

SUMMARY PLAN DESCRIPTION

OF THE

BMC SOFTWARE, INC.

WELFARE BENEFIT PLAN

(Amended and Restated Effective as of January 1, 2022)

Revision Date: January 1, 2022

**SUMMARY PLAN DESCRIPTION OF THE
BMC SOFTWARE, INC. WELFARE BENEFIT PLAN
(Amended and Restated Effective as of January 1, 2022)**

TABLE OF CONTENTS

	<u>Page</u>
ARTICLE I DEFINITIONS	3
1.1 Affiliate	3
1.2 Beneficiary	3
1.3 Board	3
1.4 Civil Union Partner	3
1.5 Claims Administrator	3
1.6 Claims Fiduciary	3
1.7 Code	3
1.8 Dependent	3
1.9 Disclosure Administrator	3
1.10 Domestic Partner	3
1.11 Effective Date	4
1.12 Eligibility Administrator	4
1.13 Employee	4
1.14 Employer	5
1.15 ERISA	5
1.16 Former Employee	5
1.17 Fully-Insured Program	5
1.18 Participant	5
1.19 Participant Contribution	5
1.20 Partner	5
1.21 Payee	5
1.22 Plan	5
1.23 Plan Administrator	5
1.24 Plan Sponsor	6
1.25 Plan Year	6
1.26 Spouse	6
1.27 Summary Plan Description or SPD	6
1.28 Welfare Program	6
1.29 Welfare Program Document	6
1.30 Wrap-Plan	7
1.31 Wrap-SPD	7
ARTICLE II INTERPRETATION	7
ARTICLE III ELIGIBILITY AND PARTICIPATION	7
3.1 Eligibility	7
3.2 Enrollment	8
3.3 Termination of Participation	8
3.4 Leave of Absence Under the Family and Medical Leave Act.	8

3.5	Leave of Absence Under the Uniformed Services Employment and Reemployment Rights Act	9
ARTICLE IV FUNDING.....		9
ARTICLE V BENEFITS.....		9
5.1	Generally.....	9
5.2	Elimination of Exclusion.....	10
ARTICLE VI CLAIMS PROCEDURES		10
6.1	General.....	10
6.2	Definitions.	12
6.3	Initial Claim Procedure and Time Limits.....	12
6.4	Notification of Benefit Determination.	14
6.5	Appeal Procedures.....	15
6.6	Benefit Determination on Review.	18
6.7	Calculating Time Periods.	20
6.8	Relevance to Claim.....	21
6.9	Exhaustion of Administrative Remedies.....	21
6.10	Action for Recovery.....	22
6.11	Participant’s Responsibilities.	22
6.12	Standards for Culturally and Linguistically Appropriate Notifications.	22
ARTICLE VII RIGHT OF SUBROGATION AND REIMBURSEMENT		23
7.1	Benefits Subject to this Provision	24
7.2	When this Provision Applies	24
7.3	Amount Subject to Subrogation or Reimbursement.....	26
7.4	When Recovery Includes the Cost of Past or Future Expenses.....	27
7.5	When a Participant Retains an Attorney	27
7.6	When the Participant is Deceased	27
7.7	When a Participant Does Not Comply	27
ARTICLE VIII AMENDMENT OR TERMINATION		28
8.1	Right to Amend.	28
8.2	Right to Terminate.....	28
ARTICLE IX ADMINISTRATION		29
9.1	Allocation of Authority.....	29
9.2	Powers and Duties of Plan Administrator.....	29
9.3	Delegation by the Plan Administrator.....	30
9.4	Disclosure Responsibility.	30
9.5	Rules and Decisions.	31
9.6	Facility of Payment for Incapacitated Participant.....	31
9.7	Non-Alienation of Benefits.....	32
9.8	Overpayments.....	32
9.9	Governing Law; Jurisdiction.....	32
ARTICLE X IMPORTANT ERISA INFORMATION		34
ARTICLE XI STATEMENT OF ERISA RIGHTS.....		35
APPENDIX A		A-1

APPENDIX B	B-1
APPENDIX C	C-1
APPENDIX D.....	D-1
APPENDIX E.....	E-1

**SUMMARY PLAN DESCRIPTION OF THE
BMC SOFTWARE, INC. WELFARE BENEFIT PLAN
(Amended and Restated Effective as of January 1, 2022)**

Introduction

BMC Software, Inc. (the “**Plan Sponsor**”) maintains the BMC Software, Inc. Welfare Benefit Plan (the “**Plan**”) for the benefit of the eligible Employees and eligible Former Employees of the Plan Sponsor and the other adopting Employers. The Plan Sponsor has amended and restated the Plan effective as of January 1, 2022.

The Plan is an “employee welfare benefit plan”, as defined in the Employee Retirement Income Security Act of 1974, as amended (“**ERISA**”). The Plan provides benefits to Participants, in accordance with the terms, conditions and limitations of the Plan. Terms of the Plan pertaining to eligibility, coverage, exclusions and limitations on coverage, and other rules pertaining to the benefits available under the Plan are set forth in this wrap-around summary plan description of the Plan (including any exhibits or appendices hereto) (the “**Wrap-SPD**”) and the Welfare Program Documents (as defined herein), which are attached hereto as Appendix C, incorporated into this Wrap-SPD in their entirety by reference and, together with this Wrap-SPD, constitute the full “**Summary Plan Description**” of the Plan as required by ERISA.

Please review this Wrap-SPD and the Welfare Program Documents carefully, paying particular attention to the provisions in this Wrap-SPD and the Welfare Program Documents concerning exclusions and limitations on coverage.

The masculine gender of words used in this Wrap-SPD include the feminine gender, and words used in the singular include the plural, and vice-versa, when applicable. Terms with initial capital letters used in this Wrap-SPD are defined in Article I. The capitalized terms used in this Wrap-SPD shall have the meanings set forth herein; provided, however, the definitions of certain capitalized terms contained in this introduction are provided solely for convenience of reference within this introduction. Any reference to an “Appendix” in this Wrap-SPD shall mean an Appendix to this Wrap-SPD unless otherwise stated.

FOREWORD

The benefits provided under the Plan are for the exclusive benefit of the eligible Employees and eligible Former Employees of the Plan Sponsor and the other adopting Employers of the Plan. These benefits are intended to be continued indefinitely; however, the Plan Sponsor reserves the unilateral right and discretion to make any changes, without advance notice, to the Plan which it deems to be necessary or appropriate, in its discretion, to comply with applicable law, regulation or other authority issued by a governmental entity. The Plan Sponsor also reserves the unilateral right and discretion to amend, modify, or terminate, without advance notice, all or any part of the Plan and to make any other changes that it deems necessary or appropriate in its discretion. Changes in the Plan may occur in any or all parts of the Plan, including, but not limited to, benefit coverage, exclusions, limitations, definitions, eligibility and the like, under any or all of the Welfare Programs identified in Appendix B. You should not, therefore, assume that the benefits which are provided under the Plan will continue to be available and remain unchanged, and you should disregard any information or communication (written or oral) that would seem to limit the Plan Sponsor's absolute right and discretion to terminate, suspend, discontinue or amend such benefits. Furthermore, the Plan Administrator and the Claims Fiduciary, as applicable, each reserve the absolute right, authority and discretion to interpret, construe, construct and administer the terms and provisions of the Plan in their discretion, including, without limitation, correcting any error or defect, supplying any omission, reconciling any inconsistency, and making all decisions concerning benefits, including any factual determinations that may impact eligibility or a claim for benefits. All decisions, interpretations and other determinations of the Plan Administrator or Claims Fiduciary, as applicable, will be final, binding and conclusive on all persons and entities, subject only to the claims appeal provisions of the Plan.

ARTICLE I DEFINITIONS

The following terms, where capitalized, shall have the meanings set forth below when used in this Wrap-SPD and thus supersede any other meanings for the same terms set forth in the Welfare Program Documents, unless a different meaning is plainly required by the context:

1.1 Affiliate means a corporation or other entity which is controlled by the Plan Sponsor, or under common control with the Plan Sponsor, as determined by the Plan Sponsor after taking into consideration the common control rules under Section 3(40)(B) of ERISA (*i.e.*, multiple employer welfare associations).

1.2 Beneficiary means a Beneficiary under the Plan as defined under the terms of the respective Welfare Program.

1.3 Board means the Board of Directors of the Plan Sponsor.

1.4 Civil Union Partner means a person with whom an Employee (or Former Employee) has entered into a civil union, to the extent such civil union is legally recognized as valid in the state or foreign jurisdiction in which such civil union took place. The Employee (or Former Employee) must provide proof of the civil union, such as a certificate of civil union, if requested by the Plan Administrator. Notwithstanding the foregoing, if the applicable Welfare Program Document for a Fully-Insured Program provides a definition of "Civil Union Partner" (or similar term) that is more restrictive than the definition in this Section 1.4, the definition in such Welfare Program Document will control for purposes of that Fully-Insured Program.

1.5 Claims Administrator means the third party administrator, insurance company or other entity, as set forth in Appendix D to this Wrap-SPD, designated by the Plan Administrator to process claims and perform other administrative duties under the Plan or a Welfare Program.

1.6 Claims Fiduciary means the person or entity that serves as the named claims fiduciary with respect to reviewing and making final decisions regarding claims under a Welfare Program. The "Claims Fiduciary" shall be the Plan Administrator unless otherwise set forth in Appendix D to this Wrap-SPD.

1.7 Code means the Internal Revenue Code of 1986, as amended, and the implementing regulations and other authority issued thereunder by the appropriate governmental authority. References herein to any section of the Code shall also refer to any successor provision thereof.

1.8 Dependent means a dependent (which may include a Spouse or Partner) of a Participant who is covered under the Plan, as such term is defined under the terms of the respective Welfare Program.

1.9 Disclosure Administrator means the individual or entity, as designated in Article X of this Wrap-SPD, to whom the Plan Administrator has delegated the authority, duty and discretion to furnish, on its behalf, the disclosures that are required by Section 104(b)(4) of ERISA and which are requested in accordance with Section 9.4 of this Wrap-SPD.

1.10 Domestic Partner means a person claimed by the Employee (or Former Employee) as his or her domestic partner, and who meets either of the following requirements:

- (a) Together with the Employee (or Former Employee), has filed a registered domestic partnership registration in the Employee's (or Former Employee's) state of residence, in accordance with its requirements; or
- (b) Is in an ongoing, exclusive and committed relationship with the Employee (or Former Employee) in which each is responsible for the other's welfare, and which has existed for a minimum of the preceding twelve (12) consecutive months and is intended to continue indefinitely.

The Employee (or Former Employee) must provide proof of such domestic partnership, such as a certification or affidavit of domestic partnership, if requested by the Plan Administrator. Notwithstanding the foregoing, if the applicable Welfare Program Document for a Fully-Insured Program provides a definition of "Domestic Partner" (or similar term) that is more restrictive than the definition in this Section 1.10, the definition in such Welfare Program Document will control for purposes of that Fully-Insured Program.

1.11 Effective Date means the effective date of the amendment and restatement of the Plan, *i.e.*, January 1, 2022.

1.12 Eligibility Administrator means the Plan Administrator, or the third party administrator or other entity, as set forth in Section 6.1(d), designated by the Plan Administrator to perform eligibility determination services with respect to certain Welfare Programs on behalf of the Plan Administrator.

