BENEFITS THAT FIT *your health*

2012 BMC Software U.S. Benefits Guide

bmcsoftware

Table of Contents

Disability Benefits

Work/Life Solutions

Plan Contact Information 53

Appendices

BMC "Benefits That Fit"

Benefits Overview

Wealth accumulation. Healthy living. Financial protection against large medical bills. Financial security for your family. Significant tax advantages.

These are just a few of the valuable features of your employee benefits at BMC Software—a significant part of your total compensation.

We continually look for ways to offer a comprehensive benefits package that represents contemporary thinking in benefit plan design and at the same time provides an important combination of financial protection and security to address both your short-term needs and your long-range goals.

BMC "benefits that fit" lets you build an individual program featuring protection and security that best meets your individual and family needs. Our programs provide support for you and your family in three main categories:

- **Health and Wellness:**
  Promote healthy lifestyles for employees and their families, ensure quality of care and offer excellent preventive benefits—all at a competitive cost. Programs include medical, dental and vision plans, flexible spending accounts, and wellness and health incentives.
- **Financial Well-Being:**
  Enable and encourage employees' involvement in managing and securing their financial future. Programs include the 401(k) plan, life insurance, stock purchase plan, and long-term care insurance.
- **Work/Life Solutions:**
  Balance the personal needs of employees while maintaining and improving productivity and client satisfaction. Benefits include group prepaid legal, auto/homeowner's insurance, and even pet health insurance.

A Shared Responsibility

Your benefits represent a partnership between you and BMC:

- The company offers a sound, comprehensive benefits program for you and your family and equips you with tools and resources so you can make appropriate decisions for your personal situation.
- You are responsible for understanding the benefits you choose and the rules of each plan—the similarities and differences among your choices—and making the best decisions to provide you and your family with the most appropriate coverage at the most reasonable cost.

Take Control

You have the chance to build a personalized benefits package each year. "Benefits that fit" offers you:

- **Choice.** Three types of medical plans, various coverage levels for life insurance and other personal protection plans.
- **Tax advantages.** The Health Savings Account allows you to pay for health care expenses with tax-free money and roll over unused money in your account from year to year, helping you grow an untaxed resource for future medical expenses. The Flexible Spending Accounts allow you to pay for health care and dependent care expenses with tax–free money. The BMC 401(k) Plan gives you the ability to grow your wealth while sheltering your savings and investment earnings from current taxes. Or, you may choose—through the Roth option—to pay taxes on the contributions now and shelter future earnings from taxes. Gains on the sale of BMC stock purchased through the Employee Stock Purchase Plan (ESPP) may receive preferential capital gains tax treatment based on the length of time you own your shares.
- **Flexibility.** Because your benefit needs change from year to year, you can choose different benefits coverage during annual enrollment, or even during the year if your family situation changes. You can adjust your Health Savings Account contributions and your 401(k) savings rate and investment choices at anytime and your ESPP contributions twice a year.
- **Easy, real-time access.** For health care and other benefits, log on anytime to Your Benefits Resources™ website to find detailed information about benefit choices and coverages. For the 401(k) and ESPP, log on to Fidelity Netbenefits® (www.netbenefits.com) to enroll, keep track of your account balances, and make savings and investment changes.

Enrolling & Making Changes

Accessing Your Benefits

Detailed, personalized information about your BMC benefits is available from two websites:

- Your Benefits Resources (www.yourbenefitsresources.com/bmc)—health and insurance benefits and costs
- Fidelity Netbenefits® (www.netbenefits.com)—401(k) Plan and Stock Purchase Plan.

The Your Benefits Resources website is your one-stop location for benefits information. Using Your Benefits Resources gives you two ways to make or change your benefit elections—online at yourbenefitsresources.com/bmc or by telephone at 1-877-BMC-4849.

Fidelity Netbenefits® makes managing your 401(k) savings and stock accounts as simple as possible. It gives you easy access to view and manage your portfolio and to take action on your accounts, and the online tools can help you determine your retirement readiness.

Need Help?
Call 1-877-BMC-4849

- **Enter your identification and password**
- **Select Health and Insurance**
- **Say "representative"**

You will be routed directly to someone that can help you. Representatives are available from Monday through Friday, 8 a.m. to 9 p.m., Eastern time.

Eligibility

You are eligible to participate in all BMC benefits if you're an active, full-time, regular employee scheduled to work at least 30 hours a week. All of your benefits begin on your first day of employment. You receive full medical benefits with no waiting periods and no pre-existing health condition exclusions.

Your dependents may also be enrolled in BMC benefits if they meet eligibility requirements. Eligible dependents include your:

- Lawful spouse
- Same- or opposite-gender domestic partner with whom you are in a long-term relationship (at least six months) and your partner's legal dependent children
- Children under the age of 26 regardless of whether they are married or a full-time student, including natural or legally adopted children, foster children, step-children, grandchildren in your court-ordered custody, and any other child who lives with you in a parent-child relationship, or whose parent is covered as a dependent under the plan
- Unmarried disabled children of any age who depend on you for support

Newly Hired Employees

If you don't enroll yourself or your eligible dependents within 31 days of your hire date, you're automatically covered by these BMC benefits:

- **Employee-only Aetna HSA Medical**
- **Basic Life Insurance**
- **Short-Term Disability**
- **Basic Long-Term Disability**
- **Business Travel Accident**
- **Employee Assistance Program**

Changing Your Elections

Generally, any benefit choices that you make upon joining BMC as a new employee remain in effect for the entire calendar year. In some situations, you can make limited changes to your coverage during the year. Those situations are called qualified family status changes (life events).

