

**SUMMARY PLAN DESCRIPTION
OF THE
BMC SOFTWARE, INC.
CAFETERIA BENEFIT PLAN
(Amended and Restated Effective as of January 1, 2023)**

Revision Date: January 1, 2023

Table of Contents

	<u>Page</u>
I. Plan Introduction	2
II. Important Terms.....	3
III. Overview of the Plan.....	7
IV. The Plan’s Flexible Spending Accounts at a Glance.....	10
V. Health Care Flexible Spending Account Benefit.....	12
VI. Dependent Care Flexible Spending Account Benefit.....	21
VII. Tax Advantages of The Flexible Spending Accounts’	26
VIII. Reimbursement Rules for Flexible Spending Accounts	27
IX. How to Participate in the Flexible Spending Accounts	27
X. Health Savings Account Funding Benefit	28
XI. Plan Rules and Limitations	29
XII. Conclusion	37
XIII. General Plan Information	39
XIV. Your Rights Under ERISA	40
Covered Benefits Appendix.....	42
Claims Procedures for Health Care Flexible Spending Account Benefit Appendix .	43
HIPAA Medical Privacy and Security Appendix	47
HIPAA Privacy Employee Designation Appendix.....	54
Adopting Employers Appendix	55

I. PLAN INTRODUCTION

The Better You Plan, The More You Save.

It's more than a slogan. The BMC Software, Inc. Cafeteria Benefit Plan (the “**Plan**”) is a real solution to issues facing all of us. Simply stated, by taking advantage of tax laws, the Plan works to save you money.

The Plan offers you three tax-advantaged ways to help pay for (1) coverage for you and your eligible Dependents under the group health plans (the “**Group Health Plans**”) and other employee welfare benefit plans maintained by BMC Software, Inc. (the “**Company**”) which are available as optional Covered Benefits under the Plan, (2) dependent care expenses that allow you and your Spouse to work, and (3) out-of-pocket health care expenses that are not covered by a health benefit plan or insurance.

The Company is pleased to sponsor the Plan for you and your fellow employees. Under federal tax laws, the Plan is considered a “cafeteria plan” because it lets you choose from several different benefit programs according to your individual needs. The Plan provides you with the opportunity to use pre-tax dollars to pay for your benefits simply by entering into a Covered Benefits Agreement instead of using a corresponding amount of your after-tax regular pay. This arrangement helps you because the benefits you elect are nontaxable; you save Social Security and income taxes on the amount of your Covered Benefits.

This Summary Plan Description (“**SPD**”) describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it.

The various Covered Benefits options available under the Plan are described in information materials distributed prior to each open enrollment period. For the details regarding eligibility provisions, benefit amounts, and contribution or premium schedules applicable to each Covered Benefit, please refer to the summary plan description of each Covered Benefit.

This SPD will help you understand the Plan. It covers how the Plan works, the Plan's Dependent Care and Health Care Flexible Spending Account Benefits, how the Plan can save you money, the Plan's rules, and how you can elect to participate in the Plan.

Because using the Plan wisely can save you a significant amount of money each year, it is important that you understand how the Plan works and how you can make the most of the advantages that the Plan has to offer.

After you read this material, if you have any questions or if you would like a copy of the official Plan document, please feel free to contact the Benefits Department. The capitalized terms in this SPD are defined in Article II below. Whenever appropriate, the use of masculine pronouns in this SPD includes the feminine gender and the singular tense includes the plural. References in this SPD to “you” means a Participant (or Employee, as applicable in context). Any reference to an “Appendix” in this SPD will mean an Appendix to this SPD unless otherwise stated.

Plan Controls

This booklet contains only a summary of the Plan. In the event of any discrepancy between the Plan and this SPD, the Plan will control.

II. IMPORTANT TERMS

The following is a list of defined terms that are used in this SPD.

1. **“Affordable Care Act”** means the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010, and the authoritative guidance issued thereunder by the appropriate governmental entities.
2. **“Benefits Department”** means the Benefits Department of the Plan Administrator.
3. **“Change in Status Event”** means an event described in the Plan which will permit a participant to change his Covered Benefit election during a Plan Year.
4. **“Claims Administrator”** means the person or third-party entity that has been retained by the Company or Plan Administrator to provide claims processing and other administrative services on behalf of the Plan.
5. **“Code”** means the Internal Revenue Code of 1986, as amended, and the regulations and other authority issued thereunder by the IRS or other appropriate governmental authority.
6. **“Company”** means BMC Software, Inc. or its successor in interest.
7. **“Compensation”** means your earned wages or salary from the Employer.
8. **“Covered Benefit”** means (a) contribution or insurance premium reimbursement benefits for any of the separate Group Health Plans or other welfare benefit plans maintained by the Employers, as referenced in the Covered Benefits Appendix to this SPD, (b) reimbursement of eligible dependent care expenses under the Dependent Care Flexible Spending Account Benefit described in this SPD, (c) reimbursement of eligible medical care expenses under the Health Care Flexible Spending Account Benefit described in this SPD, or (d) funding of contributions to a Health Savings Account on a pre-tax basis as described in this SPD. The types and costs of coverage available under a particular Employer’s Group Health Plan or other welfare benefit plan, and the other terms, conditions and limitations of coverage and benefits, are set forth in the summary plan description which describes each such plan. You can obtain copies upon request to the Benefits Department. However, the rules affecting the Dependent Care Flexible Spending Account Benefit, the Health Care Flexible Spending Account Benefit, and the Health Savings Account Funding Benefit are described in more detail in the Plan and this SPD, and not in a separate summary plan description.
9. **“Covered Benefits Agreement”** means a written or electronic agreement whereby your Compensation is reduced each payroll period in an amount equal to your elected contributions to the Plan.

10. **“Dependent”** means an individual who qualifies as your dependent for federal income tax purposes, as defined in Code Section 152, with the following exceptions:
- (b) For purposes of accident or health coverage (as described in Code Sections 105(b) or 106) under a Covered Benefit, including the Health Care Flexible Spending Account Benefit, “Dependent” means an individual who qualifies as your dependent as defined in Code Sections 105(b) and 106, as amended by the Affordable Care Act; and
 - (c) For purposes of the Dependent Care Flexible Spending Account Benefit, “Dependent” means a Qualifying Individual.

The Plan Administrator and/or Claims Administrator each reserve the right to require evidence from a Participant of an individual’s status as a “Dependent”. If the Plan Administrator and/or Claims Administrator so requires, the Participant must provide such evidence to the Plan Administrator and/or the Claims Administrator (or the delegate of either) in the form and manner, and within the timeframe, specified by the Plan Administrator and/or the Claims Administrator (or the delegate of either). Such evidence may include, but is not limited to, certifications, affidavits or other written or electronic documentation. The Plan Administrator and/or the Claims Administrator (or the delegate of either) shall determine, in its or their discretion, whether such evidence reasonably substantiates such individual’s status as a “Dependent” under the Plan.

Nothing in this section is intended to restrict or enlarge the definition of “Dependent” established by any Covered Benefit offered under the Plan.

11. **“Dependent Care Flexible Spending Account”** means the account to which your elected pre-tax payroll deductions are applied to reimburse your eligible dependent care expenses.
12. **“Dependent Care Flexible Spending Account Benefit”** means the Covered Benefit described in Article VI of this SPD.
13. **“Employee”** means an employee or officer of an Employer whose income is reportable by the Employer on an IRS Form W-2 and who has been designated in the Employer’s Human Resource Information System as being eligible to participate in the Plan; provided, however the term “Employee” does not include (a) any person who is employed as an independent contractor or is designated in the Employer’s payroll records as a temporary employee (*i.e.*, hired for a prescribed period of less than six months), or (b) any sole proprietors, partners in a partnership, and 2% shareholders of an S corporation.
14. **“Employer”** means the Company and any of its affiliates which adopt the Plan.
15. **“Entry Date”** means the first day of each Plan Year. However, for new Employees who are employed during a Plan Year or whose Employers adopt the Plan during the Plan Year, “Entry Date” means the first date on which the Employee satisfies the eligibility and enrollment requirements of the respective Covered Benefit.

16. **“Flexible Spending Account”** means the Dependent Care Flexible Spending Account, Health Care Flexible Spending Account, or Limited Use Health Care Flexible Spending Account, as applicable in context.
17. **“Flexible Spending Account Benefit”** means either the Dependent Care Flexible Spending Account Benefit or the Health Care Flexible Spending Account Benefit, as applicable in context.
18. **“Group Health Plan”** means an employee healthcare plan which is sponsored by the Company, as listed in the Covered Benefits Appendix, that provides certain types of health coverage to you and your covered Spouse and Dependents.
19. **“Health Care Flexible Spending Account”** means the account to which your elected pre-tax payroll deductions are allocated to be applied to reimburse your qualifying health expenses.
20. **“Health Care Flexible Spending Account Benefit”** means the Covered Benefit described in Article V and includes participation in either the Health Care Flexible Spending Account or the Limited Use Health Care Flexible Spending Account.
21. **“Health Savings Account”** or **“HSA”** means a health savings account established under Code Section 223 by an HSA-Covered Employee. The funding of contributions to an HSA is offered as a Covered Benefit under the Plan. No HSA itself is a Covered Benefit under the Plan.
22. **“Health Savings Account Funding Benefit”** means the Covered Benefit described in Article X of the SPD.
23. **“High Deductible Health Plan”** means a “high deductible health plan” as defined in Code Section 223(c)(2).
24. **“HSA-Covered Employee”** means an Employee who meets the requirements of Code Section 223 for participation in, and has coverage under, a Health Savings Account. Whether an Employee is an HSA-Covered Employee is based solely on the Employee’s certification of his HSA status during the Plan’s enrollment process. The Employee must provide certification of his HSA status as required by the Plan Administrator. The Plan Administrator has no obligation to verify the Employee’s status as an HSA-Covered Employee or to confirm whether the Employee meets the requirements under the Code for HSA coverage.
25. **“HSA Custodian”** means the person or entity that has been designated by the Plan Sponsor to serve as the custodian of the HSAs that are (a) established by Participants in conjunction with participation in the Employer’s High Deductible Health Plan, and (b) funded through participation in the Health Savings Account Funding Benefit.
26. **“Limited Use Health Care Flexible Spending Account”** means a Health Care Flexible Spending Account for which reimbursement of qualifying health expenses is limited to expenses for preventive care, dental care and vision care expenses before you meet your

deductible in the High Deductible Health Plan. After you have met your deductible in the High Deductible Health Plan, the Limited Use Health Care Flexible Spending Account can be used for the reimbursement of any qualifying health expense.

27. **“Participant”** means an eligible Employee who is participating in the Plan.
28. **“Period of Coverage”** generally means the Plan Year; however, the initial Period of Coverage for a new Employee who becomes eligible to participate after a Plan Year has begun is the interval beginning on the new Employee’s Entry Date and ending on the last day of the Plan Year. If an Employee terminates employment for whatever reason during a Plan Year, his Period of Coverage automatically ends on his termination date.
29. **“Plan”** means the BMC Software, Inc. Cafeteria Benefit Plan, as it may be amended from time to time.
30. **“Plan Administrator”** means the BMC Software, Inc. Benefits Committee, which has the authority and responsibility to manage and direct the operation and administration of the Plan in its discretion. The day-to-day administration of the Plan shall be the responsibility of the Plan Administrator. However, the Plan Administrator may assign or delegate duties to third parties, such as the Claims Administrator, under the terms of the Plan or by means of a separate written agreement. References in this SPD to the “Plan Administrator” will also include, when appropriate, any Claims Administrator or other person or entity who has been delegated the appropriate authority by the Plan Administrator under the terms of the Plan or a separate written agreement.
31. **“Plan Sponsor”** means the Company.
32. **“Plan Year”** means the twelve (12) consecutive month period beginning on January 1st, ending on each December 31st.
33. **“Qualifying Individual”** means, in accordance with Code Section 21(b)(1):
 - (a) Your “qualifying child” dependent for federal income tax purposes (as defined in Code Section 152(a)(1)) who is under the age of thirteen (13);
 - (b) Your Dependent for federal income tax purposes, without regard to subsections (b)(1) (*i.e.*, the “exclusion of dependents of dependents”), (b)(2) (*i.e.*, the “exclusion of married dependents filing joint tax return”), and (d)(1)(B) (*i.e.*, the “gross income limit for qualifying relatives”) of Section 152, who is physically or mentally incapable of caring for himself and who has the same principal place of abode as you for more than half of the taxable year; or
 - (c) Your Spouse, if your Spouse is physically or mentally incapable of caring for himself, and who has the same principal place of abode as you for more than half of the taxable year.