1.13 Employee means, unless otherwise specified in a Welfare Program Document for a particular Welfare Program, any individual who is (a) considered to be in an employer-employee relationship as a "common law" employee with the Employer and (b) on the U.S. payroll records of the Employer for purposes of federal income tax withholding. Except as may otherwise be expressly stated in a Welfare Program Document for a particular Welfare Program, the term "Employee" will not include any person during any period that such person was classified on the Employer's records as other than an Employee. For example, the term "Employee" will not include anyone classified on the Employer's records as an independent contractor, agent, leased employee, contract employee or similar classification, regardless of whether any agency (governmental or otherwise) or court determines that any such person is, or was, a common law employee of an Employer, even if such determination has a retroactive effect. For purposes of this definition, (a) a "leased employee" means any person, regardless of whether or not he is a "leased employee" as defined in Code Section 414(n)(2), whose services are supplied by an employment, leasing, or temporary service agency and who is paid by or through an agency or third-party, (b) an "independent contractor" means any person rendering service directly or indirectly to the Employer and whom the Employer treats as an independent contractor by reporting payments for the person's services on IRS Form 1099 (or its successor), and (c) a "contract employee" means a person who is employed by a third-party entity which is retained by the Employer through a contract for services, pursuant to which such person indirectly renders services to, or for the benefit of, the Employer.

Furthermore, employees who (i) are non-resident aliens and (ii) receive no earned income (within the meaning of Code Section 911(d)(2)) from an Employer which constitutes income from sources within the United States (within the meaning of Code Section 861(a)(3)) will not be considered Employees who are eligible to participate in the Plan.

1.14 Employer means the Plan Sponsor, or any of its Affiliates that have adopted the Plan with the consent of the Plan Sponsor. The adopting Employers of the Plan shall be listed in Appendix A (attached hereto), as such Appendix may be revised from time to time by the Plan Sponsor without the need for a formal amendment to the Plan.

1.15 ERISA means the Employee Retirement Income Security Act of 1974, as amended.

1.16 Former Employee means any person formerly employed as an Employee of the Employer.

1.17 Fully-Insured Program means each of the following Welfare Programs that are fully-insured with an insurance carrier:

- The BMC Software, Inc. Basic and Supplemental Life Insurance Program;
- The BMC Software, Inc. Supplemental Accidental Death and Dismemberment Insurance Program;
- The BMC Software, Inc. Business Travel Accident Insurance Program;
- The BMC Software, Inc. Basic and Supplemental Long-Term Disability Insurance Program; and
- BMC Software, Inc. Prepaid Legal Services Program.

1.18 Participant means an Employee or Former Employee of the Employer who meets the requirements for eligibility as set forth in Article III and who is properly enrolled for coverage under the Plan. A person shall cease to be a Participant when he no longer meets the requirements for eligibility as set forth in applicable provisions of the Plan.

1.19 Participant Contribution means the pre-tax or after-tax contribution required to be paid by a Participant, if any, for coverage under a Welfare Program, as determined under each Welfare Program. The term "Participant Contribution" includes, but is not limited to, contributions used for the provision of benefits under a self-funded arrangement of the Plan Sponsor or an Employer, as well as contributions used to purchase coverage under insurance contracts or policies.

1.20 Partner means an Employee's (or Former Employee's) Domestic Partner or Civil Union Partner.

1.21 Payee means (apart from the Participant) a Beneficiary, assignee, or other person or entity, including the Participant's estate, who is entitled to a benefit under the Plan pursuant to the terms of a Welfare Program.

1.22 Plan means the "BMC Software, Inc. Welfare Benefit Plan", which consists of (a) the Wrap-Plan, (b) the Policies set forth in the Policy Appendix to the Wrap-Plan and incorporated therein by reference, (c) this Wrap-SPD, and (d) each Welfare Program Document as incorporated hereunder by reference, as such Plan may be amended from time to time. The Wrap-Plan, Policies, Wrap-SPD and Welfare Program Documents each contain certain terms of the Plan and together constitute the complete Plan.

1.23 Plan Administrator means the person or entity which has the authority and responsibility to manage and direct the operation of the Plan in its discretion. However, the Plan Administrator may assign or delegate duties to third parties, such as the Claims Administrator or the Claims Fiduciary, under the terms of either the Plan or any Welfare Program, or by means of a separate written

agreement. The Plan Administrator is the “plan administrator” for purposes of Section 3(16)(A) of ERISA. The “Plan Administrator” shall be the Plan Sponsor. References herein to the Plan Administrator shall include, when appropriate, any Employee, Claims Administrator, Claims Fiduciary or other person or entity who has been delegated the appropriate authority by the Plan Administrator in accordance with Section 9.3.

1.24 Plan Sponsor means BMC Software, Inc., or its successor in interest.

1.25 Plan Year means each twelve (12) month calendar year commencing January 1st and ending on December 31st.

1.26 Spouse means a person to whom an Employee or Former 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 shall not include an individual separated from the Employee under a legal separation or divorce decree. The term “Spouse” will also include a common law spouse if the Employee and spouse became common law married in a state which recognizes common law marriages and meet all of the requirements for common law marriage in that state. The Employee must provide proof of marriage if requested by the Plan Administrator, such as, for example, an affidavit of marriage, or a marriage license or certificate of common law marriage issued by the applicable state. Notwithstanding the foregoing, if the applicable Welfare Program Document for a Fully-Insured Program provides a definition of “Spouse” that is more restrictive than the definition in this Section 1.26, the definition in such Welfare Program Document will control for purposes of that Fully-Insured Program.

1.27 Summary Plan Description or SPD means, together, this Wrap-SPD and each Welfare Program Document as attached to this Wrap-SPD and incorporated hereunder by reference, as all such documents may be amended from time to time, and which, together, constitute the full “Summary Plan Description” of the Plan as required by ERISA. The Summary Plan Description is incorporated into the Wrap-Plan by reference and constitutes a part of the Plan.

1.28 Welfare Program means a program of benefits that is offered by the Plan Sponsor (and/or another Employer) under the Plan to provide certain employee welfare benefits coverage to eligible Employees and eligible Former Employees which would be an “employee welfare benefit plan” under Section 3(1) of ERISA if offered separately. The Welfare Programs are incorporated into this Wrap-SPD, which is, in turn, incorporated into the Wrap-Plan. Each Welfare Program under the Plan is identified in Appendix B of this Wrap-SPD. The Plan Sponsor may add or delete a Welfare Program from the Plan by amending Appendix B of this Wrap-SPD.

1.29 Welfare Program Document means a written arrangement, including (a) a benefits booklet, summary of coverage, plan document or summary plan description, (b) a certificate of insurance, schedule of benefits, notice or other instrument, or (c) a group insurance policy issued by the insurance carrier to the Plan Sponsor (or other Employer), under which a Welfare Program is established, operated or maintained. Each of the documents referenced in items (a), (b) and (c) (above) is incorporated into this Wrap-SPD as part of Appendix C. A Welfare Program Document (or any portion thereof) shall not, in and of itself, constitute either the written “Plan document” or the official “Summary Plan Description” of the Plan, as required by ERISA, notwithstanding any references in any Welfare Program Document to the contrary; however, such Welfare Program

Document does contain certain terms of the Plan. Any reference to a Welfare Program Document also refers to any amendment, rider, endorsement, exhibit or attachment thereto.

1.30 Wrap-Plan means the wrap-around Plan document, as amended from time to time.

1.31 Wrap-SPD means this wrap-around summary plan description document, including any exhibits and appendices hereto, as amended from time to time.

ARTICLE II INTERPRETATION

Notwithstanding any reference in a Welfare Program Document that such Welfare Program Document, in and of itself (or any portion thereof), constitutes a “summary plan description” of the Plan, as required by ERISA, the official Summary Plan Description consists of this Wrap-SPD and the Welfare Program Documents incorporated herein by reference. If a term or provision of this Wrap-SPD directly conflicts with a term or provision of a Welfare Program Document or a Policy, the term or provision of this Wrap-SPD shall control unless specifically stated otherwise herein. Further, if a term or provision of this Wrap-SPD directly conflicts with any term or provision of the Wrap-Plan, then the term or provision of the Wrap-Plan will control unless specifically stated otherwise in the Wrap-Plan.

Notwithstanding the foregoing, if there is a conflict between a term or provision of the Wrap-Plan, a Policy, this Wrap-SPD or a Welfare Program Document, and such conflict involves a term or provision required by ERISA, the Code or other controlling law, on the one hand, and a term or provision not so required on the other, the term or provision required by controlling law shall control. This determination shall be made by the Plan Administrator. The terms and provisions of this Wrap-SPD shall not enlarge the rights of an Employee, Participant, Beneficiary or Payee to any benefit available under a Welfare Program.

The terms and provisions of the Plan include the terms and provisions of the Wrap-Plan, the Policies listed in the Policy Appendix to the Wrap-Plan, this Wrap-SPD, and the Welfare Program Documents.

ARTICLE III ELIGIBILITY AND PARTICIPATION

3.1 Eligibility.

An Employee is eligible to participate in the Plan if:

- (a) the Employee is on the United States payroll; and
- (b) the Employee is a full-time Employee who works a minimum of thirty (30) hours per week; or the Employee is employed in the “BMC Bridging to Retirement Group”, as designated in the Employer’s personnel records.

Notwithstanding, effective as of January 1, 2018, an Employee who participates in the “BMC Software, Inc. California Voluntary Disability Insurance Plan” or the “BMC Software Federal California Voluntary Disability Insurance Plan” (either plan, a “**California VDI Plan**”) shall be ineligible to participate in the BMC Software, Inc. Short-Term Disability Program hereunder. For

purposes of clarifying the foregoing, if an Employee incurs a claim for short-term disability benefits while covered under either the BMC Software, Inc. Short-Term Disability Program or a California VDI Plan, such claim and any associated short-term disability benefits coverage shall be administered and provided under the program or plan (*i.e.*, the BMC Software, Inc. Short-Term Disability Program or the California VDI Plan) in which the Employee was a participant on the date that the claim was incurred.

A Former Employee may be eligible to receive benefits under the BMC Software, Inc. Basic and Supplemental Long-Term Disability Insurance Program in accordance with the terms of that program.

Subject to the foregoing provisions of this Section 3.1, an Employee or Former Employee will be eligible to participate in the Plan only if and to the extent such person is eligible with respect to the particular benefit in question under a Welfare Program, as determined by the Eligibility Administrator or Plan Administrator, as applicable. Each Welfare Program Document also (a) designates the Beneficiaries and Payees of an Employee who are eligible to receive benefits under the Welfare Program, and (b) sets forth the criteria for coverage thereunder.

3.2 Enrollment.

The Plan Administrator may establish procedures in accordance with the Welfare Programs for the enrollment of Employees under the Plan. The Plan Administrator shall provide enrollment forms, either paper or electronic, that must be completed by the prescribed deadline prior to commencement of coverage under the Plan. However, an eligible Employee shall be automatically enrolled in (a) basic life insurance coverage under the BMC Software, Inc. Basic and Supplemental Life Insurance Program, (b) coverage under the BMC Software, Inc. Short-Term Disability Program, (c) basic disability insurance coverage under the BMC Software, Inc. Basic and Supplemental Long-Term Disability Insurance Program, and (d) coverage under the BMC Software, Inc. Business Travel Accident Insurance Program.

3.3 Termination of Participation.

A Participant will cease being a Participant in the Plan and coverage under the Plan for the Participant and his Beneficiaries shall terminate in accordance with the provisions of the applicable Welfare Program.

3.4 Leave of Absence Under the Family and Medical Leave Act.

An Employee Participant shall be entitled to benefits under the Plan during a period of leave pursuant to the federal Family and Medical Leave Act of 1993, as amended ("**FMLA**"), at a minimum, to the same extent that similarly-situated Employees on other forms of leave (paid or unpaid, as appropriate) are entitled to benefits under the Plan during such other forms of leave, as determined by the Employer's established leave of absence policy.