You have 31 days from the date of the qualified family status change (life event) to make new benefit elections for the remainder of the year. Changes are allowed only for the benefit coverages that are consistent with the change. (For example, the birth of a child allows you to add your new dependent to your health plan and to add dependent life insurance.)

The following events may qualify as family status changes (life events):

Making Benefit Changes

Online

1) **Go to www.yourbenefitsresources.com/bmc (available anytime from any computer with Internet access).**
2) **On the main menu under Health and Insurance, click Your Benefits Resources.**
3) **Hover over Health and Insurance and select TAKE ACTION —Change Coverage.**
4) **Select the life event from the drop-down menu.**
5) **Follow the instructions.**

Telephone Access

Call Your Benefits Resources by dialing 1-877-BMC-4849.

Representatives are available between 8 a.m. and 9 p.m. (Eastern time) Monday through Friday.

- Marriage or divorce
- Formation or dissolution of a domestic partnership
- Birth, adoption or placement for adoption of a child
- Death of your spouse, domestic partner or dependent
- Change in your spouse's/domestic partner's employment
- Loss of other health care coverage (if you elected "No coverage" because other coverage was available)
- Your child loses eligibility as a dependent
- Loss of COBRA coverage
- A Qualified Medical Child Support Order (QMCSO) or other court order is issued
- You or your spouse/domestic partner goes on or returns from an unpaid leave of absence
- Significant change in coverage or cost of coverage provided to your spouse/domestic partner by his or her employer
- You, your spouse/domestic partner or dependent becomes eligible for Medicare or Medicaid

If You Leave BMC

If you leave BMC, you may be eligible to continue your health care coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA). Information about continuation of coverage and the conditions and requirements for obtaining this coverage will be sent to your home address. In addition, you can call Your Benefits Resources at 1-877-BMC-4849 to speak with a Benefits Representative. See page 56 or go online to Your Benefits Resources website.

Life insurance, short-term and long-term disability and prepaid legal benefit coverage ends on your last day worked at BMC, but health insurance coverage ends on the last day of the month in which any of the following occur:

- Your employment status changes from full-time to part-time
- You terminate employment
- Your dependents are no longer eligible
- The benefit plan is discontinued

Keep Your Plan Informed of Address Changes

Be sure to keep your current address and your dependents' addresses on file with Your Benefits Resources Benefits Center.

It is critical that you maintain your current address and other contact information on Employee Direct Access (EDA) so that you receive benefits communications in a timely manner. You can access EDA through the Oracle logon link on the BMC intranet home page (https://intranet.bmc.com).

Health Benefits

Medical Plans

BMC offers three distinct medical plan choices:

- **Aetna HSA (Health Savings Account)**
  A high-deductible health plan with a tax-free Health Savings Account. This medical plan offers you a choice of medical care providers similar to a traditional PPO plan and provides in- and out-of-network benefits. In addition, BMC makes an annual contribution to your HSA for you to use during the year to pay your share of health-related expenses. Unused money in your HSA rolls over from year to year for you to use for future health expenses. Prescription drug coverage is provided through Medco. You pay prescription drug costs until you reach the plan deductible. The plan covers certain **preventive prescription drugs** at 85%, which means you pay only 15% of the costs before you satisfy the plan deductible.
- **Aetna PPO (Preferred Provider Organization)**
  A medical plan that lets you decide where to receive care each time you need it. If you use a provider in the PPO network, you pay less for health services. If you receive care from a non-network provider, you pay a larger portion of the cost, and the cost itself is higher. Prescription drug coverage is provided through Medco.
- **Kaiser HMO (Health Maintenance Organization)**
  Available only in California. A managed care medical plan that provides medical and prescription drug benefits only when you receive care within the HMO network and when the care is coordinated by your primary care physician.

Here is a Snapshot of the Medical Plan Choices

	AETNA HSA		AETNA PPO		KAISER HMO
You Receive Care From:	Any provider you choose; in-network services cost you less		Any provider you choose; in-network services cost you less		Providers in the network
Claim Forms and Paperwork Are Filed By:	In-Network: Your doctor	Out-of-Network: You	In-Network: Your doctor	Out-of-Network: You	In-Network: Your provider
Managing Your Health	You coordinate your care		You coordinate your care		Primary care physician coordinates care with you
Out-of-Area Participant Coverage	Yes		Yes		Emergencies only—check with plan
Your Cost Share	Your monthly premium is lower, but you pay for all medical services (except preventive) and prescription drug costs (except 15% of certain preventive prescription drugs) until you reach the deductible. After you reach the deductible, the cost is shared between BMC and you.		Your monthly premium is higher; you only pay a copay for doctor's visits and prescription drugs. Certain services are subject to a deductible, and then the cost is shared between BMC and you.		Your monthly premium is higher; you only pay a copay for most services.
Health Savings Account (HSA)	An HSA account is automatically opened for you. You receive employer contributions, and you may make your own before-tax payroll contributions up to the annual IRS limit. See page 19 for more information.		Not eligible to participate		Not eligible to participate
Health Care Flexible Spending Account (FSA)	You may make before-tax contributions to a **limited use** account for dental and vision care. After you have reached your deductible, you may also receive reimbursement for medical claims incurred after that date. See page 33 for more information.		You may make before-tax contributions to a Health Care Flexible Spending Account for all eligible health expenses allowed by the **IRS Publication 502.** See page 32 for more information.		You may make before-tax contributions to a Health Care Flexible Spending Account for all eligible health expenses allowed by the **IRS Publication 502.** See page 32 for more information.