If you are divorced or separated, your child will be treated as the “Qualifying Individual” of his custodial parent (in accordance with Code Section 21(e)(5)) for purposes of the

Dependent Care Flexible Spending Account Benefit, provided that your child (a) is under the age of thirteen (13) or is physically or mentally incapable of caring for himself, and (b) receives over half of his support during the taxable year from you and his other parent and is in the custody of either parent, or both of you, for more than half of the taxable year, in accordance with Code Section 152(e).

34. “**SPD**” means this Summary Plan Description of the Plan.
35. “**Spouse**” means a person to whom an Employee is lawfully married, which marriage was solemnized, authenticated and recorded as required by the state or foreign jurisdiction in which the marriage took place, to the extent such marriage is legally recognized as valid for purposes of applicable federal law (including, but not limited to, the Code and ERISA), and any regulations promulgated under such applicable federal law, but will not include an individual who is separated from the Employee under a legal separation or divorce decree. The term “Spouse” shall also include a common law spouse if the Employee and spouse became common law married in a state which recognizes common law marriages and meets the requirements for common law marriage in that state. The Employee must provide proof of a ceremonial marriage or a common law marriage that is acceptable to the Plan Administrator if requested, such as, for example, an affidavit of marriage, or a marriage license or certificate of common law marriage issued by the applicable state.

III. OVERVIEW OF THE PLAN

This SPD will tell you important information about the Plan, such as the requirements that you must satisfy before you can join and the laws that protect your rights. One of the most important features of the Plan is that the Covered Benefits can be purchased with a portion of your Compensation *before* federal income and Social Security taxes are withheld. This means that your payroll “redirection” contributions to the Plan are made before you pay taxes; therefore, you pay less tax and have more money to spend or save.

Please read this SPD carefully so that you will understand the key provisions of the Plan. You should direct any questions to the Benefits Department.

Eligibility Requirements

The Covered Benefits available under the Plan include coverage under the Company’s Group Health Plans and other employee welfare benefit plans as described in the Covered Benefits Appendix. You are eligible to participate in the Plan if (a) you are on the Employer’s United States payroll, and (b) you are either (i) a full-time Employee who works a minimum of 30 hours per week, or (ii) employed in the “BMC Bridging to Retirement Group”, as designated in the Employer’s records. If you are eligible, your participation will begin on the Entry Date that you (1) meet the requirements of clauses (a) and (b) above, and (2) are eligible to commence participation in any Covered Benefit (other than the Health Care Flexible Spending Account Benefit, the Dependent Care Flexible Spending Account Benefit, and the Health Savings Account Funding Benefit).

Other Covered Benefits available under the Plan include the Health Care Flexible Spending Account Benefit, the Dependent Care Flexible Spending Account Benefit, and the Health Savings Account Funding Benefit. The eligibility requirements for these benefits are described later in this SPD. After you satisfy the eligibility requirements and before the Period of Coverage begins, you will be furnished with information regarding the Plan and the Covered Benefits.

A former Employee who is rehired within 30 days after he terminated employment and during the same Plan Year may be able to recommence participation in the Plan when he is entitled to receive coverage under a Covered Benefit, but only by continuing the same benefit election for the remainder of that Period of Coverage.

Except in limited circumstances, Employees who were eligible to participate in the Plan for a Plan Year, but who declined to do so, will not be eligible to participate in the Plan until the next January 1st, i.e., the first day of the next Plan Year. Later in this SPD there is an explanation of the Change in Status Events which permit an Employee to elect to participate or modify a Plan election during a Plan Year.

You become a Participant by completing an individual Covered Benefits Agreement, or posting it online if done electronically, on which you elect one or more of the Covered Benefits available under the Plan, as well as agree to a compensation deduction to pay for your elected benefits. You will be provided a Covered Benefits Agreement through *Your Benefits Resources*. You must complete the form and return it to *Your Benefits Resources* online at www.yourbenefitsresources.com/bmc or by telephone at 1-877-262-4849 within the time period specified. If you do not complete and return (or post online) a Covered Benefits Agreement as required, you will be deemed to have elected to waive participation in the Plan.

In addition, a new Covered Benefits Agreement will be made available to you by the first day of each annual enrollment period, and you will be given the opportunity to confirm or change your choices made for the previous Plan Year for the coming Plan Year, effective beginning on the first day of the next Plan Year. A Participant who fails to complete and return (or post online) a Covered Benefits Agreement as required will be deemed to have elected to continue participation in the Plan with the same benefit elections for the Group Health Plans and other employee welfare benefit plans as during the prior Plan Year (adjusted to reflect any increase/decrease in applicable contributions or premiums). However, the Plan Sponsor may decide, in its discretion and with prior notice to Participants, to require Participants to affirmatively enroll in all Covered Benefits and will deem a Participant's failure to complete and return (or post online) a Covered Benefits Agreement as an election to waive participation in the Plan. In that case, the Participant will not be permitted to modify his election until the next annual enrollment period unless a Change in Status Event occurs. Notwithstanding the foregoing, annual elections for participation in the Flexible Spending Account Benefits must be made by submitting a Covered Benefits Agreement prior to the beginning of each Plan Year -- no deemed elections will occur for either Flexible Spending Account Benefit.

The Plan is comprised of three basic types of tax-advantaged components:

- (1) Contribution/Premium Benefit. When you enroll for coverage under a Group Health Plan or other employee welfare benefit plan described in the Covered Benefits Appendix, and you elect to participate in the Contribution/Premium Benefit portion of the Plan, your

portion of the cost for such coverage will be deducted from your salary or wages on a *pre-tax* basis under the Plan, if you so elect. Your share of the cost for coverage under the Group Health Plan or other employee welfare benefit plan may be changed periodically. Any such adjustment will be made on a nondiscriminatory basis with respect to similarly situated participants. No other changes to your election for Group Health Plan or other employee welfare benefit plan coverage will be allowed during a Period of Coverage, except if you have a Change in Status Event as described in the section below entitled “Plan Rules and Limitations.” Before the start of each new Plan Year, you will also have an opportunity to modify your coverage elections for the next Plan Year.

(2) Flexible Spending Account Benefits. The second basic component of the Plan is the Flexible Spending Account Benefits component. Each eligible Employee may participate in the Dependent Care Flexible Spending Account and in either the Health Care Flexible Spending Account or the Limited Use Health Care Flexible Spending Account. If you elect to participate in either or both of these Flexible Spending Account Benefits, you may set aside part of your Compensation to pay qualifying medical and/or dependent care expenses on a pre-tax basis. The Flexible Spending Account Benefits are discussed in more detail later in this SPD.

(3) Health Savings Account Funding Benefit. The third component of the Plan is the funding of your Health Savings Account. The Health Savings Account Funding Benefit under the Plan allows you to contribute to your Health Savings Account on a pre-tax basis. The Health Savings Account Funding Benefit is discussed in more detail later in this SPD.

Subsequent Plan Elections

After you enroll in the Plan, your coverage elections, if any, under the Covered Benefits (except either of the Flexible Spending Account Benefits and the Health Savings Account Funding Benefit) will automatically be renewed each year unless you otherwise notify the Benefits Department, in writing or posted online *before the start of the next Plan Year* through the Plan’s enrollment process, that you desire to change your coverage elections for the ensuing year. However, the Plan Sponsor may decide, in its discretion and with prior notice to Participants, to require you to affirmatively enroll in all Covered Benefits and will deem your failure to complete and return (or post online) a Covered Benefits Agreement as an election to waive participation in the Plan.

You must make a new election before the start of the next Plan Year regarding the amounts that you want to contribute to your Flexible Spending Accounts and to your Health Savings Account. Annual elections for participation in the Flexible Spending Account Benefits and Health Savings Account Funding Benefit must be made by submitting a new Covered Benefits Agreement, in writing or posted online, prior to the beginning of each Plan Year.

You may also change your coverage elections during a Plan Year if you have a Change in Status Event and your requested election change is consistent with the Change in Status Event (for example, if you want to add dependent coverage under a Group Health Plan because you had a newborn during the year). However, you may change your election with respect to your Health Savings Account Funding Benefit at any time during the Plan Year prospectively even if you do not

have a Change in Status Event. Change in Status Events are discussed in more detail later in this SPD.

Employee's Consent

By joining the Plan, you will be deemed (1) to consent to and abide by the terms, conditions and limitations of the Plan, including any decision made by the responsible person with respect to your rights or entitlement to benefits under the Plan, (2) to agree to provide satisfactory proof to support any claim, and (3) to consent to, and fully and honestly respond to, inquiries made by the Company, health care service providers, and their agents regarding any claim that you submit.

Your Employer may change the Covered Benefits Agreement at any time to satisfy the requirements of the Code, IRS Regulations, and other authority issued thereunder.

IV. THE PLAN'S FLEXIBLE SPENDING ACCOUNTS AT A GLANCE

The Flexible Spending Accounts

There are two Flexible Spending Account Benefits available to you under the Plan:

- ***A Health Care Flexible Spending Account Benefit*** which allows you to set aside money tax-free to help pay for your out-of-pocket medical expenses; and
- ***A Dependent Care Flexible Spending Account Benefit*** which lets you use tax-free money to help pay for dependent care services that are necessary in order for you (or, if married, for you and your Spouse) to go to work.

These Flexible Spending Account Benefits let you deduct dollars from your paycheck on a pre-tax basis. These accounts are exempt from federal income taxes, Social Security (FICA) taxes and, in most cases, state income taxes (if applicable). The more money you put in, the less tax you pay. When you use the money in your account to pay for qualifying out-of-pocket expenses, you avoid paying taxes on those dollars. Depending on your tax bracket, you may save 1/3 or more on such expenses.

Eligibility for Flexible Spending Account Benefits

- Only an Employee who is (1) on the Employer's United States payroll and (2) either (a) a full-time Employee who works a minimum of thirty (30) hours per week or (b) employed in the "BMC Bridging to Retirement Group", as designated in the Employer's records, is eligible to enroll in either Flexible Spending Account Benefit.
- An eligible Employee who enrolls in the Health Care Flexible Spending Account Benefit will begin participation in that benefit on the Entry Date that he is eligible to begin participation in any Covered Benefit which constitutes a group health plan that is not an "excepted benefit" under IRS Regulations.

- An eligible Employee who enrolls in the Dependent Care Flexible Spending Account Benefit will begin participation in that benefit on the Entry Date on or next following satisfaction of the eligibility requirements.
- An HSA-Covered Employee is not eligible to contribute to a Health Care Flexible Spending Account, other than a Limited Use Health Care Flexible Spending Account, under the Health Care Flexible Spending Account Benefit, and only an HSA-Covered Employee is eligible to contribute to a Limited Use Health Care Flexible Spending Account under the Health Care Flexible Spending Account Benefit.
- If you are eligible and want to participate, you must complete an enrollment form to authorize contributions under one or both of the Flexible Spending Account Benefits.

How You Use the Plan's Flexible Spending Accounts

In short, the Plan lets you set aside tax-free money to reimburse yourself for eligible expenses that you pay out of your own pocket. During an open enrollment period prior to the beginning of each year, you will be asked if you want to participate in the Flexible Spending Account Benefits for the next Plan Year. The Flexible Spending Accounts are non-interest bearing.

First, you should carefully estimate your upcoming health care and dependent care expenses that would be eligible for reimbursement. Later in this booklet are worksheets to help you estimate your expenses. You might also want to consult a tax adviser to investigate various alternatives and determine which of your expenses qualify.

After that, you decide how much of your Compensation you would like to contribute into your Flexible Spending Accounts. When you participate, you designate how much of your wages will be contributed to your Health Care Flexible Spending Account or Limited Use Health Care Flexible Spending Account, and how much should go to your Dependent Care Flexible Spending Account. You do not have to contribute to any Flexible Spending Account, or you can contribute to one but not the other. The money that you elect to set aside will be “redirected” from your paychecks in equal amounts throughout the year.

The term “redirected” is used because your money is contributed to your Flexible Spending Accounts before federal income or Social Security taxes are taken out. By doing this, your taxable income is reduced, and thus you pay less in taxes.