At the end of an Employee's FMLA leave, benefits under the Plan shall be resumed in the same manner and at the same levels as provided to the Employee when the leave began, and subject to any changes in benefit levels that may have taken place during the period of FMLA leave affecting all Participants, unless otherwise elected by the Employee. Upon return from FMLA leave, an Employee shall not be required to re-qualify for any Plan benefits the Employee was entitled to receive as a Participant before his FMLA leave began.

3.5 Leave of Absence Under the Uniformed Services Employment and Reemployment Rights Act.

The Plan shall comply with the Uniformed Services Employment and Reemployment Rights Act of 1994 (“**USERRA**”) with regard to continuation rights during an approved military leave of absence and reenrollment rights on return from such military leave of absence.

During a period of duty in the Uniformed Services (as defined in USERRA), the Employee shall be deemed to be “on furlough” or “leave of absence” from the Employer. The Employee shall be entitled to benefits under the Plan in accordance with the Employer’s administrative policies and procedures regarding leaves of absence for military service under USERRA, but at a minimum, to the same extent as similarly-situated Employees who are on non-USERRA leave of absence from the Employer. If Plan benefits to which Employees on non-USERRA leave of absence are entitled vary according to the type of leave, the Employee on leave under USERRA must be given at least the most favorable benefits under the Plan accorded to any comparable form of leave.

ARTICLE IV FUNDING

Notwithstanding anything to the contrary contained herein or in a Welfare Program Document, participation in the Plan by a Participant and the payment of Plan benefits shall be conditioned on such Participant Contributions towards the cost of coverage under the Plan at such time and in such amounts as the Plan Administrator shall establish from time to time, in accordance with the terms of the Welfare Programs. To the extent that a Participant is required to make Participant Contributions toward the cost of coverage under the Plan, the Plan Administrator shall designate the applicable method by which the Participant must make any Participant Contributions, and the Participant must consent in writing (including electronically, as applicable), or as otherwise required under the Plan Administrator’s procedures, to such payment method to remain covered under the Plan. Nothing herein requires an Employer or the Plan Administrator to contribute to or under the Plan, or to maintain any fund or segregate any amount for the benefit of any Participant, Beneficiary or other Payee, except to the extent specifically required under the terms of a Welfare Program. No Participant, Employee, Former Employee, Dependent, Beneficiary or Payee shall have any right to, or interest in, the assets of any Employer as the result of coverage under the Plan until actually paid. The Plan shall not be “funded” for purposes of ERISA.

Benefits or premiums for the Plan will be provided through insurance contracts or through the general assets of the Employer in accordance with the terms of the Plan, including the relevant Welfare Program. To the extent that the Plan is provided through an Employer’s purchase of insurance, payment of any benefits under such Welfare Program shall be the sole responsibility of the insurer, and the Employer shall have no responsibility for such payment.

ARTICLE V BENEFITS

5.1 Generally.

Subject to Section 5.2, the actual terms and conditions of eligibility, coverage, exclusions and limitations on coverage, and the additional rules pertaining to the benefits of Participants under the Plan, are set forth in the Welfare Program Documents, as they may be amended from time to time.

The Welfare Program Documents, as then currently in effect, are incorporated in their entirety by reference into this Wrap-SPD which, in turn, is incorporated by reference into the Plan.

Notwithstanding anything to the contrary contained herein, but subject to Section 5.2, benefits under a Fully-Insured Program will be paid solely in the form and amount specified in the relevant Welfare Program Document and pursuant to the terms and conditions of such Fully-Insured Program, except as otherwise required by ERISA, the Code or other controlling law.

5.2 Elimination of Exclusion.

Effective as of October 1, 2017, any exclusion from coverage under (a) the BMC Software, Inc. Short-Term Disability Program and (b) the BMC Software, Inc. Basic and Supplemental Long-Term Disability Insurance Program for a disability due to a gender change (including, without limitation, any operation, drug therapy or any other procedure related to a gender change) shall be inoperable, notwithstanding anything to the contrary in the applicable Welfare Program Document. Whether an exclusion meets the criteria of this Section 5.2 shall be determined by the Claims Fiduciary in its discretion.

ARTICLE VI CLAIMS PROCEDURES

6.1 General.

- (a) Except as provided in subsection (c) (below), a claim for benefits under a Welfare Program shall be submitted in accordance with, and to the party designated under, the terms of such Welfare Program. Notwithstanding the foregoing, unless a Welfare Program specifically provides otherwise, a claim for benefits must be submitted not later than twelve (12) months after the date that the claim is incurred. If a Welfare Program does provide otherwise, then the limitation under the Welfare Program will control. In the event that a claim, as originally submitted, is not complete, the Claimant shall be notified and the Claimant shall then have the responsibility for providing the missing information within the timeframe stated in such notification.
- (b) A Participant or Beneficiary may designate an authorized representative to act as “claimant” on his behalf with respect to the Plan’s claims procedures, as permitted by ERISA. The Claims Fiduciary for the applicable Welfare Program may require that any such designation be made in writing (including electronically), using a form prescribed by the Claims Fiduciary as consistent with ERISA and in accordance with the Claims Fiduciary’s procedures for such purpose, in a manner that is sufficiently clear and conspicuous to enable the Claims Fiduciary to reasonably verify the status of the authorized representative and the scope of such authorization. Whether any such designation of an authorized representation meets such requirements shall be determined by the Plan Administrator or Claims Fiduciary, as applicable, in its discretion. The Plan Administrator or the Claims Fiduciary, as applicable, may disregard any designation of an authorized representative that it deems to be defective or otherwise improper or invalid hereunder. In particular, and without limitation, such entities reserve the right and discretion to refuse to honor a Participant’s or Beneficiary’s designation of an authorized representative if the Plan Administrator or Claims Fiduciary, as applicable, determines that such designation is fraudulent; such as, for example, when the Plan Administrator or Claims Fiduciary, as applicable, determines that

the signature of approval on the designation does not belong to the Participant or Beneficiary.

- (c) To the extent that a Welfare Program does not prescribe a claims procedure for Disability Claims or Non-Health Claims that satisfies the requirements of Section 503 of ERISA and the regulations promulgated thereunder (collectively, the “**Claims Regulations**”), the claims procedures set out below in Sections 6.2 through 6.8 shall apply to a Disability Claim or a Non-Health Claim, as such terms are defined in Section 6.2. Such procedures are intended to comply with the Claims Regulations, as applicable, and shall be construed and applied accordingly.
- (d) The claims procedures applicable to claims made for benefits under the Plan do not include casual or general inquiries regarding eligibility or particular Welfare Program benefits that may be provided under the Plan. Requests for eligibility or coverage determinations which are not associated with a claim for benefits under the Plan shall not constitute a claim for benefits under ERISA or the Plan. In order for such an inquiry or request to constitute a claim for benefits or an appeal of an Adverse Benefit Determination, it must be associated with a claim for benefits that is made by a Claimant in accordance with the claim procedures under the applicable Welfare Program, or, if such procedures are not contained in such Welfare Program, then according to the claims procedures set forth in this Article VI.

Notwithstanding the foregoing, solely for administrative convenience, the Plan shall administer determinations regarding eligibility or coverage requests that are not associated with a benefit claim hereunder (each, an “**Eligibility Request**”) and appeals of denied Eligibility Requests (each, an “**Eligibility Denial**”) in accordance with the claims procedures set forth in this Article VI, subject to the following:

- (i) The term “Claims Administrator” shall mean the Eligibility Administrator, which is Aon Hewitt, at 1-877-262-4849, www.mybmcrewards.com;
 - (ii) The term “Claims Fiduciary” shall mean the Plan Administrator;
 - (iii) The term “Adverse Benefit Determination” shall mean an Eligibility Denial;
 - (iv) The term “Adverse Benefit Determination on Review” shall mean the upholding or affirmation of an appealed Eligibility Denial;
 - (v) Eligibility Requests and appeals of Eligibility Denials shall be decided according to the timeframes that apply to Disability Claims;
 - (vi) Only one level of appeal of an Eligibility Denial shall be provided under the Plan; and
 - (vii) All decisions of the Plan Administrator regarding an appeal of an Eligibility Denial shall be final and binding on the Claimant and all other parties and entities.
- (e) With respect to any Disability Claim filed after April 1, 2018, the Plan will ensure that such Disability Claim and any appeal thereof are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters

regarding any such person (such as a claims adjudicator, medical expert, or vocational expert) will not be made based upon the likelihood that such person will support the denial of benefits.

6.2 Definitions.

- (a) *Adverse Benefit Determination* means:
 - (i) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit under the Plan, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's eligibility to participate in the Plan; or
 - (ii) with respect to a Disability Claim filed after April 1, 2018, a rescission of coverage, which is a cancellation or discontinuance of coverage that has a retroactive effect (except to the extent that such cancellation or discontinuance of coverage is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage), whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time.
- (b) *Adverse Benefit Determination on Review* means the upholding or affirmation of an appealed Adverse Benefit Determination.
- (c) *Benefit Determination* means a determination by the Claims Administrator on a claim for benefits under the Plan, whether or not an Adverse Benefit Determination.
- (d) *Benefit Determination on Review* means a determination by the Claims Fiduciary (or if the applicable Welfare Program requires two levels of appeal, the Claims Administrator with respect to the first level appeal) on an appeal of an Adverse Benefit Determination, whether or not an Adverse Benefit Determination on Review.
- (e) *Claimant* means a Participant or Beneficiary under the Plan, or his authorized representative, who is designated by the Participant or Beneficiary to act on his behalf.
- (f) *Disability Claim* means a claim for benefits under a Welfare Program that is conditioned upon a showing of "disability" by the Claimant.
- (g) *Health Care Professional* means a physician or other health care service provider who is licensed, accredited, or certified to perform the specified health services consistent with state law.
- (h) *Non-Health Claim* means a claim other than (i) a Disability Claim or (ii) a claim for medical care benefits under a Welfare Program.

6.3 Initial Claim Procedure and Time Limits.

- (a) *Initial Claim Process.*

A claim and all required documentation shall be filed in writing with the applicable Claims Administrator and decided within the applicable timeframe under federal law, regardless of

whether all information required to perfect the claim is included. The timeframe for decision begins upon receipt by the Claims Administrator of a claim filed by the Claimant in accordance with the Plan's claims procedures, and is contingent upon the type of claim that is submitted, whether the claim submitted is a complete claim or incomplete claim, whether additional information is required and whether an extension is required to make a decision on the claim.

(b) *Non-Health Claims.*

- (i) If a Non-Health Claim is submitted, the Claims Administrator will render a Benefit Determination and provide notice to the Claimant of any denial, in whole or in part, of such Non-Health Claim within a reasonable period of time, but not later than ninety (90) days after receipt of the Non-Health Claim, unless the Claims Administrator determines that special circumstances require an extension of time for processing the Non-Health Claim. If the Claims Administrator determines that an extension of time for processing is required, written notice of the extension will be furnished to the Claimant prior to the termination of the initial ninety (90) day period. In no event shall such extension exceed a period of ninety (90) days from the end of such initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the Benefit Determination.
- (ii) Notification of any Adverse Benefit Determination with respect to a Non-Health Claim shall be made in accordance with Section 6.4.