See details about benefits under each plan on pages 13 through 18.

Wellness at BMC

When you and your family members take action to get healthy and stay healthy, you feel better, you're happier and you enjoy a better quality of life. Taking good care of ourselves and seeking preventive care improves our overall well-being. It also leads to better health outcomes. That's why BMC will enhance our focus on wellness in 2012 by introducing a new health management program.

The new program will provide you with tools and a support system to improve or maintain your health. You will be invited to participate in a health assessment and health screenings in 2012, providing information than can help you manage even minor health issues before they get out of control. If you get a health screening and complete the Well Being Assessment™ (WBA) by July 31, 2012, you will receive $25 per pay check (up to $600) to help pay for your 2013 medical coverage. If you are hired between May 1 and October 15 and complete the WBA by October 31, 2012, you will receive $12.50 per pay check (up to $300).

The wellness program is completely confidential. BMC never has access to individual, personal health information, such as your answers to the WBA.

Finding a Network Provider

It's easy to locate network providers for the Aetna HSA, the Aetna PPO and the Kaiser HMO. You can find a list of participating providers on the Aetna website (www.aetna.com) and on the Kaiser website (www.kp.org), or you can contact Aetna and Kaiser directly by phone to request a provider directory. You can also access the applicable provider directory through the Your Benefits Resources website (www.yourbenefitsresources.com/bmc). On the main menu under Health and Insurance, click **Your Benefits Resources**, then hover over **Health and Insurance** and select **TAKE ACTION — Find A Doctor**.

If you are enrolled in one of the Aetna coverage options and you choose not to use a network provider for your medical services, your out-of-pocket costs will be higher (for a comparison of in- and out-of-network coverage, see the charts beginning on page 13). You may also have to file a claim form to receive reimbursement for services within 12 months of the date of the service. Prescription drug claims through Medco must be processed by a Medco in-network pharmacy or through Medco's mail-order program. If you choose not to use a Medco network pharmacy, your benefit will be reduced to 50% of the drug cost and you will need to submit a claim form for reimbursement.

If you are enrolled in the Kaiser HMO coverage option, no benefits are payable for services or prescription drugs provided by facilities, providers or pharmacies outside of the Kaiser network except in certain emergency situations. This includes coverage for dependents living outside the coverage area and certain emergency situations for all covered members. Please check with Kaiser directly about this coverage.

Deductible and Out-of-Pocket Maximum

Under the Aetna medical plans, you have a deductible to meet each plan year (the Kaiser HMO has no annual deductible). The deductible is fully paid by you. Once the plan deductible is met, the provider begins paying at the appropriate level. The Aetna PPO Plan and the Aetna HSA Plan have separate deductibles for in-network and out-of-network coverage. See the charts on pages 13-18 for the deductible and coinsurance levels for each plan.

It is important to note differences in how the family deductible works under the Aetna HSA Plan and the Aetna PPO Plan. Since the Aetna HSA Plan is a qualified High Deductible Health Plan (HDHP), IRS guidelines specify that if you elect coverage for one or more family members, individual deductibles do not apply. You must meet the family deductible before the plan begins paying for any covered individual (except preventive care and certain preventive prescription drugs). Under the Aetna PPO, after you or a covered family member meet the deductible, the plan begins paying for any covered individual. However, when meeting the family deductible, the expenses applied by each covered person may be no greater than their individual deductible amount. For example, if your individual deductible is $500 and you have expenses of $800, only $500 of those expenses would be applied to the family deductible.

If you reach the annual deductible, BMC pays 85% of eligible in-network expenses, and you pay the rest through coinsurance. Once you reach the out-of-pocket maximum, BMC pays 100% of most eligible in-network expenses for the rest of the year. If you are in the Aetna HSA plan and have family coverage [employee plus spouse, employee plus child(ren) or employee plus family] the individual out-of-pocket maximum does not apply. You will need to satisfy the family out-of-pocket maximum before BMC pays 100% of the cost.

Medicare & Your BMC Medical Benefits

If you are an active employee or covered dependent and you become eligible for Medicare, you can choose to:

- Continue primary coverage under the BMC plans. You can also enroll in Medicare, but Medicare will be the secondary payer. You can enroll in both Medicare Part A and Part B, or enroll in Part A only and delay enrollment in Part B.
- Drop coverage under the BMC plans and have Medicare as your primary source of coverage.