When you have eligible out-of-pocket medical expenses or dependent care expenses, you can be reimbursed from either your Health Care Flexible Spending Account, Limited Use Health Care Flexible Spending Account or Dependent Care Flexible Spending Account, as applicable depending on the nature of the claim and the Flexible Spending Account in which you are enrolled. You can file for payment or reimbursement of your eligible expenses, and your eligible expenses for your Spouse or Dependent, after each expense has been incurred, or you can use a debit card, as explained later in this SPD. Your eligible dependent care expenses are reimbursable through your Dependent Care Flexible Spending Account Benefit, and your qualifying health expenses are reimbursable through your Health Care Flexible Spending Account Benefit.

You will have 90 days after the end of the Plan Year in which to submit a claim for reimbursement for eligible expenses incurred during the previous Plan Year.

The amount reimbursed is not subject to taxes. Since that money originally came out of your pay *before* taxes were calculated, the result of the Plan is that you pay for the eligible expenses on a tax-free basis.

Statements are available online through *Your Benefits Resources* (www.yourbenefitsresources.com/bmc) showing how much is in your Flexible Spending Accounts. That way you will know how much you have spent and how much you have left.

Special Plan Information

As you read this booklet and decide how the Plan can help you, there are some very important points to remember. Because you do not pay taxes on the money you put in, the IRS has placed some restrictions on the Plan.

Generally, once you are participating in the Plan, you cannot change the amount of money you redirect until the beginning of the next Plan Year (January 1). You may be able to change the amounts if you have a Change in Status Event. Change in Status Events are described below in the section entitled “Plan Rules and Limitations”.

Another IRS and Plan limitation requires money you do not use from your Flexible Spending Accounts for expenses incurred during the Plan Year to be forfeited and not returned back to you. If you plan ahead carefully, you can avoid being affected by this restriction.

V. HEALTH CARE FLEXIBLE SPENDING ACCOUNT BENEFIT

Benefit Description

You can use your Health Care Flexible Spending Account Benefit to pay for certain health care expenses that are not covered, or only partially covered, by the Group Health Plan or other plans, *i.e.*, expenses that you would normally pay out of your own pocket for yourself and your eligible Spouse and Dependents. Depending on whether you have a Health Care Flexible Spending Account or Limited Use Health Care Flexible Spending Account, these expenses may include deductibles and copayments, routine physical exams, eye exams, eyeglasses and contact lenses, and orthodontia and other types of health expenses. The Claims Administrator’s website contains a detailed list of the types of expenses that are reimbursable under the Health Care Flexible Spending Account Benefit (“**qualifying health expenses**”).

The Health Care Flexible Spending Account Benefit helps you save money on out-of-pocket health expenses for you and your Spouse and Dependents.

By using this Covered Benefit, you pay for qualifying health expenses with pre-tax dollars. You save a percentage of each dollar you spend on qualifying health expenses that are not covered or fully covered for payment under your Group Health Plan or other plans.

If you have a Health Care Flexible Spending Account, qualifying health expenses may include:

- Group Health Plan deductibles;
- Group Health Plan Copayments;
- Amounts over the maximum each Group Health Plan pays; and
- Other qualifying health expenses not covered by the Group Health Plans or other plans.

If you have a Limited Use Health Care Flexible Spending Account, until you reach your deductible under the High Deductible Health Plan, qualifying health expenses include:

- Preventive medical care;
- Dental care; and
- Vision care.

After you meet your deductible in the High Deductible Health Plan, the Limited Use Health Care Flexible Spending Account can be used for the reimbursement of any qualifying health expense.

Out-of-pocket expenses incurred by you, your Spouse or any Dependent which are qualifying health expenses are eligible for reimbursement. But you must enroll in the Health Care Flexible Spending Account Benefit to take advantage of the tax savings, and the expenses must be incurred while you are participating.

Insurance premiums or payments paid for coverage under your (or your Spouse's) health care plan and expenses paid by your (or your Spouse's) health care plan are generally not eligible for reimbursement under the Health Care Flexible Spending Account Benefit. Also, you cannot receive reimbursement for an expense if you also itemize that expense as a deduction on your tax return.

The **maximum amount** by which you can reduce your compensation in order to have contributions contributed to either (i) a Health Care Flexible Spending Account or (ii) a Limited Use Health Care Flexible Spending Account on your behalf is **\$3,050** for each full year while you are a Participant. The Plan Sponsor may also establish a minimum contribution amount for future Plan Years. If a minimum amount is required, you will be informed of such amount before the start of the applicable Plan Year. In any event, your elected contributions will be deducted from your pay on a pro-rata basis each payroll period.

Tax Deduction vs. Health Care Flexible Spending Account Benefit?

The IRS allows you to deduct eligible health care expenses on your tax return only if they exceed a specified percentage of your adjusted gross income. If your total out-of-pocket health care expenses exceed that amount, you may prefer to claim them as itemized deductions on your tax

return. However, you may not do so if those same expenses have already been paid with money through your Health Care Flexible Spending Account Benefit.

You can use both the Health Care Flexible Spending Account Benefit and the tax deduction, but you may not claim the same expenses for both.

Requesting Reimbursement

For reimbursement of qualifying health expenses not covered under the Group Health Plans or other plans, a special request form should be completed, unless you used a debit card as described later in this SPD. This form may be obtained from *Your Benefits Resources* at www.yourbenefitsresources.com/bmc or by calling 1-877-262-4849 and should be submitted, along with all related bills, as directed on the form in accordance with the Plan's procedures.

Account statements are available online at the *Your Benefits Resources* website. When you submit an acceptable claim, you will receive payment up to the full amount you elected for the year, less any amounts previously paid.

A description of the specific procedures for filing benefit claims, providing notification of benefit determinations, and the appeal process of adverse benefit determinations, is contained in the attached "Claims Procedures For Health Care Flexible Spending Account Benefit Appendix".

Qualifying Health Expenses

Qualifying health expenses under a Health Care Flexible Spending Account include most medical, dental and vision care expenses that are not covered by a Group Health Plan or other plans. Qualifying health expenses under a Limited Use Health Care Flexible Spending Account before you meet your deductible under the High Deductible Health Plan include preventive medical care expenses and dental and vision care expenses that are not covered by the Group Health Plan or other plans. After you meet your deductible, eligible expenses under the Limited Use Health Care Flexible Spending Account include all qualifying health expenses.

Please keep in mind that expenses for your Spouse and any Dependents may also be qualifying health expenses. IRS publications 17 and 502, available at www.irs.gov, provide more information on qualifying health expenses; the IRS will provide you with free copies upon request. (Note, however, that there are some differences between the tax deductibility of expenses, as described in these IRS publications, and the reimbursability of expenses under the Health Care Flexible Spending Account Benefit; therefore, these publications should be referenced as guidelines only.)

A qualifying health expense is a medical expense, as defined in Code Section 213(d), for which you have not otherwise been reimbursed from insurance or some other source. You should note, however, that Code Section 125 places additional restrictions on the reimbursement of such expenses. For example, premiums for accident or health insurance and expenses for long-term care services are generally not qualifying health expenses.

In addition, IRS regulations require that a medical service be actually rendered prior to the time that the medical expense is reimbursed. For example, even if your doctor requires that an

expense be paid in advance, you cannot be reimbursed until the service relating to the expense has been rendered. In order to ensure compliance with this IRS requirement, you (and/or your doctor) may be required to submit additional substantiation (such as a proposed treatment plan) with respect to certain long-term treatments (*e.g.*, orthodontic or obstetric expenses). Failure to submit the required forms could result in your reimbursement being pended and/or denied. There is an exception to this rule for orthodontia services. If you are required to make payments before you, your Spouse, or your Dependent receives orthodontia services, you can be reimbursed after you make this payment, even if it is before the orthodontia services are rendered, provided that the orthodontia treatment to which such services are related, such as “banding”, has already begun.

Expenses incurred for a medicine or drug are qualifying health expenses under the Health Care Flexible Spending Account Benefit only if you are prescribed such medicine or drug (regardless of whether the drug or medicine is available over-the-counter) or the medicine or drug is insulin. This means that expenses incurred for a medicine or drug are eligible for reimbursement under the Health Care Flexible Spending Account Benefit only if the medicine or drug:

1. requires a prescription;
2. is available without a prescription (*i.e.*, an over-the-counter medicine or drug) but you, your Spouse or your Dependent, has a prescription; or
3. is insulin.

A detailed list of qualifying health expenses is available on the Claims Administrator’s website. For many qualifying health expenses you will first file a claim for coverage under the Group Health Plan. Any amount not paid by that plan may then be submitted for payment through your Health Care Flexible Spending Account or your Limited Use Health Care Flexible Spending Account. Note that qualifying health expenses under the Limited Use Health Care Flexible Spending Account before you meet your deductible under the High Deductible Health Plan are limited to preventive medical care expenses and dental and vision care expenses. After you meet your deductible under the High Deductible Health Plan, the Limited Use Health Care Flexible Spending Account can be used for the reimbursement of any qualifying health expense.

Use of Debit Card or Stored Value Card

A qualifying health expense incurred during the Period of Coverage may be paid or reimbursed through your use of a debit card or stored value card (referred to in this section as “**Card**”).

Certification

If you are issued a Card, you must certify upon enrollment in the Plan (or issuance of the Card, if different) and each annual enrollment period thereafter that (1) the Card will be used only in payment of a qualifying medical care expense incurred during a Period of Coverage by you, your Spouse or your eligible Dependent, and (2) any medical care expense for which payment is made by use of the Card has not previously been reimbursed to you, or on your behalf, nor will you seek payment or reimbursement for the same medical care expense under any other plan. You must

affirm such certification each time the Card is presented for payment or reimbursement of a medical care expense.

Documentation

You must acquire and retain sufficient documentation for any expense paid or reimbursed with the Card.

Limitation on Expense

No payment or reimbursement of a claim made by use of the Card for a medical care expense incurred during a Period of Coverage (referred to in this section as a “**Card Claim**”) can exceed the amount of coverage you elected under your Health Care Flexible Spending Account, less the amount of benefits paid from your Health Care Flexible Spending Account, at the time when the claim for reimbursement or payment is to be settled by the Plan’s Claims Administrator.

Restriction on Merchants and Medical Care Providers

Except as provided in paragraph (4) of the “Substantiation Procedures” section below, the Card may only be used at merchants and service providers authorized as “medical care providers” by the Plan Sponsor based on their merchant category codes. The Plan Sponsor or Claims Administrator will adopt such policies and procedures as it deems necessary to help ensure that no merchant or service provider is authorized to receive payment by use of the Card unless it is a medical care provider.

Use of the Card is not permitted at any merchant or service provider with the “Drug Stores and Pharmacies” merchant category code unless (1) the Card processor provides a system for approving and rejecting Card transactions using “inventory control information” (e.g., stock keeping units or “**SKUs**”) with such merchants or service providers, or (2) on a store location by store location basis, ninety (90) percent of the merchant/service provider’s gross receipts during the taxable year prior to the date of the Card Claim consisted of items that qualify as expenses for medical care under Section 213(d) of the Code (such merchant/service provider referred to as a “**90% Pharmacy**”).

Substantiation Procedures

Every Card Claim must be substantiated. However, a Card Claim with respect to the following will be deemed “substantiated” without meeting the Plan’s ordinary substantiation requirements:

- (1) Co-payments: Permitted if your group health plan has copayments in specific dollar amounts and:
 - (A) the dollar amount of the transaction at a medical care provider equals the dollar amount of the copayment for that service under your group health plan;

- (B) the dollar amount of the transaction at a medical care provider equals an exact multiple of not more than five times the dollar amount of the copayment for the specific service under your group health plan; or
- (C) your group health plan has multiple copayments for the same benefit, and the dollar amount of the transaction at a medical care provider equals an exact match of multiples or combinations of the copayments, but not more than the exact multiple of five times the maximum copayment.

The copayment schedule required under your group health plan must be independently verified by the Plan Sponsor, Claims Administrator or other independent third-party, in accordance with the Plan Sponsor's procedures. Statements or other representations by you are not sufficient to meet these requirements.

- (2) Recurring transactions: Permitted if the expenses incurred are the same with respect to dollar amount, medical care provider, and time period as expenses previously approved under the Plan.
- (3) Real-time substantiation: Permitted if the merchant, service provider, or other independent third party, at the time and point of sale, provides information to the Claims Administrator, electronically or otherwise, that the expense incurred is a qualifying medical care expense.
- (4) Inventory Information Approval System: Permitted if the Card processor provides a system for approving and rejecting Card transactions using "inventory control information" (e.g., stock keeping units or SKUs) with merchants or service providers who need not be medical care providers.
- (5) Direct Third Party Substantiation: Permitted if the Plan Sponsor or Claims Administrator is provided with information from an independent third-party (such as an explanation of benefits from an insurance company) indicating the date of the Medical Care Expense and your responsibility for payment for that service.
- (6) Select Merchants: Permitted from select merchants that primarily provide eligible health care expenses.