(c) *Disability Claims.*

- (i) If a Disability Claim is submitted, the Claims Administrator will render a Benefit Determination and provide notice to the Claimant of any such Adverse Benefit Determination within a reasonable period of time, but not later than forty-five (45) days after receipt of the Disability Claim (the "**Initial Period**"). The Initial Period may be extended by the Plan for up to thirty (30) days (the "**First Extension**"), provided that the Claims Administrator both (A) determines that such an extension is necessary due to matters beyond the control of the Plan, and (B) notifies the Claimant, prior to the expiration of the Initial Period, of the circumstances requiring the First Extension and the date by which the Plan expects to render a decision.
- (ii) If, prior to the end of the First Extension, the Claims Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within the First Extension, the period for making the determination may be extended for up to an additional thirty (30) days (the "**Second Extension**"), provided that the Claims Administrator notifies the Claimant, prior to the expiration of the First Extension, of the circumstances requiring the Second Extension and the date as of which the Plan expects to render a decision.
- (iii) In the case of any extension under this subsection (c), the notice of extension shall specifically explain (A) the standards on which entitlement to a benefit is based, (B) the unresolved issues that prevent a decision on the claim, and (C) the additional information needed to resolve those issues, and the Claimant shall be afforded at least forty-five (45) days within which to provide the specified information.

- (iv) Notification of any Adverse Benefit Determination with respect to a Disability Claim shall be made in accordance with Section 6.4.

6.4 Notification of Benefit Determination.

- (a) The Claims Administrator shall provide a Claimant with written or electronic notification of any Adverse Benefit Determination. The notification shall set forth in a manner calculated to be understood by the Claimant:
 - (i) the specific reason or reasons for the Adverse Benefit Determination;
 - (ii) reference to the specific Plan provisions upon which the determination is based;
 - (iii) a description of additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;
 - (iv) a description of the Plan's appeal procedures and time limits applicable to such procedures, including 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 (or, with respect to a Disability Claim under a Welfare Program that requires two levels of appeal, following an Adverse Benefit Determination on Review with respect to the second appeal);
 - (v) with respect to a Disability Claim filed on or prior to April 1, 2018:
 - (A) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; or
 - (B) if the Adverse Benefit Determination is based on a medical necessity or experimental and/or investigational treatment or similar exclusion or limit, either 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 to the Claimant upon request; and
 - (vi) with respect to a Disability Claim filed after April 1, 2018:
 - (A) A discussion of the decision regarding the Disability Claim, including an explanation of the basis for disagreeing with (or not following):
 - (1) The views of any Health Care Professionals treating the Claimant and any vocational professionals who evaluated the Claimant, as presented to the Claims Administrator by the Claimant;

- (2) The views of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's Adverse Benefit Determination, without regard to whether such advice was relied upon in making the Adverse Benefit Determination; and
 - (3) Any disability determination regarding the Claimant that was made by the Social Security Administration, as presented to the Claims Administrator by the Claimant;
 - (B) If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for such 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 to the Claimant upon request;
 - (C) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the Adverse Benefit Determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and
 - (D) 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 Disability Claim; whether a document, record, or other information is "relevant" to a Disability Claim will be determined by reference to Section 6.8.
- (b) Any notification of an Adverse Benefit Determination with respect to a Disability Claim filed after April 1, 2018, shall be provided in a culturally and linguistically appropriate manner, as described in Section 6.12.

6.5 Appeal Procedures.

- (a) *General Appeal Procedures.*
 - (i) Each Claimant shall have a reasonable opportunity to appeal an Adverse Benefit Determination to the Claims Fiduciary (or, if the applicable Welfare Program requires two levels of appeal, to the Claims Administrator with respect to the first level appeal) as set forth hereafter.
 - (ii) Each Claimant shall have the opportunity to submit written comments, documents, records, and other information relating to the claim appealed.
 - (iii) Each Claimant shall be provided, 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 under the Plan. Whether a document, record, or other information is "relevant" to a claim for benefits under the Plan shall be determined by reference to Section 6.8.
 - (iv) The appeal shall take into account all comments, documents, records, and other

information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial Benefit Determination.

- (v) The Claimant shall have sixty (60) days (one-hundred eighty (180) days in the case of a Disability Claim) following receipt of notification of an Adverse Benefit Determination within which to appeal said Determination. In the case of a Disability Claim, if the applicable Welfare Program requires two levels of appeal, the Claimant will have sixty (60) days following receipt of notification of an Adverse Benefit Determination on review of the first appeal within which to file a second appeal of the Adverse Benefit Determination.

(b) *Disability Claims Appeal Procedures.*

The following appeal procedures, in addition to those set forth in subsection (a) (above), shall apply to Disability Claims:

- (i) The appeal shall not afford deference to the initial Adverse Benefit Determination and shall be conducted by a decision maker who is neither the individual who made the Adverse Benefit Determination that is on appeal, nor the subordinate of such decision maker.
- (ii) In deciding an appeal of an Adverse Benefit Determination that is based in whole or in part on a medical judgment, the decision maker shall consult with a Health Care Professional who has appropriate training and experience in the field of medicine involving the medical judgment.
- (iii) All medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination on appeal shall be identified without regard to whether the advice was relied upon in making the Adverse Benefit Determination.
- (iv) All Health Care Professionals engaged for purposes of consultation under Section 6.5(b)(ii) shall be an individual who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is on appeal, nor the subordinate of such individual.
- (v) A Claimant shall not be required to file more than two appeals of an Adverse Benefit Determination prior to bringing a civil action under Section 502(a) of ERISA. To the extent that the claims procedures set forth in any Welfare Program provide for more than two levels of appeal of an Adverse Benefit Determination, any level of appeal beyond the second level of appeal shall be “voluntary”.
- (vi) To the extent that any Welfare Program offers a voluntary level of appeal (“**Voluntary Appeal**”) (except to the extent the Plan is required to do so by State law), including voluntary arbitration or any other form of dispute resolution, and notwithstanding anything in such Welfare Program to the contrary:
 - (A) The Plan waives any right to assert that a Claimant has failed to exhaust administrative remedies because the Claimant did not elect to submit a

benefit dispute to a Voluntary Appeal;

- (B) Any statute of limitations or other defense based on timeliness is tolled during the time that a Voluntary Appeal is pending;
 - (C) A Claimant may elect to submit a benefit dispute to a Voluntary Appeal only after exhaustion of the appeals permitted by the Welfare Program under which the benefit dispute arose, subject to Section 6.5(b)(v);
 - (D) A Claimant will be provided, upon request, sufficient information relating to the Voluntary Appeal to enable the Claimant to make an informed judgment about whether to submit a benefit dispute to Voluntary Appeal, including a statement that the decision of a Claimant as to whether or not to submit a benefit dispute to Voluntary Appeal will have no effect on the Claimant's rights to any other benefits under the Plan, and information about the applicable rules, the Claimant's right to representation, the process for selecting the decision maker, and the circumstances, if any, that may affect the impartiality of the decision maker, such as any financial or personal interests in the result or any past or present relationship with any party to the review process; and
 - (E) No fees or costs will be imposed on the Claimant as part of the Voluntary Appeal.
- (vii) Notwithstanding anything in a Welfare Program to the contrary, a Claimant shall not be subject to mandatory arbitration of an Adverse Benefit Determination, except to the extent that:
- (A) The arbitration is counted as one of the two appeals described in Section 6.5(b)(v) and is conducted in accordance with the requirements applicable to such appeals; and
 - (B) The Claimant is not precluded from challenging the decision resulting from such arbitration under section 502(a) of ERISA or other applicable law.
- (viii) With respect to a Disability Claim filed after April 1, 2018:
- (A) Prior to the issuance of an Adverse Benefit Determination on Review regarding the Disability Claim, the Claimant will be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by the Claims Fiduciary (or, if the applicable Welfare Program requires two levels of appeal, by the Claims Administrator with respect to the first level appeal), or at the direction of such decision maker, in connection with such claim;
 - (B) Prior to the issuance of an Adverse Benefit Determination on Review regarding the Disability Claim that is based on a new or additional rationale, the Claims Fiduciary (or, if the applicable Welfare Program requires two levels of appeal, the Claims Administrator with respect to the first level appeal) will provide the Claimant, free of charge, with such rationale; and

- (C) In the case of either subsection (A) or (B), such evidence or rationale will be provided to the Claimant as soon as possible and sufficiently in advance of the date on which the notice of an Adverse Benefit Determination on Review is required to be provided under Section 6.6(a), in order to give the Claimant a reasonable opportunity to respond prior to that date.

6.6 Benefit Determination on Review.

(a) *Timing of Notification.*

- (i) Disability Claims. In the case of a Disability Claim, the Claims Fiduciary (or, if the applicable Welfare Program requires two levels of appeal, the Claims Administrator with respect to the first level appeal) shall notify the Claimant, in accordance with Section 6.6(b), of the Plan's Benefit Determination on Review within a reasonable period of time, but not later than forty-five (45) days after receipt by the Plan of the Claimant's appeal of an Adverse Benefit Determination, unless the Claims Fiduciary determines that special circumstances require an extension of time for processing the claim. If the Claims Fiduciary determines that an extension of time for processing is required, written notice of the extension shall be furnished to the Claimant prior to the termination of the initial forty-five (45) day period. In no event shall such extension exceed a period of forty-five (45) days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the Benefit Determination on Review.
- (ii) Non-Health Claims. In the case of a Non-Health Claim, the Claims Fiduciary (or, if the applicable Welfare Program requires two levels of appeal, the Claims Administrator with respect to the first level appeal) shall notify the Claimant, in accordance with Section 6.6(b), of the Plan's Benefit Determination on Review within a reasonable period of time, but not later than sixty (60) days after receipt by the Plan of the Claimant's appeal of an Adverse Benefit Determination, unless the Claims Fiduciary determines that special circumstances require an extension of time for processing the claim. If the Claims Fiduciary determines that an extension of time for processing is required, written notice of the extension shall be furnished to the Claimant prior to the termination of the initial sixty (60) day period. In no event shall such extension exceed a period of sixty (60) days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the Benefit Determination on Review.
- (iii) In the case of an Adverse Benefit Determination on Review, the Claims Fiduciary (or, if the applicable Welfare Program requires two levels of appeal, the Claims Administrator with respect to the first level appeal) shall provide access to, and copies of, documents, records, and other information described in Sections 6.6(b)(iii), (iv) and (vi), as appropriate.

(b) *Manner and Content of Notification of Benefit Determination on Review.*

The Claims Fiduciary (or, if the applicable Welfare Program requires two levels of appeal,

the Claims Administrator with respect to the first level appeal) shall provide a Claimant with written or electronic notification of the Plan's Benefit Determination on Review. In the case of an Adverse Benefit Determination on Review, the notification shall set forth in a manner calculated to be understood by the Claimant:

- (i) The specific reason or reasons for the Adverse Benefit Determination on Review;
- (ii) Reference to the specific Plan provisions upon which the Adverse Benefit Determination on Review is based;
- (iii) 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 under the Plan; whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to Section 6.8;
- (iv) A statement describing any Voluntary Appeal procedures offered by the Plan and the Claimant's right to obtain the information about such procedures described in Section 6.5(b)(vi)(D);
- (v) A statement of the Claimant's right to bring an action under Section 502(a) of ERISA (or, if a Welfare Program requires two levels of appeal, the Claimant's right to bring an action under Section 502(a) of ERISA following an Adverse Benefit Determination on Review with respect to the second appeal), and, if the Adverse Benefit Determination on Review is regarding a Disability Claim which is filed after April 1, 2018, a description of any contractual limitations period under the applicable Welfare Program that applies to the Claimant's right to bring such an action, as described in Section 6.10, including the calendar date on which such contractual limitations period expires for such claim; and
- (vi) with respect to a Disability Claim filed on or prior to April 1, 2018:
 - (A) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination on Review, either (1) the specific rule, guideline, protocol, or other similar criterion, or (2) a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination on Review and that a copy of the rule, guideline, protocol, or other similar criterion will be provided, free of charge, to the Claimant upon request;
 - (B) if the Adverse Benefit Determination on Review is based upon a medical necessity or experimental and/or investigational treatment or similar exclusion or limit, either (1) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or (2) a statement that such explanation will be provided, free of charge, upon request; and
 - (C) 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”;

(vii) with respect to a Disability Claim filed after April 1, 2018:

(A) A discussion of the Adverse Benefit Determination on Review, including an explanation of the basis for disagreeing with (or not following):

(1) The views of any Health Care Professionals treating the Claimant and any vocational professionals who evaluated the Claimant, as presented to the Claims Fiduciary (or, if the applicable Welfare Program requires two levels of appeal, the Claims Administrator with respect to the first level appeal) by the Claimant;

(2) The views of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination on Review, without regard to whether such advice was relied upon in making the Adverse Benefit Determination on Review; and

(3) Any disability determination regarding the Claimant that was made by the Social Security Administration, as presented to the Claims Fiduciary (or, if the applicable Welfare Program requires two levels of appeal, the Claims Administrator with respect to the first level appeal) by the Claimant;

(B) If the Adverse Benefit Determination on Review is based on a medical necessity or experimental treatment or similar exclusion or limit, either (1) an explanation of the scientific or clinical judgment for such determination, applying the terms of the Plan to the Claimant’s medical circumstances, or (2) a statement that such explanation will be provided free of charge to the Claimant upon request; and

(C) Either (1) the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the Adverse Benefit Determination on Review or, alternatively, (2) a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.