If you delay enrollment in Medicare beyond age 65 because you are covered by the BMC plans, you will be able to enroll in Medicare later (after you are no longer covered by BMC) without the usual late enrollment penalty. Typically, you will have a "special enrollment period" of eight months from the time you no longer have employer-based coverage to enroll in Medicare. If you wait longer than eight months to enroll, you will lose your special enrollment rights and will have to wait until the once-a-year annual enrollment period, and you will pay higher Medicare premiums.

Additional rules apply concerning COBRA coverage and Medicare. For more information, please see page 56.

If you are already Medicare-eligible or expect to be shortly, please contact the Social Security Administration at the Web address or phone number listed in the Plan Contact Information section of this guide.

Special Rules for Medicare & Enrollees in the Aetna HSA Plan

Employees age 65 and older who waived enrollment in Medicare may be eligible to contribute to an HSA and to receive BMC's HSA contributions. According to Internal Revenue Service (IRS) Publication 969, an individual ceases to be eligible for the HSA and BMC's HSA contributions starting with the month he or she becomes eligible for and enrolls in Medicare. It is the employee's responsibility to confirm with Social Security that they have not enrolled in any of the Medicare plans (A, B, C, D). Participation in an HSA while entitled to benefits under Medicare will result in tax implications. Remember, if you are enrolled in Medicare, you are ineligible to contribute to an HSA and therefore, you are ineligible to be covered under the Aetna HSA Plan. Becoming eligible for Medicare is considered a "life event," and you will be able to select another plan option within 31 days of the life event.

If you have an existing HSA and you enroll in Medicare, you can no longer contribute to the HSA and you should no longer be enrolled in the Aetna HSA Plan. This also applies to your spouse or domestic partner if they enroll in Medicare and are also covered under your Aetna HSA Plan. However, funds can be used for reimbursement for services and payment of premiums for Medicare Part B, but they cannot be used for premiums for Medicare Supplemental plans.

Aetna HSA Plan

PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible	$1,500 individual/$3,000 family	$3,000 individual/$6,000 family
Annual Out-of-Pocket Maximum (includes deductible and copays)	$3,000 individual/ $6,000 family	$6,000 individual/ $12,000 family (excludes amounts above usual and customary)
Lifetime Maximum Benefit	Unlimited	Unlimited
General Medical Expenses		
Primary & Specialist Doctor Office Visit (includes maternity care)	85% covered after deductible	65% covered after deductible
Inpatient Hospital Care (requires preauthorization)		
Hospitalization[1]	85% covered after deductible	65% covered after deductible
Inpatient Physician and Surgeon Services[1]	85% covered after deductible	65% covered after deductible
Inpatient Lab and X-ray	85% covered after deductible	65% covered after deductible
Maternity and Delivery Services & Newborn Nursery Services[2]	85% covered after deductible	65% covered after deductible
Outpatient Care		
Outpatient Surgery	85% covered after deductible	65% covered after deductible
Outpatient Laboratory Services & X-ray Services	85% covered after deductible	65% covered after deductible
Preventive Care		
Annual Physical Exam & Immunizations	100% covered per exam (no deductible applies)	65% covered after deductible
Well-Baby & Well-Child Exams and Immunizations	100% covered per exam (no deductible applies)	65% covered after deductible
Well-Woman Exam	100% covered per exam (no deductible applies)	65% covered after deductible
Other Preventive Care & Cancer Screenings[3]	100% covered per exam (no deductible applies)	65% covered after deductible

(1) For transplant services, the in-network benefit is reduced to 65% per admission after calendar year deductible if services are not performed at an Institute of Excellence (IOE) facility.

(2) Your newborn is automatically covered under the plan for the first 31 days. You must add your newborn as a dependent on your medical insurance through Your Benefits Resources within 31 days of birth in order for your child to have coverage after this period.

*(3) Other preventive exams and cancer screenings may have age and time limit restrictions. Review your medical plan details on the Your Benefits Resources website. Click on **Main Menu**, then **Your Benefits Resources**, hover over **Knowledge Center** and select **Plan Information**.*

(Aetna HSA Plan continues on page 14)

Aetna HSA Plan (continued)

PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK
Emergency Services		
Hospital Emergency Facility	85% covered after deductible	85% covered after deductible
Non-Emergency Care in a Hospital Emergency Room	Not covered	Not covered
Urgent Medical Care (at a non-hospital free standing facility)	85% covered after deductible	65% covered after deductible
Chiropractic Services		
Spinal Manipulation	85% covered after deductible ($1,500 maximum per year)	65% covered after deductible ($1,500 maximum per year)
Short-Term Rehabilitation Therapy [4]		
Outpatient Physical, Speech, Occupational Therapy	85% covered after deductible; 60-visit combined maximum per year	65% covered after deductible; 60-visit combined maximum per year
Mental Health, Substance Abuse Care		
Mental Health: Inpatient & Outpatient Coverage	85% covered after deductible	65% covered after deductible
Rehab and Detox: Inpatient & Outpatient Coverage	85% covered after deductible	65% covered after deductible
Residential Treatment Facility (stays in a residential treatment facility for treatment of mental disorders, alcoholism or drug abuse)	85% covered after deductible	65% covered after deductible
Other Benefits		
Disease Management	Aetna Health Connections℠ disease management program offers support for over 30 common medical conditions, including diabetes, cancer and pregnancy.	
Prescription Drugs	Prescription Drugs are covered through Medco and not through Aetna. Please see page 22 for more information.	
Health Savings Account	You will have a Health Savings Account opened for you through UMB Bank. BMC deposits employer contributions, and you may choose to deposit your own contributions into this account. Please see pages 19 through 21 for more information.	