If your Card Claim does not meet the foregoing criteria for deemed substantiation, your entitlement to reimbursement for your claim will be conditional, pending substantiation of the claim according to the Plan's ordinary substantiation procedures and other applicable terms of the Plan.

Recovery Procedures

In the event that reimbursement of a Card Claim is made to you, or on your behalf, and is subsequently determined to be impermissible under the terms of the Plan, the following recovery procedures will be followed by the Plan Sponsor or Claims Administrator:

- (1) First, you must repay to the Plan any amounts reimbursed to you, or on your behalf, with respect to the impermissible claim.
- (2) Second, if you fail to repay to the Plan the amounts reimbursed under the impermissible claim, or any portion thereof, the Company will withhold such unpaid amount from your wages or other compensation to the extent not inconsistent with applicable law.
- (3) Third, if wage or compensation withholding fails to result in complete recovery of the unpaid amount, the Claims Administrator will offset your future claims reimbursements with such unpaid amount.
- (4) Fourth, if the recovery procedures described in this section fail to result in complete recovery of the unpaid amount, the Plan Sponsor will treat the unpaid amount as an ordinary business debt until such unpaid amount is recovered.

Pending complete recovery of the amounts reimbursed to you, or on your behalf, with respect to an impermissible claim, the Claims Administrator may, in its discretion, deny your further use of the Card until all such amounts are recovered.

Debit Card Purchase of Prescribed Over-the-Counter Medicines

Notwithstanding the foregoing, the Card may be used to purchase prescribed over-the-counter medicines or drugs only in accordance with this section.

The Card may be used to purchase prescribed over-the-counter medicines or drugs at drug stores and pharmacies, at non-health care merchants that have pharmacies and at mail order and web-based vendors that sell prescription drugs, if:

- (1) Prior to purchase, (A) the prescription for the over-the-counter medicine or drug is presented (in any format) to the pharmacist; (B) the over-the-counter medicine or drug is dispensed by the pharmacist in accordance with applicable law and regulations pertaining to the practice of pharmacy; and (C) an Rx number is assigned;
- (2) The pharmacy or other vendor retains a record of the Rx number, the name of the purchaser (or the name of the person for whom the prescription applies), and the date and amount of the purchase in a manner that meets IRS recordkeeping requirements;
- (3) All of these records are available to the Employer or its agent upon request;
- (4) The Card will not accept a charge for an over-the-counter medicine or drug unless an Rx number has been assigned; and
- (5) The requirements of this “Use of Debit Card or Stored Value Card” section are otherwise satisfied.

The Card may be used to purchase prescribed over-the-counter medicines or drugs from vendors (other than drug stores and pharmacies, non-health care merchants that have pharmacies, and mail order and web-based vendors that sell prescription drugs) having health care related merchant codes if:

- (1) The vendor retains a record of the name of the purchaser (or the name of the person for whom the prescription applies) and the date and amount of the purchase in a manner that meets IRS recordkeeping requirements;
- (2) All of these records are available to the Employer or its agent upon request; and
- (3) The requirements of this “Use of Debit Card or Stored Value Card” section are otherwise satisfied.

The Card may be used to purchase prescribed over-the-counter medicines and drugs at a 90% Pharmacy, provided that substantiation is properly submitted, in accordance with the terms of the Plan, including the prescription (or a copy of the prescription or other documentation that a prescription has been issued) and other information from an independent third party that satisfies applicable IRS requirements.

For all other providers and merchants, other than those described in this subsection, the Card may not be used to purchase over-the-counter medicines or drugs.

Estimating Your Reimbursable Medical Expenses

It is very important that you use all of the money in your Health Care Flexible Spending Account or Limited Use Health Care Flexible Spending Account for a Plan Year because unused amounts must be forfeited and not returned back to you. Good planning and careful estimating are the best ways to take full advantage of your account. You have 90 days after the end of the Plan Year to submit claims for reimbursement that were incurred during that Plan Year.

This worksheet will help you determine the amount of your Compensation that you should consider redirecting into your Health Care Flexible Spending Account. If you are an HSA-Covered Employee, you can use a similar worksheet to determine the amount of your Compensation that you should consider redirecting to your Limited Use Health Care Flexible Spending Account; however, remember that only certain preventive medical care expenses and dental and vision care expenses can be reimbursed through your Limited Use Health Care Flexible Spending Account before you meet your deductible under the High Deductible Health Plan. After you meet your deductible under the High Deductible Health Plan, the Limited Use Health Care Flexible Spending Account can be used for the reimbursement of any qualifying health expense. You should conservatively estimate enough to cover your family’s allowable medical expenses. Because of that, when you estimate your expenses PLEASE BE SURE TO INCLUDE EXPENSES FOR YOU, YOUR SPOUSE, AND YOUR DEPENDENT CHILDREN.

Part of the worksheet shows an example of estimated amounts for a representative employee. This example assumes an employee who is married and has one child.

Review your family’s medical, dental and vision care bills to estimate your expected expenses for the next Plan Year. INCLUDE ONLY THOSE EXPENSES NOT PAID BY A GROUP HEALTH PLAN OR INSURANCE.

	<u>Example</u>	<u>You</u>
1. Medical, Dental and Vision Care Deductibles	\$ 1,500	_____
2. Your share of Medical, Dental and Vision Care Copayments	200	_____
3. Coinsurance	_____	_____
4. Charges over “reasonable and customary”	_____	_____
5. Surgical Expenses	_____	_____
6. Routine Health Exams and Lab Work	_____	_____
7. Prescriptions (including prescribed over-the counter medications)	_____	_____
8. Vision Exams, Glasses, Contact Lenses	150	_____
9. Hearing Aids	_____	_____
10. Outpatient Psychiatric Care	_____	_____
11. Orthodontia	450	_____
12. Physical Examinations	_____	_____
13. Other Allowable Expenses	_____	_____
TOTAL ESTIMATED MEDICAL EXPENSES NOT PAID BY A GROUP HEALTH PLAN OR INSURANCE	\$ 2,300	_____
14. Divide the total by 12	\$ 191.66	_____

This is the monthly figure you should consider redirecting to your Health Care Flexible Spending Account.

The **maximum** amount by which you can reduce your compensation in order to have contributions contributed to either (i) a Health Care Flexible Spending Account or (ii) a Limited Use Health Care Flexible Spending Account on your behalf is **\$3,050** for each full year while you are a Participant. The Plan Sponsor may also establish a minimum contribution amount for future Plan Years. If a minimum amount is required, you will be informed of such amount before the start of the applicable Plan Year.

Privacy of Your Health Information Received by the Health Care Flexible Spending Account Benefit

The Health Care Flexible Spending Account Benefit is subject to the standards for privacy (“**Privacy Standards**”) issued under the Health Insurance Portability and Accountability Act of 1996, also known as “HIPAA.” The Health Care Flexible Spending Account Benefit is also subject to a second set of regulations issued under HIPAA that govern the security of health information which is stored or transmitted electronically (“**Security Standards**”). The HIPAA Privacy and Security Standards require the Health Care Flexible Spending Account Benefit to protect the privacy

and security of any health information that it receives or creates that either identifies you or can be used to identify you. This health information is called “Protected Health Information” or “PHI.” It is called “Electronic Protected Health Information” or “ePHI” when it is stored or transmitted in an electronic format. Specifically, the Health Care Flexible Spending Account Benefit cannot use or disclose PHI (including ePHI) in any way that would violate the HIPAA Privacy or Security Standards or the Company’s privacy and security policies for PHI and ePHI. The HIPAA Privacy and Security Standards also impose a number of other requirements on the Health Care Flexible Spending Account Benefit which are fully described in the attached HIPAA Medical Privacy and Security Appendix.

COBRA

You can elect COBRA continuation coverage for your Health Care Flexible Spending Account Benefit. Please refer to Article XI for more information.

VI. DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT BENEFIT

Benefit Description

You are *not* eligible to participate in the Dependent Care Reimbursement Account Benefit unless the dependent care service for which you file a claim is necessary in order for you to work. If you are married, the service must be necessary for both you and your Spouse to work.

Whether it is day care for children, or special care for disabled people of any age, dependent care is expensive. The Plan can help. You can convert taxable pay into tax-free money to reimburse yourself for out-of-pocket expenses for dependent care.

How Much You Can Convert

If you are eligible and choose to participate in the Dependent Care Flexible Spending Account Benefit, the maximum you can contribute to your account **per month** is the **smallest** of:

- Your annual taxable pay divided by 12; or
- Your Spouse’s annual taxable pay divided by 12.

The maximum you can contribute for a full Plan Year is \$5,000 (\$2,500 for a married person filing a separate return). The minimum amount that you can contribute for a full Plan Year is such amount, if any, as determined by the Company and communicated to Participants prior to the start of a Plan Year.

Here are the reasons for the limitations on the maximum.

There are IRS limits on the amount of money you may convert each year into the Dependent Care Flexible Spending Account. One limit is the lower of the taxable income earned by you or by your Spouse. For example, if your Spouse works part-time and has taxable income of \$1,300 per year, you cannot redirect more than \$1,300 to your account. For these guidelines, your taxable

income is determined after reducing your wages for your pre-tax contributions to the Plan and any other employer-sponsored benefits plans.

The Plan also limits dependent care benefits for a family in any one calendar year to \$5,000. If your Spouse contributes to a dependent care assistance program where he or she works, the two of you can contribute no more than a combined total of \$5,000 each calendar year. The IRS limit is \$2,500 for a married person filing a separate tax return.

For each month your Spouse is a full-time student at an educational institution, he or she is considered to have an income of \$250/month if you have one eligible Dependent, or \$500/month for more than one. A full-time student is someone who enrolls for at least five months during the taxable year for what is considered a full-time course of study in an educational organization (as defined in Code Section 170) and does not attend courses only at night. These limits also apply if your Spouse is a Qualifying Individual who is mentally or physically incapable of caring for himself or herself.

Eligibility Requirements

For dependent care expenses to be eligible for reimbursement, you must be working during the time your eligible Dependent is receiving care. Your eligible Dependents are those individuals who meet the definition of a Qualifying Individual. If you are married, your Spouse must be:

- A wage-earner;
- A full-time student for at least five months during the year; or
- A Qualifying Individual who is mentally or physically disabled and unable to provide care for himself or herself.

If you are divorced or legally separated, you may be able to use the Dependent Care Flexible Spending Account Benefit to reimburse yourself for dependent care expenses for your children who are under the age of 13, or physically or mentally incapable of caring for themselves, provided (a) your children resided with you for a longer period of the calendar year than with the other parent, (b) you and your child's other parent contribute more than half of the child's support, and (c) the child is in the custody of either one or both of you for more than half of the taxable year, in accordance with Code Section 21(e)(5).

If you file a federal income tax return, you may be eligible to receive a tax credit for dependent care expenses. However, you cannot claim the tax credit for any dependent care expenses that are paid from the Dependent Care Flexible Spending Account. You should consult a tax advisor to help you determine whether the Dependent Care Flexible Spending Account Benefit or the tax credit would be best for your particular situation. Some additional information is provided below. Also you may receive free information from the IRS at www.irs.gov (Publications 17 and 503).

Expenses Eligible for Reimbursement

In general, if you meet the eligibility requirements, you may be able to use the money in your Dependent Care Flexible Spending Account to pay yourself back for out-of-pocket expenses for the care of:

- Your child under age 13 who is a Qualifying Individual; or
- Your Spouse and your eligible Dependents of any age, who (i) are Qualifying Individuals, (ii) normally spend at least eight hours in your home each day if the services are rendered outside the home, (iii) are mentally or physically incapable of caring for themselves, and (iv) have the same principal place of abode as you for more than half of the taxable year.

