless otherwise specified in the CVS Caremark documents, in the event a benefits check issued by the Claims Administrator or Plan Administrator under the Program, remains uncashed after 12 months (or

other period set by CVS Caremark), the check will be voided and funds will be returned to the company to be applied to the payment of current benefits and administrative fees under the Plan.

Terms to Know

Below are common terms used in this SPD. If there is a conflict between a defined term in this SPD and the CVS Caremark Plan document(s), the Plan document(s) will control.

Affordable Care Act ("ACA")

In March 2010, Congress passed the Patient Protection and Affordable Care Act and the Healthcare and Education Reconciliation Act. These laws are commonly referred to as "Healthcare Reform." For purposes of this SPD, they are collectively referred to as the "Affordable Care Act" or "ACA."

Claims Administrator

CVS Caremark, who has contracted with the company to provide prescription drug services and is responsible for determining whether a particular outpatient prescription drug claim is covered.

Anthem has contracted with the company to provide medical services and supplies and is responsible for determining whether a particular medical service or supply claim is covered. Anthem's procedures are described in the Medical Benefit Booklet.

Coinsurance

The percentage of eligible expenses you are required to pay for certain prescription drugs.

Covered Person

Either the Participant or an enrolled "Dependent" (as defined in the Medical Benefit Booklet) only while enrolled and eligible for benefits under the Program. References to "You" and "Your" throughout this SPD are references to a Covered Person.

Deductible

The amount you must pay under the Silver HDHP or Bronze HDHP Medical Plan option for covered health services and prescription drugs in a calendar year before the option begins paying benefits in that calendar year.

Medicare

The program established by Title XVIII of the Social Security Act.

Participant

Any employee who is eligible for and elects to participate in a benefit under the Plan.

Physician(s)

Any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law. Any podiatrist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean benefits for prescription drugs prescribed by that Physician are covered under the Program.

Benefits are not payable for services provided to any relative by birth or marriage, including, but not limited to, you, your Spouse, or a child, brother, sister, or parent for which a claim is submitted.

Self-Insured

In a Self-Insured plan, Hitachi acts as its own insurer. That is, the company uses the money it would have paid the insurance company and instead directly pays claims.

Spouse

For the purposes of this Program, a Spouse is defined as a person who is legally married, under the laws of the state or other jurisdiction where such marriage occurred to an employee enrolled in a Medical Plan option

Summary of Benefits and Coverage ("SBC")

A concise statement of your coverage that will be provided at the time of Hitachi's annual enrollment each year. It details, in plain language, simple and consistent information about your Medical Plan options and coverage. The SBC is designed to help you better understand the coverage you have and to allow you to easily compare your coverage with other coverage options you may have available to you. It summarizes key features of the coverage, including cost-sharing provisions, coverage examples, and limitations and exceptions that may apply.

The SBCs are included with your annual enrollment materials. You can also access the SBCs by accessing the Benefitsolver website at www.benefitsolver.com.