(c) Any notification of an Adverse Benefit Determination on Review with respect to an appeal of a Disability Claim that is filed after April 1, 2018, shall be provided in a culturally and linguistically appropriate manner, as described in Section 6.12.

6.7 Calculating Time Periods.

For the purposes of Sections 6.3 and 6.6(a), the period of time within which a Benefit Determination or a Benefit Determination on Review is required to be made, shall begin at the time a claim or appeal, as the case may be, is filed in accordance with the procedures of the Plan, without regard to whether all information necessary to make a Benefit Determination or a Benefit Determination on Review, as the case may be, accompanies the filing. In the event that a period of time is extended as permitted under Sections 6.3 or 6.6(a) due to a Claimant’s failure to submit

information necessary to decide a claim or the appeal, the period for making the Benefit Determination or the Benefit Determination on Review shall be tolled from the date on which the notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.

6.8 Relevance to Claim.

For the purposes of Sections 6.5(a)(iii) and 6.6(b)(iii), a document, record, or other information shall be considered “relevant” to a Claimant’s claim if such document, record, or other information:

- (a) was relied upon in making the Benefit Determination;
- (b) was submitted, considered, or generated in the course of making the Benefit Determination, without regard to whether such document, record, or other information was relied upon in making the Benefit Determination;
- (c) demonstrates compliance with any administrative processes and safeguards in making the Benefit Determination; or
- (d) in the case of a Disability Claim, 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 Benefit Determination.

6.9 Exhaustion of Administrative Remedies.

- (a) *Exhaustion Required Prior to Action for Recovery.*

Notwithstanding anything to the contrary in a Welfare Program, no action at law or in equity may be brought to recover under the Plan until all administrative remedies have been exhausted (including two appeals of an Adverse Benefit Determination if required by the applicable Welfare Program). If a Claimant fails to file a timely claim, or if the Claimant fails to request a review in accordance with the Plan’s claim procedures, such Claimant shall have no right of review and shall have no right to bring any action in any court. The denial of the claim shall become final and binding on all persons for all purposes.

- (b) *Deemed Exhaustion – Disability Claim Filed After April 1, 2018.*

If the Plan fails to strictly adhere to all of the applicable requirements of Sections 6.3 through 6.8 with respect to a Disability Claim filed after April 1, 2018, the Claimant is deemed to have exhausted the administrative remedies available under the Plan (except as provided in subsection (c), below) with respect to such claim. Accordingly, the Claimant is entitled to pursue any available remedies under Section 502(a) of ERISA on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If the Claimant chooses to pursue remedies under Section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

- (c) *De Minimis Violations.*

Notwithstanding subsection (b), above, the administrative remedies under the Plan with respect to a Disability Claim filed after April 1, 2018, will not be deemed exhausted based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant, so long as the Plan demonstrates that the violation (i) was for good cause or due to matters beyond the control of the Plan and (ii) occurred in the context of an ongoing, good faith exchange of information between the Plan and the Claimant (provided, however, this exception shall not be applicable if the violation is part of a pattern or practice of violations by the Plan). The Claimant may request a written explanation of the *de minimis* violation from the Plan, and the Plan will provide such explanation within 10 days, including a specific description of the Plan's basis, if any, for asserting that the violation should not cause the administrative remedies of the Plan with respect to such Disability Claim to be deemed exhausted. If a court rejects the Claimant's request for immediate review on the basis that the Plan met the standards for the exception, then such Disability Claim shall be considered as re-filed on appeal upon the Plan's receipt of the decision of the court, and, within a reasonable time after such receipt, the Plan shall provide the Claimant with notice of the resubmission.

6.10 Action for Recovery.

Unless stated otherwise in a Welfare Program, and subject to Section 6.9, any action at law or in equity with respect to any and all claims relating to the Plan must be brought for recovery within one year from the earlier of (a) the date of a final Adverse Benefit Determination on Review, if applicable, or (b) the accrual of any claim under or relating to the Plan that does not result in a final Adverse Benefit Determination on Review. If the particular Welfare Program expressly states a limitations period for bringing an action thereunder, then the Welfare Program will control.

6.11 Participant's Responsibilities.

Each Participant shall be responsible for providing the Claims Administrator, Claims Fiduciary, Plan Administrator, Plan Sponsor and/or Employer with the Participant's and each Beneficiary's current U.S. mailing address and electronic address, as specified in the Welfare Programs. Accordingly, any notices required or permitted to be given by the Claims Administrator, Claims Fiduciary, Plan Administrator, Plan Sponsor or Employer hereunder shall be deemed given if directed to such address furnished by the Participant and mailed by regular United States mail, delivered by messenger or other professional delivery service, or provided by electronic means as specified in Section 2520.104b-1(c) of ERISA. The Claims Administrator, Claims Fiduciary, Plan Administrator, Plan Sponsor and Employer shall not have any obligation or duty to locate a Participant or Beneficiary.

In the event that a Participant or Beneficiary becomes entitled to a payment under the Plan, the amount of such payment, if and when made, shall be determined under the provisions of the applicable Welfare Program.

To the extent that the entitlement of a Participant, Beneficiary or other individual to a benefit under the Plan is the subject of an interpleader action in a court of competent jurisdiction, the Plan Administrator, Plan Sponsor and any other Plan fiduciary may act in reliance upon any order issued by such court regarding any individual's entitlement to benefits under the Plan, which action shall satisfy its fiduciary and other duties under the Plan.

6.12 Standards for Culturally and Linguistically Appropriate Notifications.

The notifications described in Sections 6.4(b) and 6.6(c) with respect to Disability Claims filed after April 1, 2018 (for purposes of this Section 6.12, each a “**Determination Notice**”, and, collectively, “**Determination Notices**”), shall be administered in accordance with the requirements set forth in subsection(a), below, for the applicable non-English languages described in subsection (b), below.

(a) *Requirements.*

- (i) The Plan shall provide oral language services to a Claimant that include (A) answering questions in any applicable non-English language and (B) providing assistance with filing claims and appeals of any Adverse Benefit Determinations in any applicable non-English language;
- (ii) The Plan shall provide, upon request by a Claimant, a Determination Notice in any applicable non-English language; and
- (iii) The Plan shall include in the English versions of all Determination Notices a statement, prominently displayed in any applicable non-English language, which clearly indicates the Plan’s procedures by which a Claimant may access the language services provided by the Plan.

(b) *Applicable Non-English Language.*

With respect to an address in any United States county to which a Determination Notice is sent, a non-English language is an “applicable non-English language” if ten percent or more of the population residing in such county is literate only in the same non-English language, as determined in guidance published by the U.S. Department of Labor.

ARTICLE VII RIGHT OF SUBROGATION AND REIMBURSEMENT

The provisions of this Article VII will apply to, and govern and control the Plan’s rights to subrogation and reimbursement under, only the Welfare Programs which are not Fully-Insured Programs and will supersede any subrogation and reimbursement provisions set forth in the Welfare Program Documents for such Welfare Programs to the extent that such other provisions are more restrictive or limited regarding the rights of the Plan than are these provisions. The Plan reserves all its subrogation and reimbursement rights, at law and in equity, to the full extent not contrary to applicable law as determined by the Plan Administrator.

The Plan Administrator may, in its discretion, designate a third party service provider or other person or entity to exercise the rights described in this Article VII on behalf of the Plan. In addition, the Plan Administrator may, in its discretion and on a case-by-case basis, waive or limit any of the subrogation and reimbursement rights set forth in this Article VII on behalf of the Plan to the extent deemed appropriate. Any such waiver or limitation in a particular case will not limit or diminish in any way the Plan’s rights in any other instance or at any other time.

7.1 Benefits Subject to this Provision

For purposes of this Article VII, certain terms are defined as follows:

- (a) **“Recovery”** means any and all monies and property paid by a Third Party to (i) the Participant, (ii) the Participant’s attorney, assign, legal representative, or Beneficiary, (iii) a trust of which the Participant is a beneficiary, or (iv) any other person or entity on behalf of the Participant, by way of judgment, settlement, compromise or otherwise (no matter how those monies or property may be characterized, designated or allocated and irrespective of whether a finding of fault is made as to the Third Party) to compensate for any losses or damages caused by, resulting from, or in connection with, the injury, illness or disability (for purposes of this Article VII, **“Disability”**).
- (b) **“Reimbursement”** means repayment to the Plan for benefits that it has paid to or on behalf of the Participant toward care and treatment of the Disability and for the expenses incurred by the Plan in collecting this amount, including the Plan’s equitable rights to recovery.
- (c) **“Subrogation”** means the Plan’s right to pursue the Participant’s claims against a Third Party for any or all lost wages or other benefits or charges paid by the Plan.
- (d) **“Third Party”** means any individual or entity, other than the Plan, who is or may be liable, or legally or equitably responsible, to pay expenses, compensation or damages in connection with a Participant’s Disability.

The term “Third Party” will include the party or parties who caused the Disability; the insurer, guarantor or other indemnifier or indemnitor of the party or parties who caused the Disability; a Participant’s own insurer, such as an uninsured, underinsured, medical payments, no-fault, homeowner’s, renter’s or any other liability insurer; a workers’ compensation insurer; and any other individual or entity that is or may be liable or legally or equitably responsible for Reimbursement or payment in connection with the Disability.

7.2 When this Provision Applies

A Participant may incur lost wages or other charges related to a Disability caused by the act or omission of a Third Party. Consequently, such Third Party may be liable, or legally or equitably responsible, for payment of charges incurred in connection with the Disability. If so, the Participant may have a claim against that Third Party for payment of the medical or other charges. In that event, the Plan will be secondary payer, not primary, and the Plan will be Subrogated to all rights the Participant may have against that Third Party.

Furthermore, the Plan will have a right of first and primary Reimbursement enforceable by an equitable lien against any Recovery paid by the Third Party. The equitable lien will be equal to 100% of the amount of benefits paid by the Plan for the Participant’s Disability and expenses incurred by the Plan in enforcing the provisions of this Article VII (including, without limitation, attorneys’ fees and costs of suit, and without regard to the outcome of such an action), regardless of whether or not the Participant has been made whole by the Third Party. This equitable lien will attach to the Recovery regardless of whether (a) the Participant receives the Recovery or (b) the Participant’s attorney, a trust of which the Participant is a beneficiary, or other person or entity receives the Recovery on behalf of the Participant. This right of Reimbursement enforceable by an

equitable lien is intended to entitle the Plan to equitable relief under Section 502(a)(3) of ERISA, and will be construed accordingly.