Generally, these expenses must meet all of the following conditions for them to be eligible dependent care expenses:

- The expenses are incurred for services rendered after the date that you elect to participate in the Dependent Care Flexible Spending Account Benefit and during the Plan Year to which it applies.
- The expenses are incurred for the care of an eligible Dependent (as described above), or for related household services, and are incurred to enable you to be gainfully employed.
- If the expenses are incurred for services outside your household and such expenses are incurred for the care of an eligible Dependent who is age 13 or older, such Dependent regularly spends at least 8 hours per day in your home.
- If the expenses are incurred for services provided by a dependent care center (*i.e.*, a facility that provides care for more than six (6) individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.
- The expenses are not paid or payable to a child of yours who is under age 19 at the end of the year in which the expenses are incurred or an individual for whom you or your Spouse is entitled to a personal tax exemption as a dependent.

These expenses include charges for such things as:

- Licensed nursery school and day care centers for children;
- Licensed day care centers for disabled Dependents; and
- Individuals who have the responsibility of providing care for your eligible Dependents, either inside or outside your home. If outside your home, generally the provider must meet all licensing requirements.

IRS regulations do not allow reimbursement for such expenses as:

- Days you are not working, including sick leave, vacation days, or breaks between semesters;
- Care provided by your children who are under the age of 19 or by anyone you claim as a dependent for federal income tax purposes;
- Transportation, education, clothing, or entertainment; and
- Babysitting for social events.

Only expenses that are adequately documented will be reimbursed.

Food and education will be covered if provided by the nursery school or day care center as part of its preschool care services. Food and education expenses are not covered for kindergarten or higher.

The IRS requires the reporting of the Taxpayer Identification Number or Social Security Number and name and address of the dependent care provider with each request for reimbursement.

Tax Deduction vs. Dependent Care Flexible Spending Account Benefit?

You can pay eligible expenses through the Dependent Care Flexible Spending Account Benefit with pre-tax dollars, or take a tax credit for these expenses on your federal income tax return. You cannot have expenses paid through your account and then take the tax credit for the same expenses. The method that produces the greater tax savings for you depends on your personal situation. Therefore you should determine, before enrolling in the account, that reimbursement is more advantageous than a tax credit. Here are some general guidelines to keep in mind as you make your decision.

The dependent care tax credit is a reduction of your federal income tax for dependent care expenses that permits you – or, if you are married, you and your Spouse – to continue to work. It is subtracted from your actual tax liability. In contrast, the Dependent Care Flexible Spending Account Benefit reduces your taxable income before your taxes are calculated.

The amount of the federal tax credit is a percentage of your eligible dependent care expenses. Your income level determines the percentage used in calculating the tax credit. The percentage decreases gradually.

The IRS limits the amount of dependent care expenses which are eligible for a tax credit on your federal income tax return. The actual amount of your tax credit is determined by applying a percentage to your total work-related, dependent care expenses. Currently, these expenses may not exceed \$3,000 for one eligible Dependent or \$6,000 for two or more eligible Dependents (and these limits may be revised from time to time).

You do not have to itemize expenses on your income tax return to qualify for a tax credit for dependent care expenses. In general, the higher your tax bracket, the more advantageous it is for you to use the Dependent Care Flexible Spending Account Benefit rather than take a tax credit. Keep in mind that your tax credit will be reduced by the amount excluded from your income under

the Dependent Care Flexible Spending Account Benefit. For example, if you have two eligible Dependents, incur \$6,000 in day care expenses, and pay \$4,800 on a tax-free basis through your account, under current IRS rules, you could be eligible for a tax credit with respect to the remaining \$1,200, since the maximum tax credit is based on \$6,000 in dependent care expenses (for two or more Dependents), and \$4,800 has been offset by the \$4,800 you contributed to your account. You are advised to consult with your personal tax advisor to decide what is best for your particular situation.

Amounts used to calculate your tax credit will be reduced, dollar for dollar, by any amounts paid from the Dependent Care Flexible Spending Account. For example, if you \$3,000 in eligible dependent care expenses for one child, and elected to pay \$1,000 of those expenses through your Dependent Care Flexible Spending Account Benefit, the expenses you could claim under the tax credit would be reduced by that \$1,000 reimbursement to \$2,000 (\$3,000 limit - \$1,000 of expenses). However, you could elect during open enrollment to pay the entire \$3,000 in expenses through your Dependent Care Flexible Spending Account Benefit by redirecting \$3,000 of your compensation to such Account.

Estimating Your Reimbursable Dependent Care Expenses

It is very important that you use all of the money in your Dependent Care Flexible Spending Account for a Plan Year because unused amounts by law must be forfeited and will not be returned back to you. Good planning and careful estimating are the best ways to take full advantage of your account. You have 90 days after the end of the Plan Year to submit claims for reimbursement that were incurred during that Plan Year.

The worksheet below can help you determine the amount of your Compensation that you might consider redirecting into a Dependent Care Flexible Spending Account. Part of the worksheet shows an example of estimated amounts for a representative employee. The example assumes an employee who is married and has one child.

Review your records for the last few months and estimate your expected dependent care expenses for the Plan Year:

	<u>Example</u>	<u>You</u>
1. Child Day Care Expenses	\$2,400	_____
2. Pre-School Expenses	_____	_____
3. Summer Day Camp Expenses	_____	_____
4. Adult Day Care Expenses	_____	_____
5. Other Eligible Expenses	_____	_____
TOTAL ESTIMATED DEPENDENT CARE EXPENSES	\$2,400	_____
6. Divide the total amount by 12	\$ 200	_____

This is the *monthly* figure you might consider contributing to your Dependent Care Flexible Spending Account. Remember, if you participate, the maximum you can contribute in any month is the ***smallest*** of:

- Your annual taxable pay divided by 12; or
- Your Spouse's annual taxable pay divided by 12.

The annual limits for a full year are as follows:

- \$5,000 (\$2,500 for a married spouse filing a separate return); or
- The IRS limits explained earlier in this SPD.

Requesting Reimbursement

If you have a Dependent Care Flexible Spending Account, you may submit your dependent care expenses using a special request form that is available at *Your Benefits Resources* online at www.yourbenefitsresources.com/bmc or by calling 1-877-262-4849. This form, along with all related bills and receipts, should be submitted to as directed on the form to obtain reimbursement. IRS regulations require you to provide the name, address, and taxpayer identification (the Social Security Number in some cases) of your dependent care service provider on your reimbursement request form.

An account statement will be provided to you periodically and at least once per year on or before January 31. If you submit a request for more than your account balance, partial payment will be made with the funds available. Remaining amounts will be paid when additional deposits have been credited to your account.

If you terminate employment, under a special dependent care “spend-down provision”, you may submit reimbursement claims for eligible dependent care expenses incurred through the end of the Plan Year in which your employment terminated. *You cannot elect COBRA continuation coverage for your Dependent Care Flexible Spending Account Benefit.*

VII. TAX ADVANTAGES OF THE FLEXIBLE SPENDING ACCOUNTS'

By using the Plan to help pay for your contributions and premiums for coverage under the Group Health Plans and the other Covered Benefits on a pre-tax basis, as well as for medical and dependent care expense reimbursements, you may take home more of your pay. The amounts you contribute to the Health Care Flexible Spending Account (or Limited Use Health Care Flexible Spending Account) and the Dependent Care Flexible Spending Account are not subject to:

- Federal income taxes;
- Social Security and Medicare (FICA) taxes; and
- In many cases, state and local income taxes.

This chart illustrates the potential tax savings when using the Flexible Spending Accounts.

If you contribute	Your annual tax savings could be:
\$500	\$173
\$1,000	\$347
\$1,500	\$520
\$2,000	\$693
\$3,000	\$1,040
\$4,000	\$1,386
\$5,000	\$1,733

These tax savings are based on a 27% personal federal income tax rate and the FICA rate of 7.65%. If your income tax rate is higher, and/or you also pay state and local taxes, you could save even more in taxes by using the Reimbursement Accounts. Note: This is an example. Your personal tax situation may differ.

VIII. REIMBURSEMENT RULES FOR FLEXIBLE SPENDING ACCOUNTS

If you submit a claim for dependent care expense reimbursement for more than is currently in your Dependent Care Flexible Spending Account, a partial reimbursement (up to the amount you have in your account) will be made. Then, as more money goes into your account, you will continue to be reimbursed until the entire eligible expense is covered. On the other hand, medical expense reimbursement claims are reimbursed based on the dollar amount of coverage you elected for the entire Plan Year, even though even though you may not have currently contributed amounts to your Health Care Flexible Spending Account (or Limited Use Health Care Flexible Spending Account, as applicable) equal to the medical expense reimbursement claimed.

If you terminate employment during the year, any eligible expenses you incurred while still employed by the Employer are reimbursable under your Health Care Flexible Spending Account or Limited Use Health Care Flexible Spending Account to the extent of your previously elected coverage limit for the Plan Year, and any eligible expenses you incurred during the Plan Year in which your employment terminated are reimbursable under your Dependent Care Flexible Spending Account to the extent of the remaining cash in such Account. You must file all claims for reimbursement against your Dependent Care Flexible Spending Account, Health Care Flexible Spending Account, or Limited Use Health Care Flexible Spending Account within 90 days following the end of the Plan Year in which your employment terminated. Your Spouse and Dependents may continue submitting claims during that period if you should die.

IX. HOW TO PARTICIPATE IN THE FLEXIBLE SPENDING ACCOUNTS

If you are a current Employee who is eligible to participate in the Flexible Spending Account Benefits, you must fill out a written or electronic enrollment form and return it to *Your Benefits Resources*, online at www.yourbenefitsresources.com/bmc or by telephone at 1-877-262-4849, by the designated due date. The form must be completed and returned or posted during the open enrollment period unless you incur a Change in Status Event. Employees who are hired during a Plan Year should visit www.yourbenefitsresources.com/bmc or call 1-877-262-4849 to obtain an enrollment form.

X. HEALTH SAVINGS ACCOUNT FUNDING BENEFIT

Your Health Savings Account is not a Covered Benefit under the Plan. You have the responsibility of establishing and maintaining your Health Savings Account if you are eligible. The Health Savings Account Funding Benefit under the Plan allows you to contribute to your Health Savings Account on a pre-tax basis. This means that your Employer will deduct the amount you elect as salary reduction contributions from your paycheck and contribute it, along with any Employer nonelective contributions, to your Health Savings Account on your behalf.

Eligibility

An Employee will be eligible to participate in the Health Savings Account Funding Benefit on the first day of any month if the Employee meets the following requirements on such day:

- Is a participant in the Employer's High Deductible Health Plan;
- Meets the eligibility requirements under the Internal Revenue Code for participation in a Health Savings Account (based solely on the Employee's certification of his status); and
- Establishes a Health Savings Account through the person or entity that has been designated by the Plan Sponsor to serve as the custodian of the HSAs.

An Employee who is covered under a Spouse's general-purpose health flexible spending arrangement or health reimbursement arrangement will not be permitted to participate in the Health Savings Account Funding Benefit.

Contribution Amounts

The amount that you can contribute to your Health Savings Account is regulated by the Internal Revenue Service. The maximum you can contribute depends on whether you have employee-only coverage, family or any other level of coverage under the Employer's High Deductible Health Plan. For 2023, the annual maximum that can be contributed to your Health Savings Account is \$3,850 if you have employee-only coverage, or \$7,750 if you have any other coverage level. In addition, you may be eligible to make age-related "catch up contributions" of up to \$1,000 in the aggregate if you (i) will have attained age 55 by the end of the taxable year, and (ii) are not enrolled in Medicare. It is your responsibility to ensure that you comply with the foregoing limits.

Your Employer may decide to make a nonelective contribution to your Health Savings Account. If so, you will be notified of the amount of the contribution before the beginning of the Plan Year. Any Employer contribution to your Health Savings Account counts towards the maximum amount that you may contribute for the year.

At any time, you can change the amount you want to contribute to your Health Savings Account. Any such change will be effective as of the next administratively feasible payroll period. However, you must make a new election before the start of each Plan Year. If you do not make an election before the start of the Plan Year, you will not be able to participate in the Health Savings

Account Funding Benefit for the Plan Year, unless you prospectively change your election for this benefit during the Plan Year.

Note: You cannot elect COBRA continuation coverage for your Health Savings Account Funding Benefit.

XI. PLAN RULES AND LIMITATIONS

Possible Effect of Plan On Social Security Benefits

Because you do not pay Social Security taxes on your Compensation that is contributed to the Plan, your eventual Social Security benefits at retirement or disability may be reduced. Any reduction will depend on the length of time between now and when you retire (or become disabled) and whether or not your taxable income exceeds the Social Security maximum wage level.

For most Employees, the advantages of using the money tax-free would likely outweigh any potential reduction in Social Security benefits in the future.