(4) Additional plan authorization review required after the first 25 visits.

Aetna PPO Plan

PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible	$500 individual/$1,000 family	$1,500 individual/$3,000 family
Annual Out-of-Pocket Maximum (includes deductible and office visit copays only)	$2,000 individual/ $4,000 family	$6,000 individual/ $12,000 family (excludes amounts above usual and customary)
Lifetime Maximum Benefit	Unlimited	Unlimited
General Medical Expenses		
Primary Doctor Office Visit	$25 copay	65% covered after deductible
Specialist Office Visit	$40 copay	65% covered after deductible
Inpatient Hospital Care (requires preauthorization)		
Hospitalization[1]	85% covered after deductible	65% covered after deductible
Inpatient Physician and Surgeon Services[1]	85% covered after deductible	65% covered after deductible
Inpatient Lab and X-ray	85% covered after deductible	65% covered after deductible
Outpatient Care		
Outpatient Surgery	85% covered after deductible; if performed as a part of an office visit and billed by a physician applicable copay applies	65% covered after deductible
Outpatient Laboratory Services & X-ray	85% covered after deductible; if performed as part of an office visit and billed by a physician applicable copay applies	65% covered after deductible
Chiropractic Services		
Spinal Manipulation	$40 copay ($1,500 maximum per year)	65% covered after deductible ($1,500 maximum per year)
Preventive Care		
Annual Physical Exam & Immunizations	100% covered	65% covered after deductible
Well-Baby & Well-Child Exams & Immunizations	100% covered	65% covered after deductible
Well-Woman Exam	100% covered	65% covered after deductible
Other Preventive Care & Cancer Screenings[2]	100% covered	65% covered after deductible

(1) For transplant services, the in-network benefit is reduced to 65% per admission after calendar year deductible if services are not performed at an Institute of Excellence (IOE) facility.

*(2) Other preventive exams and cancer screenings may have age and time limit restrictions. Review your medical plan details on the Your Benefits Resources website. Click on **Main Menu**, then **Your Benefits Resources**, hover over **Knowledge Center** and select **Plan Information**.*

(Aetna PPO Plan continues on page 16)

Aetna PPO Plan (continued)

PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK
Maternity Care[3]		
Office Visit: Prenatal/Postnatal	$25 copay, initial visit only	65% covered after deductible
In-Hospital Delivery & Newborn Nursery Services	85% covered after deductible	65% covered after deductible
Short-Term Rehabilitation Therapy[4]		
Outpatient Physical, Speech, Occupational Therapy	85% covered after deductible; 60-visit combined maximum per year	65% covered after deductible; 60-visit combined maximum per year
Emergency Services		
Hospital Emergency Facility	85% covered after deductible and after $100 copay	85% covered after deductible and after $100 copay
Non-Emergency Care in a Hospital Emergency Room	Not covered	Not covered
Urgent Medical Care (at a non-hospital free standing facility)	85% covered after $40 copay	65% covered after deductible
Non-Urgent Use of Urgent Care Provider (at a non-hospital free standing facility)	85% covered after deductible	65% covered after deductible
Mental Health, Substance Abuse Care		
Mental Health/Rehab & Detox Outpatient Coverage	$40 copay	65% covered after deductible
Mental Health/Rehab & Detox Inpatient Coverage	85% covered after deductible	65% covered after deductible
Residential Treatment Facility (stays in a residential treatment facility for treatment of mental disorders, alcoholism or drug abuse)	85% covered after deductible	65% covered after deductible
Other Benefits		
Disease Management	Aetna Health Connections℠ disease management program offers support for over 30 common medical conditions, including diabetes, cancer and pregnancy.	
Prescription Drugs	Prescription Drugs are covered through Medco and not through Aetna. Please see page 22 for more information.	

(3) Your newborn is automatically covered under the plan for the first 31 days. You must add your newborn as a dependent on your medical insurance through Your Benefits Resources within 31 days of birth in order for your child to have coverage after this period.

(4) Additional plan authorization review required after the first 25 visits.