As a condition to receiving benefits under the Plan, the Participant hereby agrees to immediately notify the Plan Administrator, in writing, of whatever benefits are payable under the Plan that arise out of any Disability that provides, or may provide, the Plan with Subrogation and/or Reimbursement rights under this Article VII.

The Plan's equitable lien supersedes any right that the Participant may have to be "made whole." In other words, the Plan is entitled to the right of first Reimbursement out of any Recovery the Participant procures, or may be entitled to procure, regardless of whether the Participant has received compensation for any or all of his damages or expenses, including any of his attorneys' fees or costs. Additionally, the Plan's right of first and primary Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. The Plan is not responsible for a Participant's legal fees and costs, is not required to share in any way for any payment of such fees and costs, and its equitable lien will not be reduced by any such fees and costs. As a condition to coverage and receiving benefits under the Plan, the Participant agrees that acceptance of benefits, as well as participation in the Plan, is constructive notice of the provisions of this Article VII, and the Participant hereby automatically grants an equitable lien to the Plan to be imposed upon and against all rights of Recovery with respect to Third Parties, as described above.

In addition to the foregoing, the Participant:

- (a) Authorizes the Plan to sue, compromise and settle in the Participant's name to the extent of the amount of benefits paid for the Disability under the Plan and the expenses incurred by the Plan in collecting this amount, and assigns to the Plan the Participant's rights to Recovery when the provisions of this Article VII apply;
- (b) Must notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement; and
- (c) Must cooperate fully with the Plan in its exercise of its rights under this Article VII, do nothing that would interfere with or diminish those rights, and furnish any information as required by the Plan to exercise or enforce its rights hereunder.

Furthermore, the Plan Administrator reserves the absolute right and discretion to require a Participant who may have a claim against a Third Party for payment of lost wages or other Disability charges that were paid, or are payable, by the Plan to execute and deliver a Subrogation and Reimbursement agreement acceptable to the Plan Administrator and, subject to Section 7.5, that acknowledges and affirms: (i) the conditional nature of payments with respect to lost wages or other Disability charges which are subject to Reimbursement and (ii) the Plan's rights of full Subrogation and Reimbursement, as provided in this Article VII ("**S&R Agreement**").

When a right of Recovery exists, and as a condition to any payment by the Plan (including payment of future benefits for the same or other Disabilities), the Participant will execute and deliver all required instruments and papers, including any S&R Agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any benefits will be paid by the Plan for the Disability. The Plan may file a copy of an S&R Agreement signed by the Participant and his attorney with such other parties, or the

Plan may notify any other parties of the existence of Plan's equitable lien; provided, the Plan's rights will not be diminished if it fails to do so.

To the extent the Plan requires execution of an S&R Agreement by a Participant (and his attorney, as applicable), a Participant's claim for any Disability benefits will be incomplete until an executed S&R Agreement is submitted to the Plan Administrator. Such S&R Agreement must be submitted to the Plan Administrator within the timeframe applicable to the particular type of benefits claimed by the Participant, as specified in the Plan's claims procedures. Any failure to timely submit the required S&R Agreement in accordance with the Plan's claims procedures will constitute the basis for denial of the Participant's claim for Disability benefits, and will be subject to the Plan's claims appeal procedures.

The Plan Administrator may determine, in its sole discretion, that it is in the Plan's best interests to pay benefits for the Disability before an S&R Agreement and other papers are signed and actions are taken; however, in that event, any payment by the Plan of such benefits prior to or without obtaining a signed S&R Agreement or other papers will not operate as a waiver of any of the Plan's Subrogation and Reimbursement rights and the Plan still will be entitled to Subrogation and Reimbursement. In addition, the Participant will do nothing to prejudice the Plan's right to Subrogation and Reimbursement, and hereby acknowledges that participation in the Plan precludes operation of the "made-whole" and "common-fund" doctrines. A Participant who receives any Recovery has an absolute obligation to immediately tender the Recovery (to the extent of 100% of the amount of benefits paid by the Plan for the Participant's Disability and expenses incurred by the Plan in enforcing the provisions of this Article VII, including attorneys' fees and costs of suit, regardless of an action's outcome) to the Plan under the terms of this Article VII. A Participant who receives any such Recovery and does not immediately tender the Recovery to the Plan will be deemed to hold such Recovery in constructive trust for the Plan because the Participant is not the rightful owner of such Recovery to the extent the Plan has not been fully reimbursed. By participating in the Plan, or receiving benefits under the Plan, the Participant automatically agrees, without further notice, to all the terms and conditions of this Article VII and any S&R Agreement.

The Plan Administrator has maximum discretion to interpret the terms of this Article VII and to make changes in its interpretation as it deems necessary or appropriate.

7.3 Amount Subject to Subrogation or Reimbursement

Any amounts Recovered will be subject to Subrogation or Reimbursement, even if the payment the Participant receives is for, or is described as being for, damages other than lost wages or other Disability benefits paid, provided or covered by the Plan. This means that any Recovery will be automatically deemed to first cover the Reimbursement, and will not be allocated to or designated as reimbursement for any other costs or damages the Participant may have incurred, until the Plan is reimbursed in full and otherwise made whole. In no case will the amount subject to Subrogation or Reimbursement exceed the amount of benefits paid for the Disability under the Plan and the expenses incurred by the Plan in collecting this amount. The Plan has a right to recover in full, without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise, even if the Participant does not receive full compensation for all of his charges and expenses.

7.4 When Recovery Includes the Cost of Past or Future Expenses

In certain circumstances, a Participant may receive a Recovery that includes amounts intended to be compensation for past and/or future expenses for treatment of the Disability that is the subject of the Recovery. The Plan will not cover any expenses for which compensation was provided through a previous Recovery. This exclusion will apply to the full extent of such Recovery or the amount of the expenses submitted to the Plan for payment, whichever is less. Participation in the Plan also precludes operation of the “made-whole” and “common-fund” doctrines in applying the provisions of this Article VII.

It is the responsibility of the Participant to inform the Plan Administrator when expenses incurred are related to a Disability for which a Recovery has been made. Acceptance of benefits under the Plan for which the Participant has already received a Recovery will be considered fraud, and the Participant will be subject to any sanctions determined by the Plan Administrator, in its sole discretion, to be appropriate. The Participant is required to submit full and complete documentation of any such Recovery in order for the Plan to consider eligible expenses that exceed the Recovery.

7.5 When a Participant Retains an Attorney

If the Participant retains an attorney, the Plan will not pay any portion of the Participant’s attorneys’ fees and costs associated with the Recovery, nor will it reduce its Reimbursement pro-rata for the payment of the Participant’s attorneys’ fees and costs. Attorneys’ fees will be payable from the Recovery only after the Plan has received full Reimbursement.

The Plan Administrator reserves the absolute right and discretion to require the Participant’s attorney to sign an S&R Agreement as a condition to any payment of benefits under the Plan and as a condition to any payment of future Plan benefits. Additionally, pursuant to such S&R Agreement, the Participant’s attorney must acknowledge and consent to the fact that the “made-whole” and “common fund” doctrines are inoperable under the Plan, and the attorney must agree not to assert either doctrine in his pursuit of Recovery.

Any Recovery paid to the Participant’s attorney will be subject to the Plan’s equitable lien, and thus an attorney who receives any Recovery has an absolute obligation to immediately tender the Recovery (to the extent of 100% of the amount paid by the Plan for the Participant’s Disability and expenses incurred by the Plan in enforcing the provisions of this Article VII, including attorneys’ fees and costs of suit regardless of an action’s outcome) to the Plan under the terms of this Article VII. A Participant’s attorney who receives any such Recovery and does not immediately tender the recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan because neither the Participant nor his attorney is the rightful owner of the Recovery to the extent the Plan has not received full Reimbursement.

7.6 When the Participant is Deceased

The provisions of this Article VII shall apply to the heirs or personal representatives of the estate of a deceased Participant, regardless of applicable law and whether or not the representative has access to or control of the Recovery.

7.7 When a Participant Does Not Comply

When a Participant does not comply with the provisions of this Article VII, the Plan

Administrator will have the power and authority, in its sole discretion, to (i) deny payment of any claims for benefits by or on behalf of the Participant and (ii) deny or reduce future benefits payable (including payment of future benefits for the same or other Disabilities) under the Plan by the amount due as Reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for the same or other Disabilities) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required Reimbursement. If the Plan must bring an action against a Participant to enforce the provisions of this Article VII, the Participant will be obligated to pay the Plan's attorneys' fees and costs regardless of the action's outcome.

ARTICLE VIII AMENDMENT OR TERMINATION

8.1 Right to Amend.

The Board (or a committee of the Board), or any Benefits Committee that is duly authorized by the Board (or such committee of the Board) for this purpose, or any Employee who is a member of the Benefits Committee who has been duly authorized by the Benefits Committee for such purpose, shall each have the right, authority and power to make, at any time, and from time to time, any amendment to the Plan; provided, however, no amendment shall retroactively prejudice any claim for benefits under the Plan that was incurred but not paid prior to the date of the amendment, unless the person or entity responsible above for the amendment, as applicable, determines that such amendment is necessary or desirable to comply with applicable law or is required under the terms of a particular Welfare Program. However, an amendment may reduce or eliminate a Participant's right to receive Plan benefits with respect to a claim if such claim is incurred on or after the date of the amendment, except to the extent otherwise required under a Fully-Insured Program.

8.2 Right to Terminate.

The Board (or a committee of the Board), or any Benefits Committee that is duly authorized by the Board (or such committee of the Board) for this purpose, or any Employee who is a member of the Benefits Committee who has been duly authorized by the Benefits Committee for such purpose, shall each have the right, authority, power and discretion to terminate the Plan at any time, in whole or in part, without prior notice, to the extent deemed advisable in its or his discretion; provided, however, such termination shall not retroactively prejudice any claim under the Plan that was incurred but not paid prior to the termination date unless the Board (or such committee thereof), such Benefits Committee or such authorized member thereof, as applicable, determines it is necessary or desirable to comply with applicable law.

Furthermore, the Board (or such committee), such Benefits Committee, or such Employee authorized by such Benefits Committee may, in its or his discretion, terminate the participation of any Employer, with respect to its Employees and Former Employees only, in the Plan, effective as of any date that such entity or person deems advisable. The Plan Sponsor may revise Appendix A to the Wrap-SPD, as needed, to reflect the termination of an Employer from participation in the Plan, without regard to the formal amendment provisions of the Plan.

ARTICLE IX ADMINISTRATION

9.1 Allocation of Authority.

The Plan Sponsor shall be the “Plan Administrator”. The Plan Administrator shall control and manage the operation and administration of the Plan, except to the extent such duties have been delegated to other persons or entities as provided in the Wrap-Plan, this Wrap-SPD or a Welfare Program Document. Any decisions made by the Plan Administrator or Claims Fiduciary, as applicable (or any other person or entity delegated authority by the Plan Administrator or Claims Fiduciary, as applicable, to determine benefits in accordance with the applicable Welfare Program) shall be final and conclusive on all Participants, Payees and all other persons and entities, subject only to the claims appeal provisions of the Plan. Neither the Plan Administrator nor any Employee shall receive any compensation with respect to services provided under the Plan, except as an Employee may be entitled to benefits hereunder.