When Coverage Ends

Your coverage under the Plan ends when you choose not to participate for a Plan Year. Also, your coverage ends when:

- You are no longer an eligible Employee;
- You terminate employment for whatever reason;
- You validly revoke your existing elections or fail to make a required contribution to the Plan;
- The Plan is amended to terminate participation with respect to the class of Employees of which you are a member; or
- The Plan is terminated.

What Expenses Are Not Covered

In addition to the IRS restrictions listed in the above sections about the Health Care Flexible Spending Account, Limited Use Health Care Flexible Spending Account and the Dependent Care Flexible Spending Account, there are some general rules about expenses that are not eligible for reimbursement. Expenses that are not covered under the Plan include:

- Expenses claimed as a deduction or credit for federal income tax purposes;
- Expenses reimbursed under any other policy or plan, including Medicare or other federal programs; and

- Expenses incurred before you enrolled in the Plan.

To be eligible for reimbursement, the expense must be incurred during your Period of Coverage (subject to the dependent care “spend-down provision” applicable to the Dependent Care Flexible Spending Account, as described in Article VI). *An expense will be incurred when the service is rendered regardless of when the claim is paid.* You should remember this when you estimate your expenses.

There is an exception to the above rule for orthodontia services. If you are required to make payments before you, your Spouse or your Dependent receives orthodontia services, you can be reimbursed after you make this payment, even if it is before the orthodontia services are rendered, provided that the orthodontia treatment to which such services are related, such as “banding”, has already begun.

The money in your Health Care Flexible Spending Account can only be used for qualifying health expenses, and the money in your Limited Use Health Care Flexible Spending Account can only be used for qualifying health expenses incurred for preventive care or dental or vision care before you meet your deductible under the High Deductible Health Plan. After you meet your deductible under the High Deductible Health Plan, the Limited Use Health Care Flexible Spending Account can be used for the reimbursement of any qualifying health expense. Likewise, the money in your Dependent Care Flexible Spending Account can only be used for qualifying dependent care expenses. You cannot transfer money between these accounts.

Changing Your Plan Election (Change in Status Events)

Because the Plan allows you to save money on your taxes, the IRS has placed some restrictions on “cafeteria plans” like the Plan.

Generally you cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections. These are called “Change in Status Events”. You are permitted to change your Flexible Spending Account or other Covered Benefit elections if you have a “Change in Status Event” that applies to the particular Flexible Spending Account or Covered Benefit, as described in the Plan. The IRS considers the following events to be examples of Change in Status Events:

- You get married or divorced.
- You have a child or adopt one.
- Your Spouse or one or more of your children dies.
- You, your Spouse, or your Dependent commences or terminates employment.
- You or your Spouse take an unpaid leave of absence.
- Your Spouse has a change in coverage directly attributable to your Spouse’s employment.

- You qualify for special enrollment under the Group Health Plan due to the Health Insurance Portability and Accountability Act (“**HIPAA**”), including special enrollment rights provided under the Children’s Health Insurance Program Reauthorization Act of 2009 and the Affordable Care Act.
- You (or your Spouse or Dependent) change your place of residence or work.
- You receive a court order resulting from a divorce, legal separation, annulment, or change in legal custody that requires health coverage for your child.
- You or your Spouse or Dependent become entitled to Medicare or Medicaid coverage.

There are other events that are considered to be Change in Status Events, as described in the Plan and IRS regulations. *All election changes must be consistent with the Change in Status Event* and comply with the other conditions of the Plan and IRS regulations. That means, for example, you cannot drop coverage because you gained a new Dependent child.

If you believe you have a Change in Status Event and want to change your election, you must visit www.yourbenefitsresources.com/bmc or call 1-877-262-4849 to request a written or electronic election form for changing your benefit elections. ***You must notify the Plan Administrator via written or electronic election of a Change in Status Event within thirty-one (31) days of its occurrence.*** However, if you have a gain or loss of eligibility for coverage under a Medicaid plan or a State child health plan under Title XXI of the Social Security Act that qualifies as a HIPAA special enrollment event, you must notify the Plan Administrator within sixty (60) days of the event. This section provides an overview of the circumstances when a mid-year election change may be permitted under the Plan. You must refer to the actual Plan document for complete information.

With respect to Covered Benefit elections, including Flexible Spending Account elections, any election change made during the Plan Year will not be effective until the date designated by the Plan Administrator, which effective date will not be before the date that the completed and signed election change form is received and accepted by the Plan Administrator (or, if the form is electronic, posted online in accordance with the Plan’s procedures). However, changes pursuant to HIPAA special enrollment rights for the acquisition of a Dependent child due to birth, adoption or placement for adoption will be effective as of the date of the birth, adoption or placement. You must submit a form through Your Benefits Resources (online or by telephone) to notify the Plan Administrator of a Change in Status Event within thirty-one (31) days of its occurrence (or within sixty (60) days in the case of certain HIPAA special enrollment rights related to CHIP or Medicaid).

During the open enrollment period before the beginning of each Plan Year, you can change your elections before the start of the Plan Year, even if you did not have a Change in Status Event, upon your timely submission of a change form to *Your Benefits Resources* (online at www.yourbenefitsresources.com/bmc or by telephone at 1-877-262-4849 and its receipt and acceptance by the Plan Administrator.

Using All Contributions Made to Your Flexible Spending Accounts

Based on IRS regulations and the terms of the Plan, if there is any money left in any of your Flexible Spending Accounts after all reimbursable claims have been paid for a Plan Year, that money will be forfeited and will not be returned back to you. Without exception, you will not be able to receive any unused balance left in your account. This is sometimes called the “use it or lose it rule.”

Limitations that Apply to Highly Compensated and Key Employees

“Highly compensated employees” and “key employees” generally are Participants who are officers, shareholders or highly paid employees as defined in the Code. If you are within these categories, the amount of your contributions and benefits may be limited so that the Plan as a whole does not disproportionately favor such employees and their Spouses and Dependents.

Plan experience will dictate whether contribution limitations on “highly compensated employees” or “key employees” will apply. You will be notified if you are affected by these limits.

Denial of Claim for Benefits

If you have a claim for benefits under one of the Covered Benefits, you will generally proceed under the claim procedures applicable to that particular Covered Benefit. However, if you are denied a benefit under the Plan (such as the ability to pay for contributions or premiums on a pre-tax basis) due to an issue that is solely germane to your coverage under the Plan (e.g., determination of a Change in Status Event), the claim procedures under the Plan will apply. You will be notified in writing by the Plan Administrator within 60 days of the date you submitted your request if the request is denied. Such notification will set out the reasons your request was denied, and advise you of the steps, if any, that you can take to validate your claim. It will further advise you of your right to request an administrative review of the claim denial; you may request a review any time within the 60-day period after you have received notice of the claim denial. You or your authorized representative will have the opportunity to review any relevant documents held by the Plan Administrator, and to submit comments and other supporting information. In most cases, a decision will be reached within 60 days of the date of your request for a review, and you will be notified of such decision.

Denial of Claim for Benefits under the Health Care Flexible Spending Account Benefit

A description of the procedures governing the denial and appeal of a claim for benefits under the Health Care Flexible Spending Account Benefit is contained in the attached “Claims Procedures for Health Care Flexible Spending Account Benefit Appendix”. Please note that different time limitations apply for making claims for benefits and appealing denied claims under the Health Care Flexible Spending Account.

COBRA Continuation Coverage

Federal law requires most employers sponsoring group health plans to offer employees and their covered dependents the opportunity for a temporary extension of health care coverage (called “COBRA continuation coverage”) at group rates in certain instances where coverage under the plans

would otherwise end. These rules apply to the Health Care Flexible Spending Account Benefit (and any other Group Health Plans offered as Covered Benefits under the Plan).

The rules regarding COBRA coverage which apply to the Health Care Flexible Spending Account Benefit are described in the following sections. The Group Health Plans offered as Covered Benefits under the Plan maintain separate COBRA coverage provisions. References to “Plan” in the following sections regarding COBRA coverage mean the Health Care Flexible Spending Account Benefit.

Eligibility

Subject to the other rules regarding COBRA coverage below, a Participant (and/or his Spouse and Dependents) is eligible for COBRA coverage under his Health Care Flexible Spending Account or Limited Use Health Care Flexible Spending Account, as applicable. The Participant (and or/his Spouse and Dependents) who is a Qualified Beneficiary (defined below) may elect COBRA coverage under the Health Care Flexible Spending Account Benefit only through the last day of the Plan Year in which his Qualifying Event occurred.

If you are a Participant in the Health Care Flexible Spending Account Benefit and you are eligible for COBRA coverage, then you have a right to choose continuation coverage under the Health Care Flexible Spending Account Benefit if you lose your coverage because of:

- A reduction in your hours of employment;
- A voluntary or involuntary termination of your employment (for reasons other than gross misconduct);
- A military leave of absence that lasts thirty-one (31) days or longer (in accordance with USERRA, as discussed below); or
- Your failure to return from FMLA leave.

If you are the Spouse of a Participant who is eligible for COBRA coverage, then you have the right to choose continuation coverage for yourself if you lose coverage for any of the following reasons:

- Death of the Participant;
- The Participant becomes entitled to Medicare benefits (under Part A, Part B, or both);
- Voluntary or involuntary termination of the Participant’s employment (for reasons other than gross misconduct) or reduction in the Participant’s hours of employment;
- Divorce or legal separation from the Participant; or
- Failure of the Participant to return from FMLA leave.

In the case of a Dependent child of a Participant who is eligible for COBRA coverage, such child has the right to choose continuation coverage if coverage is lost for any of the following reasons:

- Death of the parent-Participant;
- Voluntary or involuntary termination of the parent-Participant's employment (for reasons other than gross misconduct) or reduction in the Participant's hours of employment;
- The parent-Participant becomes entitled to Medicare benefits (Part A, Part B, or both);
- His or her parents' divorce or legal separation;
- He or she ceases to be an eligible Dependent child under the provisions of the Plan; or
- Failure of the parent-Participant to return from FMLA leave.

A Dependent child who is born to, or placed for adoption with, the Employee during a period of continuation coverage is also entitled to continuation coverage under COBRA. Those who are entitled to COBRA continuation coverage are called “**Qualified Beneficiaries**”.

Notice of Qualifying Event

The Plan will offer COBRA coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a qualifying event as described above (“**Qualifying Event**”) has occurred. When the Qualifying Event is the end of employment or reduction of hours of employment, death of the Employee, or the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the Plan Administrator of the Qualifying Event within thirty (30) days after it occurs. For the other Qualifying Events (divorce or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Plan Administrator within a maximum of sixty (60) days after the latest of (a) the Qualifying Event, (b) the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event, or (c) the date on which you are informed, including through this SPD or a COBRA general notice, of your responsibility to provide a Qualifying Event notice as described in this section and the Plan's procedures for providing such notice. You must provide this notice to the Plan's COBRA Administrator, as designated below in the section of this SPD entitled “Questions and Other Information Regarding COBRA Coverage”. This notice must be in writing and must contain the name of the Qualified Beneficiary, the name of the Plan to which the notice applies, a description of the Qualifying Event, and the date on which the Qualifying Event occurred. If you mail the notice, it must be postmarked no later than the last day of the applicable notice period described above. Failure to make timely notification will result in a termination of the Qualified Beneficiary's rights to COBRA coverage under the Plan.

If you choose continuation coverage, you may continue the level of coverage you had in effect immediately preceding the Qualifying Event. However, if Plan benefits are modified for similarly situated active Employees, then they will be modified for you and other Qualified Beneficiaries as well. You will be eligible to make a change in your benefit election with respect to the Plan during your COBRA coverage period upon the occurrence of any event that permits a similarly situated active Employee to make a benefit election change during a Plan Year.

If you do not choose continuation coverage, your coverage under the Health Care Flexible Spending Account Benefit will end with the date you would otherwise lose coverage.

Birth, Adoption or Placement for Adoption of a Child

A Qualified Beneficiary must notify the Plan Administrator in writing or by electronic election of the birth to, adoption by or placement for adoption of a child with a Participant receiving COBRA coverage. This notice must contain (a) the name of the Participant, (b) the name of the Plan to which the notice applies, (c) the reason for the notice (*i.e.*, the birth, adoption or placement for adoption of a child, as applicable), and (d) the date of such child's birth, adoption or placement for adoption.