Kaiser HMO (Northern and Southern California)[1]

PLAN FEATURE	IN-NETWORK
Annual Deductible	$0 individual/$0 family
Annual Out-of-Pocket Maximum	$1,500 individual/$3,000 family
Lifetime Maximum Benefit	Unlimited
General Medical Expenses	
Primary & Specialist Doctor Office Visit	$20 copay
Inpatient Hospital Care (requires preauthorization)	
Hospitalization	100% covered
Inpatient Physician and Surgeon Services	100% covered
Inpatient Lab and X-ray	100% covered
Maternity and Delivery Services & Newborn Nursery Services[2]	100% covered
Outpatient Care	
Outpatient Surgery	$20 copay
Outpatient X-ray & Laboratory Services	100% covered
Emergency Services	
Emergency Room	$50 copay if not admitted to hospital/$0 if admitted directly to hospital
Urgent Care Clinic	$20 copay
Ambulance Services	$50 per trip
Preventive Care	
Annual Physical Exam & Immunizations	100% covered
Well-Baby & Well-Child Exams & Immunizations	100% covered
Well-Woman Exam	100% covered
Other Preventive Care	100% covered

(1) Review your medical plan details on the Your Benefits Resources website. Go to ***Your Benefits Resources****, click on* ***Main Menu****, then* ***Your Benefits Resources****, hover over* ***Knowledge Center*** *and select* ***Plan Information****.*

(2) Your newborn is automatically covered under the plan for the first 31 days. You must add your newborn as a dependent on your medical insurance through Your Benefits Resources within 31 days of birth in order for your child to have coverage after this period.

(Kaiser HMO continues on page 18)

Kaiser HMO (Northern and Southern California) (continued)

PLAN FEATURE	IN-NETWORK
Mental Health, Substance Abuse Care	
Mental Health: Outpatient Coverage	$10 copay for group visit; $20 copay for individual visit
Mental Health: Inpatient Coverage	100% covered
Detox Rehab: Outpatient Coverage	$5 copay for group visit; $20 copay for individual visit
Detox Rehab: Inpatient Coverage	100% covered
Other Benefits	
Durable Medical Equipment	20% coinsurance
Home Health Care	100% covered (up to 100 visits per calendar year)
Skilled Nursing Facility	100% covered (up to 100 days per benefit period)
Chiropractic Services	$10 copay (up to 30 office visits per calendar year) plus a $50 allowance per calendar year for chiropractic appliances
Covered Infertility Treatment	50% coinsurance
Prescription Drugs	Prescription drug coverage is provided through Kaiser. See page 22 for details.

Health Savings Account

The Aetna HSA medical plan offers some unique features not available with the other medical plans.

When you enroll in the Aetna HSA Plan, you receive a BMC contribution that's based on who you cover and your base salary.

IF YOUR BASE SALARY IS:	AND YOU CHOOSE:	
	Employee-Only Coverage	Other Coverage Levels
	BMC's Contribution for 2012 is:	
$75,000 or less	$750	$1500
More than $75,000	$500	$1000

*Please note: You are eligible for BMC's HSA contribution if you are actively employed by BMC on the date the company contribution is deposited to your HSA. (**See page 20** for company contribution dates).*

You can also make your own before-tax contribution into your HSA account through payroll deductions, or you can make a personal check deposit into your HSA. The IRS limits total annual contributions (employee and employer) to an HSA; the limit in 2012 for employee-only coverage is $3,100 and $6,250 for family coverage. If you are age 55 or older, you can make an additional catch-up contribution of $1,000.

If you elect both payroll deductions and make a personal check deposit into your HSA, and that results in you exceeding the annual limits, BMC will not automatically turn off your payroll deductions. You are responsible for monitoring the balance in your HSA and contacting Your Benefits Resources to discontinue regular payroll deductions.

The money in your account is always yours to keep, and it's up to you to decide whether you want to use your HSA to cover day-to-day health care expenses, as a savings vehicle for the future, or a combination of both.

The money in your HSA always belongs to you and can't be forfeited, even if you leave BMC.

The HSA can be either an effective way to save for retirement medical expenses or a means to cover copayments and deductibles today. The choice is yours.

Your HSA Account

When you enroll in the Aetna HSA Plan, an HSA account through Your Spending Account™ and UMB Bank will be opened. This process occurs automatically with your enrollment in the plan. In most instances, you will not need to take any additional action to open your HSA account; you will receive an HSA welcome kit along with your debit card when the account opening process is complete. However, sometimes UMB Bank will need additional information from you in order to open the account (verification of birth date, Social Security number or other information). If this occurs, you will receive notification in the mail at your home address from UMB Bank that additional information is needed. If you do not respond to this request within 60 days, your HSA account will automatically close, and you will be ineligible to make your own contributions or receive company contributions.

Once your account is open, BMC will deposit half of the company contribution in January and half in July. Newly hired employees will receive prorated amounts. Those hired between January 1 and June 30 will receive the entire annual amount, half within 30 days of when they become eligible and the other half in July. Those hired between July 1 and December 1 will receive 50 percent of the annual amount within 30 days of eligibility. You are eligible for BMC's HSA contribution if you are actively employed by BMC on the date the companycontribution is deposited to your HSA.

One of the main advantages of the Aetna HSA Plan is the opportunity to save any unused dollars in your account. If you don't spend all the money in your account during the year, the balance rolls over into the next year and is added to any future amount you elect to contribute.

Your HSA will earn interest at competitive money market rates and be credited each month. Once your HSA balance reaches $2,000, you can invest in a variety of HSA funds. Complete information about your account, investment options, fees and legal considerations can be found on the UMB HSA website (http://hsa.umb.com/).

For more information, read IRS Publication 969—Health Savings Accounts and Other Tax Favored Health Plans.