9.2 Powers and Duties of Plan Administrator.

The Plan Administrator (and the Claims Fiduciary, but only with respect to reviewing and making decisions regarding claims under a Welfare Program) will each have such powers as may be necessary to discharge its duties hereunder, including, but not by way of limitation, the following:

- (a) to have final discretionary authority to (i) administer, enforce, construe, and construct the Plan, including the Welfare Program Documents, (ii) make decisions relating to all questions of eligibility to participate, (iii) make determinations of benefits, and (iv) reconcile any inconsistency, correct any defect, supply any omission and make all findings of fact, including, without limitation, in cases where such the exercise of such authority may impact eligibility or a claim for benefits;
- (b) to prescribe procedures to be followed by Participants filing application for benefits;
- (c) to prepare and distribute, in such manner as the Plan Administrator determines to be appropriate, any information that explains the Plan and benefits thereunder;
- (d) to receive from the Employer and from Participants such information as necessary for the proper administration of the Plan;
- (e) to furnish the Employer and the Participants such annual reports with respect to the administration of the Plan as necessary;
- (f) to receive, review and keep on file (as it deems necessary) reports of benefit payments by the Employer and reports of disbursements for expenses;
- (g) to exercise such authority and responsibility as it deems appropriate in order to comply with the terms of the Plan relating to the records of Participants, including an examination at the Employer’s expense of the records of the Plan to be made by such attorneys, accountants, auditors or other agents as it may select, in its discretion, for that purpose; and
- (h) to appoint persons or entities to assist in the administration as it deems advisable;

and the Plan Administrator may delegate thereto any power or duty imposed upon or granted to it under the Plan.

If, due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by prior interpretations or other evidence of intent, or as determined by the Plan Administrator in its sole and exclusive judgment, the provision will be considered ambiguous and will be interpreted by the Plan Administrator (or the Claims Fiduciary) in a fashion consistent with its intent, as determined by the Plan Administrator (or the Claims Fiduciary). The Plan may be amended retroactively to cure any such ambiguity, notwithstanding anything in the Plan to the contrary.

The Plan Administrator and Claims Fiduciary may rely upon the direction or information from a Participant relating to such Participant's entitlement to benefits hereunder as being proper under the Plan, and will not be responsible for any act or failure to act. Neither the Plan Administrator nor the Employer makes any guarantee to any Employee or Former Employee in any manner for any loss that may result because of the Employee's or Former Employee's participation in the Plan.

All decisions, interpretations, determinations and actions in the exercise of the powers and duties described in this Section will be final and conclusive on all persons and entities subject only to the claims appeal provisions of the Plan. Benefits under the Plan will be paid only if the Plan Administrator (or Claims Fiduciary) determines in its discretion that the Participant is entitled to them. There will be no *de novo* review of any such decision, interpretation, determination or action by any court. Any review of such decision, interpretation, determination or action will be limited to determining whether the decision, interpretation, determination or action in question was so arbitrary and capricious as to be an abuse of discretion under ERISA standards.

9.3 Delegation by the Plan Administrator.

The Plan Administrator may delegate to other persons or entities any of the administrative functions relating to the Plan, together with all powers necessary to enable its designee(s) to properly carry out such duties hereunder including, without limitation, delegation to the Claims Administrator, the Claims Fiduciary and the Disclosure Administrator. The Plan Administrator may employ such counsel, accountants, Claims Administrators, Claims Fiduciaries, consultants, actuaries and such other persons or entities as it deems advisable in its discretion. The Plan Administrator, as well as any person to whom any duty or power in connection with the operation of the Plan is delegated, may rely upon all valuations, reports, and opinions furnished by any accountant, consultant, third-party administration service provider, legal counsel, or other specialist. Moreover, the Plan Administrator or such delegate shall be fully protected in respect to any action taken or permitted in good faith in reliance on such information.

9.4 Disclosure Responsibility.

- (a) *General.* The Disclosure Administrator shall, in response to a written request by a Participant or Beneficiary, furnish a copy of the documents and instruments specified in Section 104(b)(4) of ERISA ("**Plan Disclosures**") as required by ERISA. A Participant's or Beneficiary's request for Plan Disclosures must be submitted to the Disclosure Administrator in writing, at the address listed in Article X of this Wrap-SPD, and must identify the particular Plan Disclosures that are being requested. The Disclosure Administrator may, in

its discretion, impose a reasonable charge to cover the cost of copying and furnishing the requested Plan Disclosures to the extent permitted by ERISA.

- (b) *Requests by an Authorized Representative.* A request for Plan Disclosures may be submitted to the Disclosure Administrator by an authorized representative of the Participant or Beneficiary, provided that (i) the authorization of such representative is designated in writing by the Participant or Beneficiary in a manner that is sufficiently clear and conspicuous, as determined by the Disclosure Administrator in its discretion, to enable the Disclosure Administrator to reasonably verify the status of the authorized representative and the scope of such authorization, and (ii) a copy of the signed authorization is submitted to the Disclosure Administrator with the request for Plan Disclosures. The Disclosure Administrator will not make any Plan Disclosures to a person or entity claiming to be an authorized representative prior to receipt of an authorization that meets the criteria in clauses (i) and (ii), as determined by the Disclosure Administrator. The Disclosure Administrator may disregard any designation of an authorized representative that it deems to be defective or otherwise improper or invalid hereunder. In particular, and without limitation, the Disclosure Administrator reserves the right and discretion to refuse to honor a Participant's or Beneficiary's designation of an authorized representative if the Disclosure Administrator determines that such designation is fraudulent; such as, for example, when the Disclosure Administrator determines that the signature of approval on the designation does not belong to the Participant or Beneficiary.
- (c) *Examination of Records.* Participants and Beneficiaries shall have the right to examine such records, documents and other data as required by ERISA at reasonable times during regular business hours. Nothing contained in the Plan shall give any Participant the right to examine any data or records with respect to any other Participant except as required by applicable law which cannot be waived.

9.5 Rules and Decisions.

The Plan Administrator may adopt such rules and procedures, as it deems necessary or appropriate for the proper administration of the Plan. The Plan Administrator shall be entitled to rely upon information furnished to it which appears proper without the necessity of any independent verification or investigation.

9.6 Facility of Payment for Incapacitated Participant.

Except as otherwise provided under the terms of a Fully-Insured Program, whenever, in the Claims Fiduciary's opinion, a Participant is entitled to receive any payment of a benefit hereunder and is under a legal disability or is incapacitated in any way so as to be unable to manage his own financial affairs (including physical and mental incompetence or status as a minor), the Claims Fiduciary may direct payments to such person or to the person's legal representative (such as a guardian or conservator, upon proper proof of appointment furnished to the Claims Fiduciary), Dependent, or relative of such person for such person's benefit, or the Claims Fiduciary may direct payment for the benefit of such person in such manner as the Claims Fiduciary considers advisable in its discretion. Any payment of a benefit, to the full extent thereof, in accordance with the provisions of this Section 9.6 will be a complete discharge of any liability for the making of such payment under the Plan.

9.7 Non-Alienation of Benefits.

No benefit, right or interest of any Participant or Payee under the Plan shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, seizure, attachment or legal, equitable or other process, or be liable for, or subject to, the debts, liabilities or other obligations of such person, except as otherwise required by law. The Employer shall not be in any manner liable for or subject to the debts, contracts, liabilities, engagements or torts of any Participant or Payee entitled to benefits hereunder.

9.8 Overpayments.

If, for any reason, any benefit, premium or fee under the Plan is erroneously paid to a Participant, Beneficiary or other Payee (collectively, a “**Plan Recipient**”), or a services provider, insurance company or other person or entity for the benefit of a Plan Recipient (collectively, a “**Third-Party Payee**”), such person or entity shall be responsible for refunding the overpayment to the Plan. If such overpayment is not refunded within a reasonable time period as determined by the Plan Administrator, the overpayment shall be (a) charged directly to the Plan Recipient or Third-Party Payee as a reduction of the amount of future benefits otherwise payable on behalf of the Plan Recipient, or (b) recouped by any other method which the Plan Administrator or Claims Fiduciary deems appropriate in its discretion, as permitted by applicable law. For example, the selected repayment method may include, without limitation, (i) payroll deduction in the case of a Plan Recipient who is an Employee (in which case the Plan Recipient must execute such forms authorizing payroll deduction as the Plan Administrator shall require as a mandatory condition of his participation, or continued participation, in the Plan) or (ii) offsetting other payments made by the Plan to the Plan Recipient or to the same Third-Party Payee on the Plan Recipient’s behalf (in which case, such payment offset to a Third-Party Payee shall not constitute an adverse benefit determination that is subject the ERISA claims and appeals procedures of the Plan). For purposes of clarity and not limitation, in the event of the application of any overpayment offset to a Third-Party Payee pursuant to the foregoing provisions of this Section 9.8, the offset of the overpayment hereunder is simply an adjustment to the amount owed to the Third-Party Payee to reflect the overpayment and shall not be considered to be the denial or partial denial of any benefit claim under the Plan.

Notwithstanding the foregoing, if the relevant Welfare Program Document for a Fully-Insured Program contains provisions regarding the subject matter of this Section 9.8 which directly conflict with the provisions herein, as determined by the Plan Administrator, to resolve such direct conflict, the provisions of such Welfare Program Document with control with respect to that Fully-Insured Program.

9.9 Governing Law; Jurisdiction.

Except as otherwise required for a Fully-Insured Program, all matters or issues relating to the interpretation, construction, validity, and enforcement of the Plan shall be governed by the laws of the State of Texas, without giving effect to any choice-of-law principle that would cause the application of the laws of any jurisdiction other than Texas, except to the extent such laws are preempted by ERISA or other controlling federal law. As the Plan is administered in Harris County, Texas, mandatory venue for any claim, legal suit, action or other proceeding arising out of, or relating to, the Plan, other than an interpleader action under the Plan that is initiated by the Plan Sponsor, the Plan Administrator or a designee thereof, shall be the Federal District Court for the

Southern District of Texas—Houston Division or any judicial district court that is situated in Harris County, Texas, subject to removal of any such action under ERISA (under 28 U.S.C. §§ 1441 et seq. or any successor provision). Venue for an interpleader action under the Plan that is initiated by the Plan Sponsor, the Plan Administrator or a designee thereof shall be, as decided by the Plan Administrator in its discretion, in (a) the state where the deceased Participant resided at his death (if the benefits which are the subject of the interpleader action are those of a deceased Participant), (b) the state in which at least one defendant in the interpleader action resides, or (c) the Federal District Court for the Southern District of Texas—Houston Division or any judicial district court that is situated in Harris County, Texas.

Each Participant, as the result of, and in consideration for, participation in the Plan, and his designated representative, with respect to any claim or dispute relating in any way to, or arising out of, the Plan, consents and agrees to such jurisdiction and venue as described in this Section 9.9 and waives any objection to such jurisdiction or venue including, without limitation, that it is inconvenient. Such parties shall not commence any legal action other than before the above-named courts. Notwithstanding the previous sentence, a party may commence any legal action in a court other than the above-named courts solely for the purpose of enforcing an order or judgment issued by one of the above-named courts.

ARTICLE X
IMPORTANT ERISA INFORMATION

Name of Plan: BMC Software, Inc. Welfare Benefit Plan.

Plan Sponsor and Plan Administrator: BMC Software, Inc. 2101 CityWest Blvd. Houston, TX 77042

Plan Sponsor and Plan Administrator's Telephone Number: 1-877-262-4849.

Employer Identification Number: 74-2126120.

Plan Number: 511.