Electing COBRA Continuation Coverage

Each Qualified Beneficiary is entitled to make a separate election for continuation coverage under the Plan. In order to elect continuation coverage, you must complete the election form(s) provided to you by the Plan Administrator. You have a maximum of sixty (60) days from the date you would lose coverage for one of the reasons described above or the date you are sent notice of your right to elect continuation coverage, whichever is later, to provide your completed election form to the Plan Administrator indicating that you wish to continue coverage. Failure to return the election form within the maximum 60-day period will be considered a waiver, and you will not be allowed to elect continuation coverage.

Contributions

You will have to pay the entire cost of your continuation coverage. The cost of your continuation coverage will not exceed 102% of the applicable cost for the period of continuation coverage. The first contribution payment after electing continuation coverage will be due forty-five (45) days after making your election. Subsequent contributions must be paid within a 30-day grace period following the due date. Failure to pay contributions within this time period will result in termination of your continuation coverage. Claims incurred during any period will not be paid until your contribution payment is received for that period. If you timely elect continuation coverage and pay the applicable contribution, then continuation coverage will relate back to the first day on which you would have lost regular coverage.

Duration of COBRA Continuation Coverage

The maximum period for which coverage may be continued under the Health Care Flexible Spending Account Benefit will be until the end of the Plan Year in which the Qualifying Event occurs. You will be notified of the duration of continuation coverage when you have a Qualifying Event. However, continuation coverage may end earlier for any of the following reasons:

- The contribution for your continuation coverage is not paid on time or it is insufficient (Note: If your payment is insufficient by the lesser of 10% of the required COBRA contribution, or \$50, you will be given thirty (30) days to cure the shortfall);
- The date that you first become covered under another group health plan under which you are not subject to a pre-existing condition exclusion limitation, after you elect continuation coverage;
- The date that you first become entitled to Medicare, after you elect continuation coverage; or
- The date the Employer ceases to maintain a group health plan within its controlled group.

Questions and Other Information Regarding COBRA Coverage

It is your responsibility to keep the Plan Administrator informed of any changes in the address of you, your Spouse and your Dependents. You should also keep a copy for your records of any notices you send to the Plan Administrator.

Questions concerning your COBRA coverage rights should be directed to the third party administrator responsible for administering COBRA on behalf of the Plan Administrator, as follows:

BMC Software, Inc.
P.O. Box 661098
Dallas, TX 75266-1098

If the Company changes COBRA administrators or you are unable to reach the above-referenced COBRA administrator, you should direct your questions to the Plan Administrator at the address and telephone number listed in Article XIII of this SPD entitled “General Plan Information”.

Coverage While on Duty in the Uniformed Service

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (“**USERRA**”). Accordingly, if you are absent from work due to a period of active duty in the Uniformed Services for less than thirty-one (31) days, your Plan participation will not be interrupted and you will not be required to pay more than the Employee share for such coverage.

Thereafter, you may elect to continue coverage under the Plan for you and your family members for up to twenty-four (24) months. You will be required to pay up to 102% of the applicable cost for any portion of your absence that exceeds thirty-one (31) days. You must pay the contributions with after-tax funds, subject to the rules that are set out in the Group Health Plans. Your coverage under this section will run concurrently with COBRA Continuation Coverage described above in this SPD. However, continuation coverage extended under USERRA is not subject to the early termination provisions of COBRA or the provisions of COBRA allowing for an extension due to a subsequent Qualifying Event.

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

Family and Medical Leave of Absence

If you are absent from work on a leave of absence covered by the Family and Medical Leave Act (“**FMLA**”), you are entitled to maintain the health coverage you have under the Plan during your absence. You must pay the contributions for the coverage during your absence using one of the following alternative methods:

- *Pay-as-you-go.* With the pay-as-you-go option, you continue to pay contributions on a regular basis throughout the FMLA leave. If your FMLA leave is paid by a third-party administrator, or is unpaid, and you choose this option, you must pay the contributions directly during the course of your leave, on an after-tax basis, with your contributions being due for each month of coverage on the first day of each month.
- *Agreement with Employer.* You may pay your contributions by any other method that is voluntarily agreed to between you and your Employer and that is not inconsistent with applicable IRS regulations.

If your Employer pays a portion of your contributions for such coverage, it must continue those payments during your FMLA leave (unless your coverage is terminated as permitted under FMLA). However, if you do not return from FMLA leave, you may be required to repay the Employer-paid portion of the health contributions. Please refer to your Employer’s FMLA Policy for additional information.

If you go on an unpaid leave of absence which is not pursuant to the FMLA as set out above, and your leave of absence does not affect your eligibility for coverage, then you may continue to participate in the Plan, and unless otherwise agreed by your Employer, you must pay the contributions due through after-tax contributions while on your leave. If you go on a paid leave of absence, you will continue participation and pre-tax contribution payments under the Plan.

XII. CONCLUSION

The Plan offers a unique and efficient way of saving money on taxes. Through convenient payroll redirection, you can save money on your share of the contributions for the plans listed in the

Covered Benefits Appendix. You may also save money by paying for out-of-pocket medical and dependent care expenses through the Flexible Spending Account Benefits offered under the Plan, or by contributing to your HSA. In addition, through proper planning, you can be better prepared for the predictable medical and dependent care expenses that affect you and your family.

The money you earn is important to you and your family. You need it to pay your bills, enjoy recreational activities, and save for the future. The Plan will help you keep more of your income by lowering the amount of taxes you pay. The Plan contributes to our continuing efforts to find ways to help you get the most for your money.

BMC Software, Inc.

XIII. GENERAL PLAN INFORMATION

The Company is pleased to continue to sponsor the Plan for the benefit of our Employees. We value your efforts and hope that your participation will enable you to look with continued confidence to your future with us.

Plan Name:	BMC Software, Inc. Cafeteria Benefit Plan
Plan Sponsor:	BMC Software, Inc. 2103 CityWest Blvd. Houston, TX 77042 1-877-262-4849
Plan Number:	512
Employer Identification No.:	74-2126120
Plan Administrator:	BMC Software, Inc. 2103 CityWest Blvd. Houston, TX 77042 1-877-262-4849
Claims Administrator:	<i>For claims:</i> Alight, Inc./Your Benefits Resources www.yourbenefitsresources.com/bmc
Funding Medium:	Employer contributions and employee covered benefits contributions.
Agent for Service of Legal Process:	Service of process may be made to the Plan Administrator.
Amendment and Termination:	The Company intends to continue the Plan indefinitely, but reserves the right to amend or terminate the Plan at any time for any reason pursuant to the procedures described in the Plan. This SPD is intended to be brief; consequently, in the case of any conflict between the terms and provisions of the Plan (including each Covered Benefit available under the Plan), and the terms and provisions of this SPD, the Plan will control and govern.
Covered Benefits:	See attached Covered Benefits Appendix.
Adopting Employers:	See attached Adopting Employers Appendix.

XIV. YOUR RIGHTS UNDER ERISA

Although the Plan itself is not an “employee welfare benefit plan” as defined in the Employee Retirement Income Security Act of 1974 (ERISA), certain Covered Benefits, such as the Health Care Flexible Spending Account Benefit and the Company’s Group Health Plans (collectively referred to in this Article XIV as the “**ERISA Plan**”), are governed by ERISA. With respect to any of those benefits which are subject to ERISA, you, as a Plan Participant, are entitled to certain rights and protections under ERISA, as follows:

Receive Information About Your Plan and Benefits

Examine, without charge, at the ERISA Plan administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the ERISA Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the ERISA 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 ERISA Plan administrator, copies of documents governing the operation of the ERISA Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description of the ERISA Plan. The administrator may make a reasonable charge for the copies.

Receive a summary of the ERISA Plan’s annual financial report. The ERISA Plan administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the ERISA Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this SPD and the documents governing the ERISA Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for ERISA Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the ERISA Plan. The people who operate the ERISA Plan, called “fiduciaries” of the ERISA Plan, have a duty to do so prudently and in the interest of you and other ERISA Plan 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 welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of ERISA Plan documents or the latest annual report from the ERISA 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 ERISA 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, and you disagree with that denial, you must file an appeal of that denial in accordance with the claims procedures described in this SPD, including any Appendices hereto, or in the other applicable ERISA Plan documents. If your appeal is denied, and you have exhausted the administrative remedies provided to you under the applicable claims procedures, you may file suit in a state or Federal court. In addition, if you disagree with the ERISA 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 ERISA Plan fiduciaries misuse the ERISA 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 the ERISA Plan, you should contact the ERISA 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 ERISA 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.

**SUMMARY PLAN DESCRIPTION OF THE
BMC SOFTWARE, INC. CAFETERIA BENEFIT PLAN
(Amended and Restated Effective as of January 1, 2023)**

COVERED BENEFITS APPENDIX

As of January 1, 2023, the Covered Benefits, other than cash, offered pursuant to the Plan are coverages under the following employee welfare benefit plans and programs maintained by the Plan Sponsor:

- BMC Software, Inc. Health Benefit Plan;
- Dependent Care Flexible Spending Account Benefit;
- Health Care Flexible Spending Account Benefit, which includes:
 - Health Care Flexible Spending Account; and
 - Limited Use Health Care Flexible Spending Account;
- Health Savings Account Funding Benefit; and
- BMC Software, Inc. Supplemental Accidental Death and Dismemberment Insurance Program.

The operative plan and other documents evidencing the actual terms and provisions of the Covered Benefits are hereby incorporated herein by reference, including any exhibits, amendments or modifications to such documents as in effect from time to time.

**SUMMARY PLAN DESCRIPTION OF THE
BMC SOFTWARE, INC. CAFETERIA BENEFIT PLAN
(Amended and Restated Effective as of January 1, 2023)**

**CLAIMS PROCEDURES FOR HEALTH CARE
FLEXIBLE SPENDING ACCOUNT BENEFIT APPENDIX**

Background

The procedures set forth in this Claims Procedures For Health Care Flexible Spending Account Benefit Appendix apply only to claims submitted under the Health Care Flexible Spending Account Benefit. The reimbursement of expenses covered under the Employer's group health or other welfare benefit plans, as set out in the Covered Benefits Appendix, are governed by separate claims provisions set forth in such other plans.

Claims Procedure

You must submit a claim for benefits under the Health Care Flexible Spending Account Benefit within the timeframe specified in Article V of this SPD. Furthermore, a submitted claim is not treated as filed until all information necessary to process the claim is submitted. If your claim, as originally submitted, is not complete, you will be notified and then have the responsibility for providing the missing information.

Initial Claim Process

The Claims Administrator is responsible for processing all benefit claims under the Health Care Flexible Spending Account Benefit. Accordingly, to obtain benefits, you must complete, sign, and submit a written claim on the designated request form. This request, along with all related bills, must be submitted to the Claims Administrator at the address listed in Article XIII. A claim for benefits may also be submitted by your personal representative.

Applicable Time Limitations For Initial Benefit Decision

The following time limitations apply to claims submitted under the Health Care Flexible Spending Account Benefit:

You will be notified of the benefit determination by the Claims Administrator, regardless of whether the determination is adverse or not, no later than thirty (30) days after your claim for benefits is filed. If the Claims Administrator requires additional time to make a benefit determination for matters beyond the control of the Plan, the time period for making the initial benefit determination may be extended for up to fifteen (15) additional days. If such extension is required, the Claims Administrator will notify you within the initial thirty (30) day period of the circumstances requiring the extension and the date by which a Plan expects to render a benefit decision.

If additional time is required to render a benefit decision because of your failure to submit the information necessary to decide the claim (for example, you fail to submit copies of all bills related to the claim), the notice informing you of the extended period of time required to render a benefit

determination shall also include a specific description of the information necessary to decide the claim. You will then have at least 45 days from the day that you receive the notice to provide the specified information.

Notice of Adverse Benefit Determination

The Claims Administrator will provide written or electronic notification of any adverse benefit determination. The notice will set forth the following:

- The specific reason(s) for the adverse determination;
- Reference to the specific Plan provision(s) on which the determination was based;
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
- A description of the Plan's appeal procedures and the time limits applicable to such procedures, as well as a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review, and any other statement required by law; and
- A statement that the claimant 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 the purposes of the foregoing notice, a document, record, or other information will be considered "relevant" to a claimant's claim if such document, record, or other information:

- was relied upon in making the adverse benefit determination;
- was submitted, considered, or generated in the course of making the adverse benefit determination, without regard to whether such document, record, or other information was relied upon in making the adverse benefit determination;
- demonstrates compliance with any administrative processes and safeguards in making the adverse benefit determination; or
- constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the adverse benefit determination.