Eligible Expenses Under Your HSA

You can use your HSA for qualified health-related expenses as allowed by the IRS. Some expenses may not be covered by your health plan but are considered "eligible expenses" for payment with HSA dollars. Some typical examples include:

- Medical deductibles
- Diagnostic services not covered by your plan
- Dental and vision care not covered under an insurance plan
- Braces
- Long-term care premiums
- LASIK eye surgery
- Some nursing services
- Health care supplies
- Certain classes of over-the-counter drugs with a prescription

(Your HSA Account continues on page 21)

Easy Access to Your HSA

You will receive a Your Spending Account HSA debit card that allows easy access to your HSA funds. You can use the debit card to pay for all legitimate, permitted medical expenses under federal law. The choice of when and how to use the HSA debit card—or not to use it at all and let your HSA funds accumulate—is entirely up to you. You can also track your account balance, transfer funds to your personal checking account, and view deposit activity and interest earnings on the Your Spending Account website. If you contribute to a Limited Use FSA, you will use this same debit card to pay out-of-pocket expenses from this account.

Your Spending Account

Transferring your JPMorgan Chase Health Savings Account to UMB

Starting January, 1, 2012, UMB Bank replaces JPMorgan Bank as the custodian for the Health Savings Account BMC employees own. If you would like to move your Health Savings Account from JPMorgan Chase to UMB, complete a Trustee to Trustee transfer form and follow the instructions. If you keep your HSA with JPMorgan Chase, you will be responsible for the monthly account fees beginning March 1, 2012.

For more information, visit YourBenefits Resources or read IRS Publication 969.

Prescription Drugs

Prescription drug coverage is a benefit that allows you and your eligible dependents to obtain covered prescription drugs at negotiated prices. What you pay for prescriptions depends on:

- The medical plan you choose
- Whether you purchase more costly brand-name medications or less costly generic equivalents

Here's a Snapshot of Your Prescription Drug Benefits:

- Medco administers the Prescription Drug benefit for all employees enrolled in the Aetna HSA and Aetna PPO Plans. You will receive a separate ID card for this benefit from Medco.
- Certain prescription smoking cessation and weight reduction medications will be covered under the Aetna HSA and Aetna PPO Plans. Refer to Medco's drug formulary listing for more information. If you enroll in the Aetna PPO, the diabetic insulin copayment will be $20 when obtained at a retail pharmacy and $50 for mail order (90-day supply). The copayments for diabetic supplies under the Aetna PPO and Aetna HSA plans are $10 for retail pharmacy and $25 for mail order.
- The Aetna HSA Plan covers certain **preventive prescription drugs** —like insulin and blood pressure medicine—at 85% before the plan deductible. You pay 15% coinsurance for these medicines—even if you haven't satisfied the annual plan deductible. However, the coinsurance you pay for preventive prescription drugs does not count toward meeting the Aetna HSA annual deductible or out-of-pocket maximum.
- Prescription drug expenses under the Aetna HSA Plan will count toward satisfying your annual out-of-pocket maximum, whereas expenses under the Aetna PPO Plan will not count toward your out-of-pocket maximum.
- If you enroll in the Kaiser HMO, prescriptions will be covered through Kaiser pharmacies only.
- If you are prescribed a long-term medication, ask your doctor for two prescriptions: One for a 30-day supply that can be filled right away at a pharmacy, and another for a 90-day supply that you can submit for convenient and cost effective mail-order service.
- Retail prescriptions covered under the Aetna HSA and the Aetna PPO plans that are not purchased at a Medco network pharmacy will cost you more. You will pay 50% of the cost if you do not use a Medco network pharmacy.

(Prescription Drugs continues on page 23)

Here is a snapshot of your prescription drug benefits and what you pay:

PHARMACY BENEFIT MANAGER	MEDCO[1]				KAISER PERMANENTE	
Medical Plan Benefit	AETNA HSA[2]		AETNA PPO		KAISER HMO	
	Retail	Mail Order	Retail	Mail Order	Retail	Mail Order
Generic	In-Network: 15% coinsurance after deductible	15% coinsurance after deductible (90-day supply)	In-Network: $4 copay	$10 copay (90-day supply)	In-Network: $10 copay (100-day supply)	$10 copay (100-day supply)
Formulary Brand	In-Network: 15% coinsurance after deductible	15% coinsurance after deductible (90-day supply)	In-Network: 20% coinsurance ($30 min/$75 max copay)	20% coinsurance ($60 min/$150 max copay) (90-day supply)	In-Network: $25 copay (100-day supply)	$25 copay (100-day supply)
Non-Formulary Brand	In-Network: 15% coinsurance after deductible	15% coinsurance after deductible (90-day supply)	In-Network: 50% coinsurance ($60 min/$150 max copay)	50% coinsurance ($120 min/$150 max copay) (90-day supply)	In-Network: $25 copay (100-day supply)	$25 copay (100-day supply)
Specialty Drugs (Formulary)	In-Network: 15% coinsurance after deductible	15% coinsurance after deductible (30-day supply)	In-Network: 20% coinsurance ($30 min/$75 max copay)	20% coinsurance ($60 min/$150 max copay, prorated for less than 90-day supply)	Varied, refer to plan	Varied, refer to plan
Specialty Drugs (Non-Formulary)	In-Network: 15% coinsurance after deductible	15% coinsurance after deductible (30-day supply)	In-Network: 50% coinsurance ($120 min/$150 max copay)	50% coinsurance ($120 min/$150 max copay, prorated for less than 90-day supply)	Varied, refer to plan	Varied, refer to plan