Type of Plan: The Plan is an "employee welfare benefit plan" subject to ERISA that provides (1) basic, optional employee, and optional dependent life insurance benefits, (2) optional employee, and optional employee and dependent accidental death and dismemberment insurance benefits, (3) business travel accident insurance benefits, (4) basic and supplemental long-term disability insurance benefits, and (5) pre-paid legal benefits. The Plan also provides self-funded short-term disability benefits which are funded through the general assets of the Employer.

Type of Administration: The Plan is administered by the Plan Administrator, with benefits being provided in accordance with the terms, limits and conditions of the Plan. The Plan Administrator has engaged the Claims Fiduciary and Claims Administrator(s), as set forth in Appendix D, to process claims and perform other duties under the Plan.

Disclosure Administrator: AVP Total Rewards, BMC Software, Inc., 2103 CityWest Blvd., Houston, TX 77042, 1-877-262-4849.

Agent for Service of Legal Process: The Plan Administrator at the address listed above.

Plan Year: The Plan and its records are kept on a Plan Year basis. The Plan Year is the 12-month period beginning each January 1st and ending on December 31st.

Sources of Contributions: The adopting Employers and Participants pay the costs for coverage. The Plan Sponsor determines the portion of costs to be paid by the adopting Employers and the Participants. Employer contributions toward the cost of coverage under the Plan are provided through the Employer's general assets.

ARTICLE XI

STATEMENT OF ERISA RIGHTS

As a Participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants are entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all Plan documents including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain copies of all Plan documents including insurance contracts and copies of the latest annual report (Form 5500 Series) and an updated Summary Plan Description, upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan.

The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Plan Participants and Beneficiaries.

No one, including the Employer, or any other person, may terminate you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

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

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

If you have a claim for benefits which is denied or ignored, in whole or in part, and you disagree with that denial, you must file an appeal of that denial in accordance with the Claims Procedures described in this Wrap-SPD. If your appeal is denied in accordance with the Claims Procedures herein, and you have exhausted the administrative remedies provided to you under the Plan, you may file suit in a state or Federal court. If it should happen that Plan fiduciaries misuse

the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or 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 who was sued to pay these costs and fees. If you are not successful, 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 Plan, you should contact the Plan Administrator at 1-877-262-4849.

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the 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. WELFARE BENEFIT PLAN
(Amended and Restated Effective as of January 1, 2022)**

APPENDIX A

As of January 1, 2022, the following Employers have adopted and are participating in the Plan:

- BMC Software, Inc. (which is the Plan Sponsor); and
- (Effective as of August 14, 2014) BMC Software Federal, LLC.

**SUMMARY PLAN DESCRIPTION OF THE
BMC SOFTWARE, INC. WELFARE BENEFIT PLAN
(Amended and Restated Effective as of January 1, 2022)**

APPENDIX B

As of January 1, 2022, the following Welfare Programs are incorporated, in their entirety, by reference into this Wrap-SPD:

1. BMC Software, Inc. Basic and Supplemental Life Insurance Program;
2. BMC Software, Inc. Supplemental Accidental Death and Dismemberment Insurance Program;
3. BMC Software, Inc. Business Travel Accident Insurance Program;
4. BMC Software, Inc. Basic and Supplemental Long-Term Disability Insurance Program;
5. BMC Software, Inc. Prepaid Legal Services Program; and
6. BMC Software, Inc. Short-Term Disability Program.

**SUMMARY PLAN DESCRIPTION OF THE
BMC SOFTWARE, INC. WELFARE BENEFIT PLAN
(Amended and Restated Effective as of January 1, 2022)**

APPENDIX C

As of January 1, 2022, the following Welfare Program Documents are attached hereto and incorporated, in their entirety, into this Wrap-SPD by reference:

- BMC Software, Inc. Basic and Supplemental Life Insurance Program:
 - Liberty Life Assurance Company of Boston Certificate of Coverage for Policy Number SA3-890-446571-01 (Effective Date: January 1, 2011), as applicable to the basic and supplemental life insurance coverage provided thereunder.
- BMC Software, Inc. Supplemental Accidental Death and Dismemberment Insurance Program:
 - Liberty Life Assurance Company of Boston Certificate of Coverage for Policy Number SA3-890-446571-01 (Effective Date: January 1, 2011), as applicable to the supplemental AD&D coverage provided thereunder.
- BMC Software, Inc. Business Travel Accident Insurance Program:
 - Chubb Certificate of Coverage for Policy Number ADD N14286330 (Effective Date: August 1, 2018).
- BMC Software, Inc. Basic and Supplemental Long-Term Disability Insurance Program:
 - Liberty Life Assurance Company of Boston Certificate of Coverage for Policy Number GF3-890-446571-01 (Dated: September 26, 2017).
- BMC Software, Inc. Prepaid Legal Services Program:
 - METLAW Summary Plan Description for BMC Software, Inc. (Effective Date: January 1, 2017).
- BMC Software, Inc. Short-Term Disability Program:
 - Liberty Life Assurance Company of Boston Booklet for the Short Term Disability Program, dated December 10, 2012, and as further amended effective August 21, 2017 and January 1, 2018.

**SUMMARY PLAN DESCRIPTION OF THE
BMC SOFTWARE, INC. WELFARE BENEFIT PLAN
(Amended and Restated Effective as of January 1, 2022)**

APPENDIX D

As of January 1, 2022, the following third party entities serve as Claims Administrators and/or Claims Fiduciaries under the Plan with respect to the following Welfare Programs:

Welfare Program	Claims Administrator and/or Claims Fiduciary (as designated)
• BMC Software, Inc. Basic and Supplemental Life Insurance Program; • BMC Software, Inc. Supplemental Accidental Death and Dismemberment Insurance Program; and • BMC Software, Inc. Basic and Supplemental Long-Term Disability Insurance Program.	<i>Claims Administrator / Claims Fiduciary</i> The Lincoln National Life Insurance Company Disability and Life Claims P.O. Box 2578 Omaha, NE 68172-9688 1-800-320-7585
• BMC Software, Inc. Business Travel Accident Insurance Program.	<i>Claims Administrator / Claims Fiduciary</i> Chubb ACE American Insurance Company Dept CH 10678 Palatine, IL 60055-0678 1-855-327-1414
• BMC Software, Inc. Short-Term Disability Program.	<i>Claims Administrator / Claims Fiduciary</i> The Lincoln National Life Insurance Company Disability and Life Claims P.O. Box 2578 Omaha, NE 68172-9688 1-800-320-7585
• BMC Software, Inc. Prepaid Legal Services Program.	<i>Claims Administrator / Claims Fiduciary</i> Hyatt Legal Plans, Inc. 1111 Superior Avenue Cleveland, OH 44114-2407 1-800-821-6400 www.legalplans.com

**SUMMARY PLAN DESCRIPTION OF THE
BMC SOFTWARE, INC. WELFARE BENEFIT PLAN
(Amended and Restated Effective as of January 1, 2022)**

APPENDIX E – COVID-19 Provisions

A. Defined Terms.

Capitalized terms used in this Appendix shall have the definitions set forth in Section E of this Appendix, or otherwise as set forth in Article I of this Wrap-SPD. Such definitions shall supersede any other definitions for the same terms as set forth in the Welfare Program Documents for a Welfare Program (except with respect to any Fully-Insured Program), unless a different definition is plainly required by the context.

B. Application and Interpretation.

The provisions of this Appendix are effective as specified herein. Such provisions are intended to comply with the COVID-19 Laws and shall be interpreted, construed and applied accordingly. They shall supersede any contrary or inconsistent provisions elsewhere in this Wrap-SPD, as well as any provisions in a Welfare Program Document regarding the same subject that are contrary to (or inconsistent with) and more restrictive than the provisions herein, except to the extent otherwise required by applicable law.

C. Extension of Certain Timeframes.

Effective as of March 1, 2020, the following Compliance Timeframes under the Plan shall be tolled during the COVID Disregarded Period:

- (1) The timeframe within which individuals are permitted to file a benefit claim under the Plan's claim and appeal procedures; and
- (2) The timeframe within which claimants are permitted to file an appeal of an adverse benefit determination under the Plan's claim and appeal procedures.

The application of the COVID-19 Disregarded Period under the Plan is intended to comply with ERISA Section 518, Code Section 7508A(b), the Relief Notice, and any subsequent related law or authoritative guidance that is issued or adopted by the appropriate government agency and shall be interpreted and construed accordingly.

D. Good Faith Relief Regarding Disclosures.

As provided in Disaster Relief Notice 2020-01, "Guidance and Relief for Employee Benefit Plans Due to the COVID-19 (Novel Coronavirus) Outbreak", issued by the Employee Benefit Security Administration of the DOL, effective during the period beginning on March 1, 2020 and ending on the Relief End Date, the Plan and the responsible Plan fiduciary will not be in violation of ERISA for a failure to timely furnish a notice, disclosure, or document which is required by the provisions of Title I of ERISA over which the DOL has interpretive and regulatory authority (except for those notices and disclosures addressed in the Relief Notice and which must be furnished between March 1, 2020, and the Relief End Date), if the Plan and responsible fiduciary act in good faith and furnish the notice, disclosure, or document as soon as administratively practicable under

the circumstances. Good faith acts shall include, without limitation, use of electronic alternative means of communicating with Participants who the Plan fiduciary reasonably believes have effective access to electronic means of communication, including email, text messages, and continuous access websites.

E. **Definitions.**

- (1) “**Compliance Timeframe**” shall mean each elapsed timeframe under the Plan that is subject to relief under the Relief Notice.
- (2) “**COVID-19 Disregarded Period**” shall mean, as applicable to each Participant individually, and with respect to each Compliance Timeframe under the Plan, the period described as follows:
 - (a) If the first day of the Compliance Timeframe (“**Timeframe Start Date**”) occurs on or prior to March 1, 2020, the period which (i) begins on March 1, 2020, and (ii) ends on the Relief End Date, or February 28, 2021, if earlier; or
 - (b) If the Timeframe Start Date occurs after March 1, 2020 (but on or prior to the Relief End Date), the period which begins on the Timeframe Start Date and ends on the Relief End Date (or the date that is 364 days following the Timeframe Start Date, if earlier).

The COVID Disregarded Period shall be inapplicable in the case of a Compliance Timeframe that begins after the Relief End Date. The COVID Disregarded Period is intended to comply with ERISA Section 518, Code Section 7508A(b), the Relief Notice, and any applicable authoritative guidance related to the foregoing, as issued or adopted by the appropriate government agencies, and shall be interpreted and construed accordingly.

- (3) “**COVID-19 Laws**” means, collectively, (a) the Families First Coronavirus Response Act, (b) the Coronavirus Aid, Relief, and Economic Security Act, (c) IRS Notice 2020-15, (d) IRS Notice 2020-29, (e) the “Notice of Relief; Extension of Timeframes”, at 85 FR 26351 (May 4, 2020), and (f) any applicable authoritative guidance related to the foregoing as issued by the appropriate federal agencies.
- (4) “**COVID-19 National Emergency**” shall mean the national emergency beginning on March 1, 2020, as determined by the President of the United States on March 13, 2020, under Section 501(b) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 USC § 5121 et seq., as a result of the COVID-19 outbreak and declared by the President on March 13, 2020, in the “Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak”.
- (5) “**DOL**” means the U.S. Department of Labor.
- (6) “**Relief End Date**” means the 60th day following the announced end of the COVID-19 National Emergency or such other date announced by the DOL and the Treasury Department in authoritative guidance issued subsequent to the Relief Notice.

- (7) *“Relief Notice”* means the “Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak”, issued by the DOL and the Treasury Department at 86 FR 26351 (May 4, 2020).
- (8) *“Treasury Department”* means the U.S. Department of the Treasury.