In addition, if the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request.

If the adverse benefit determination is based on the fact that the treatment was not medically necessary or the experimental/investigational exclusion or similar exclusion or limit was applied, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

Appeal of Adverse Benefit Determination.

If you receive an adverse benefit determination under the Health Care Flexible Spending Account Benefit, you will have 180 days following your receipt of the notification of the initial benefit determination in which to appeal the decision to the Plan Administrator. You may submit written comments, documents, records, and other information relating to the claim. Upon request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The appeal will take into account all comments, documents, records, and other information that you submitted relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The appeal will not afford deference to the initial adverse benefit determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the initial adverse determination or any subordinate of that person.

If the adverse determination was based 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 fiduciary will consult with a health care professional who was not involved in the initial benefit determination and is not the subordinate of any health care professional that was involved in the initial benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additional medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified upon request.

Applicable Time Limitations For Appeal of Adverse Benefit Decision

The following time limitations will apply for an appeal of an adverse benefit decision under the Health Care Flexible Spending Account Benefit.

The Plan Administrator will notify you of its benefit determination on appeal no later than sixty (60) days after the Plan Administrator receives your request for review.

Notice of Adverse Determination on Appeal

The Plan Administrator will provide written or electronic notification of an adverse benefit determination on appeal. The appeal will set forth the following:

- The specific reason(s) for the adverse determination;

- A reference to the specific Plan provision(s) upon which the determination was based;
- A statement that the claimant 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 claimant's claim for benefits;
- A statement of the claimant's right to bring an action under Section 502(a) of ERISA;
- The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency"; and
- Any other information required by law.

For the purposes of the foregoing notice, a document, record, or other information will be considered "relevant" to a claimant's claim if such document, record, or other information:

- was relied upon in making the adverse benefit determination;
- was submitted, considered, or generated in the course of making the adverse benefit determination, without regard to whether such document, record, or other information was relied upon in making the adverse benefit determination;
- demonstrates compliance with any administrative processes and safeguards in making the adverse benefit determination; or
- constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the adverse benefit determination.

In addition, if the determination was based upon an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or other similar criterion will be provided free of charge. If this is not practical, a statement will be included in the notice of adverse determination that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and a copy will be provided free of charge, upon request.

If the adverse determination was based on a medical necessity, or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge, upon request, will be included in the notice of adverse determination.

**SUMMARY PLAN DESCRIPTION OF THE
BMC SOFTWARE, INC. CAFETERIA BENEFIT PLAN
(Amended and Restated Effective as of January 1, 2023)**

HIPAA MEDICAL PRIVACY AND SECURITY APPENDIX

Background

This HIPAA Medical Privacy and Security Appendix (“**HIPAA Appendix**”) is intended to comply with the requirements under the Health Insurance Portability and Accountability Act of 1996, as amended (“**HIPAA**”), the Standards for Privacy of Individually Identifiable Health Information at 45 CFR part 160 and part 164, subparts A and E (“**Privacy Standards**”) and the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR part 160 and part 164, subpart C (“**Security Standards**”), as promulgated under HIPAA, the HIPAA Enforcement Rule at 45 CFR part 160, subparts C through E (“**Enforcement Rules**”) and the “**Breach Notification Rules**” issued under the Health Information Technology for Economic and Clinical Health Act (“**HITECH**”), as each of the foregoing were amended, generally effective as of September 23, 2013, by the regulations issued on January 25, 2013 (“**HIPAA Omnibus Rules**”). References to any section of the Privacy Standards, the Security Standards, the Enforcement Rules or the Breach Notification Rules shall include any amendments or successor provisions thereto, including the HIPAA Omnibus Rules.

For purposes of this HIPAA Appendix, “Protected Health Information” (“**PHI**”) means information, including genetic information, that is created or received by the Plan which (a) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, (b) identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual, and (c) is transmitted or maintained in any form or medium. “Electronic Protected Health Information” (“**ePHI**”) means individually identifiable health information that is created or received by the Plan and transmitted by or maintained in electronic media.

Designation of Health Care Components and Safeguard

To the extent the Plan is a hybrid entity (as defined by 45 CFR § 164.103 of the Privacy Standards), and, as such, the provisions of this HIPAA Appendix will only apply to the health care component of the Plan (referred to as the “**Health Care Component**”), as set forth below in this HIPAA Appendix. All references to Protected Health Information (PHI) or Electronic Protected Health Information (ePHI) in this HIPAA Appendix refer to PHI or ePHI that is created or received by or on behalf of the Health Care Component. The Health Care Component will thus comply with the following requirements:

- The Health Care Component will not disclose PHI to another component of the Plan in circumstances in which the Privacy Standards would prohibit such disclosure if the Health Care Component and the other component were separate and distinct legal entities; and

- If an employee of the Plan Sponsor performs duties for both the Health Care Component and for another component of the Plan, such employee will not use or disclose PHI created or received in the course of, or incident to, the employee's work for the Health Care Component in a way prohibited by the Privacy Standards.

For purposes of this HIPAA Appendix, the Health Care Component of the Plan is the Health Care Flexible Spending Account Benefit. The Group Health Plans identified in the attached Covered Benefits Appendix maintain separate HIPAA privacy and security provisions.

Use and Disclosure of PHI

The Plan Sponsor may only use and disclose PHI that it receives from the Health Care Component, which is considered a "group health plan" as defined by the Privacy Standards, as permitted and/or required by, and consistent with, the Privacy Standards. This includes, but is not limited to, the right to use and disclose a Participant's PHI in connection with payment, treatment, and health care operations, or as otherwise permitted or required by law. The Plan is prohibited from using or disclosing PHI that is genetic information for underwriting purposes.

Payment includes activities undertaken by the Health Care Component to obtain contributions, premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

- Determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, Plan maximums and copayments as determined for an individual's claim);
- Coordination of benefits or non-duplication of benefits;
- Adjudication of health benefit claims (including appeals and other payment disputes);
- Subrogation of health benefit claims;
- Establishing employee contributions;
- Risk adjusting amounts due based on enrollee health status and demographic characteristics;
- Billing, collection activities and related health care data processing;
- Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to Participant inquiries about payments;
- Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);

- Medical necessity reviews or reviews of appropriateness of care or justification of charges;
- Utilization review, including precertification, preauthorization, concurrent review and retrospective review;
- Disclosure to consumer reporting agencies related to the collection of contributions, premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and
- Obtaining reimbursements due to the Plan.

“Health Care Operations” include, but are not limited to, the following activities:

- Quality assessment;
- Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
- Rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;
- Enrollment, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess loss insurance);
- Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies; and
- Business management and general administrative activities of the Plan, including, but not limited to:
 - Management activities relating to the implementation of, and compliance with, HIPAA’s administrative simplification requirements;
 - Customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;
 - Resolution of internal grievances; and

- Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a “covered entity” under HIPAA or, following completion of the sale or transfer, will become a covered entity.

Certification of Amendment of Plan Documents by the Plan Sponsor

The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the provisions set forth in this HIPAA Appendix.

Plan Sponsor Agrees to Certain Conditions for PHI

The Plan Sponsor agrees to:

- Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;
- Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- Not use or disclose PHI for employment-related actions and decisions unless the use or disclosure is made pursuant to an authorization in compliance with HIPAA;
- Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless the use or disclosure is made pursuant to an authorization in compliance with HIPAA;
- Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Make PHI available to an individual in accordance with HIPAA’s access requirements;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make available the information required to provide an accounting of disclosures;
- Make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the HHS Secretary for the purposes of determining the Plan’s compliance with HIPAA;
- If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible,

limit further uses and disclosures to those purposes that make the return or destruction infeasible); and

- Establish separation between the Plan and the Plan Sponsor in accordance with 45 C.F.R. § 164.504(f)(2)(iii).

With respect to ePHI, the Plan Sponsor agrees, on behalf of the Plan, to:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- Ensure that adequate separation required by 45 C.F.R. §164.504(f)(2)(iii) under the Privacy Standards is supported by reasonable and appropriate security measures;
- Ensure that any agent, including a subcontractor, to whom it provides this information or who receives this information on behalf of the Plan agrees to implement reasonable and appropriate security measures to protect the information; and
- Report to the Plan any security incident of which it becomes aware, in accordance with the administrative procedures adopted by the Plan for compliance with the Security Standards.

Adequate Separation Between the Plan and the Plan Sponsor

In accordance with the Privacy Standards, only the employees or classes of employees designated in the HIPAA Privacy Employee Designation Appendix may be given access to PHI.

Limitations of PHI Access and Disclosure

The persons described in the HIPAA Privacy Employee Designation Appendix may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan.

Noncompliance Issues

If the persons described in the HIPAA Privacy Employee Designation Appendix do not comply with the Plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

Additional Requirements Imposed by HITECH

In accordance with, to the extent required by, and as of the effective dates specified therein, HITECH and the regulations and other authority promulgated thereunder by the appropriate governmental authority, the Plan will (a) comply with notification requirements when unsecured PHI has been accessed, acquired, or disclosed as a result of a breach, (b) comply with an individual's request to restrict disclosure of PHI, (c) limit disclosures of PHI to a limited data set or the minimum

necessary, (d) provide an accounting of disclosures, and (e) provide access to PHI in electronic format.

Limitation on the Use and Disclosure of Genetic Information

Notwithstanding anything herein to the contrary, no “genetic information” (as defined by Section 105 of the Genetic Information Nondiscrimination Act of 2008) shall be used or disclosed for underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, or ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess loss insurance).

Notification in Case of a Breach of Unsecured PHI

In the event of the acquisition, access, use, or disclosure of PHI in a manner not permitted by the Privacy Standards that constitutes a “Breach,” as such term is defined in 45 CFR 164.402, the Plan, or its designee, shall notify each individual whose PHI has been, or is reasonably believed to have been, accessed, acquired, used or disclosed as a result of the Breach no later than sixty (60) days after the Plan, or its designee, discovers the Breach, unless notification may be delayed as permitted by 45 CFR 164.412 because such notice would impede a criminal investigation or damage national security. The Plan, or its designee, will mail individual notifications by first-class mail to the individual’s last known address or by electronic mail, provided that electronic disclosure is permitted by the applicable regulations. The individual notification will include the following information:

- A brief description of what happened, including the date of the Breach and the date of its discovery, if known;
- A description of the type of PHI involved, such as name, social security number, date of birth, address, account number, diagnosis, disability code, or other type of information involved;
- Any steps the individual should take to protect himself from potential harm resulting from the Breach;
- A brief description of what the Plan or its business associate is doing to investigate the Breach, mitigate harm to individuals, and to protect against further Breaches; and
- Contact procedures for individuals to ask questions or learn additional information, including a toll-free telephone number, e-mail address, web site, or postal address.

If the Breach involves more than 500 residents of a state or jurisdiction, the Plan, or its designee, will also notify prominent media outlets that service the state or jurisdiction of the Breach. Additionally, the Plan will notify the Secretary of the Department of Health and Human Services of the Breach as required by 45 CFR 164.408.

Other Medical Privacy Laws

The Plan will comply with the Privacy Standards and the Security Standards, as well as with any applicable federal, state and local laws governing confidentiality of health information, to the extent such laws are not preempted by HIPAA or ERISA.

**SUMMARY PLAN DESCRIPTION OF THE
BMC SOFTWARE, INC. CAFETERIA BENEFIT PLAN
(Amended and Restated Effective as of January 1, 2023)**

HIPAA PRIVACY EMPLOYEE DESIGNATION APPENDIX

The following job classifications of employees (or classes of employees) are hereby designated as being entitled to receive Protected Health Information subject to HIPAA from the Health Care Flexible Spending Account Benefit:

- Privacy Official / AVP-Total Rewards;
- Complaint Official / Director-Benefits; and
- Employees as listed by their job titles in the operative “HIPAA Workforce” document of the Plan Sponsor’s HIPAA privacy policies and procedures.

**SUMMARY PLAN DESCRIPTION OF THE
BMC SOFTWARE, INC. CAFETERIA BENEFIT PLAN
(Amended and Restated Effective as of January 1, 2023)**

ADOPTING EMPLOYERS APPENDIX

As of January 1, 2023, the Employers that have adopted and are participating in the Plan are as follows:

- BMC Software, Inc. (*i.e.*, the Plan Sponsor); and
- BMC Software Federal, LLC.