(1) If there is a generic equivalent for your prescription and you choose to purchase the formulary or non-formulary brand, then you will pay the formulary or non-formulary brand regular copay amount plus the difference in the cost between the generic equivalent and the formulary or non-formulary drug. This penalty will be waived for one year if your doctor writes a letter to Medco stating that it is medically necessary for you to use a brand name drug. You can also appeal prior penalties that you have paid. Call Medco at 1-866-577-2523 for details.

(2) The Aetna HSA Plan covers certain preventive prescription drugs—like insulin and blood pressure medicine—at 85% before the plan deductible. You pay 15% coinsurance for these medicines—even if you haven't satisfied the annual plan deductible. However, the coinsurance you pay for preventive prescription drugs does not count toward meeting the Aetna HSA annual deductible or out-of-pocket maximum.

For more information on your prescription drug benefits, the drug cost category for your prescription (generic, formulary, non-formulary or specialty), and mail-order programs, please visit the Medco website (www.medco.com) or Kaiser's website (www.kp.org).

Dental

Whether you need major dental services or regular prevention with semi-annual cleanings, the Dental PPO plan can help you take care of your smile. The Dental PPO plan, administered by Aetna, is simple. You can see any dentist, but your savings will be greater if you use a PPO provider. Seeing PPO dentists can be more convenient as well, since most providers will file claims for you and you benefit from negotiated fees, reducing your out-of-pocket expenses. If you visit a non-PPO dentist, you'll pay for your services up front, and then submit a claim within 12 months of the date of service to receive reimbursement for eligible expenses.

The BMC Dental PPO plan also provides orthodontia coverage for you and your eligible dependents. The plan reimburses 50% of usual and customary expenses up to a lifetime maximum of $1,500 for each covered person. If you are covered by the Aetna HSA or Aetna PPO, you will use the same ID card for both medical and dental. If you are enrolled in the Kaiser HMO plan, you'll receive a separate dental ID card. If the cost of your treatment is expected to be more than $300, contact Aetna for a predetermination of benefits.

You share the cost of your dental coverage with BMC and make your contributions with before-tax payroll deductions.

Dental Plan Highlights

Annual Deductible	$50 per person
Annual Maximum Benefit	$1,500 per person
Preventive Care (two exams each calendar year; includes routine exams, X-rays and three cleanings)	100%, no deductible
Annual Fluoride Treatment (under age 19 only)	100%, no deductible
Basic Restorative Services (includes fillings, extractions, root canals and denture repairs)	80% after deductible
Major Restorative Services (includes inlays, crowns, bridges and dentures)	50% after deductible
Orthodontics (adults and children)	50%, no deductible - Lifetime maximum up to $1,500 per covered person

For more information about the Dental PPO plan administered by Aetna, go to the Aetna website (www.aetna.com) or call Aetna at 1-866-214-4839.

Vision

If you or anyone in your family wears contacts or glasses, the BMC vision care plan, administered by VSP (Vision Service Plan), can help you bring things into focus. Under the plan, you can visit any provider. You'll receive the greatest benefit and convenience by using participating VSP providers—and never have to file a claim.

You pay for the cost of your vision coverage through before-tax payroll deductions.

Using a Participating VSP Doctor

VSP does not require identification cards to obtain services. If you choose a participating doctor, you pay only a $15 copayment for examinations and a $15 copayment for lenses and frames (special frames or tinted lenses will cost more). Based on a limited fee schedule, VSP will reimburse you for examinations and lenses once every 12 months and for frames once every 24 months.

No claim form is needed. When you call to make an appointment for yourself or your covered dependents, identify yourself as a VSP member and as an employee of BMC Software; then provide your Social Security number. The VSP doctor will obtain the necessary authorization and information about your eligibility and coverage.

To find the VSP doctor closest to you or to check if a doctor is a VSP provider, contact VSP at 1-800-877-7195 or go online to www.vsp.com.

Using a Nonparticipating Doctor

If you choose to use a nonparticipating doctor, VSP will reimburse you based on a limited fee schedule described on page 26. When submitting a claim to VSP from a nonparticipating doctor, use the BMC out-of-network VSP claim form and file your claim within six months of the date of service. Claim forms are available at www.vsp.com.

(Vision continues on page 26)

Vision (continued)

PLAN BENEFITS	VSP PROVIDER BENEFITS	NON-VSP PROVIDER REIMBURSEMENT AMOUNTS
Vision Exam (once per calendar year)	100% after $15 copay	Up to $40
Eyeglass Lenses (once per calendar year)	100% after $15 copay[1]	Up to $40 (Single Vision) Up to $60 (Bifocal) Up to $80 (Trifocal) Up to $125 (Lenticular)
Frames (every two calendar years)	100% after $15 copay (up to $150)	Up to $45
Necessary Contacts[2] (once per calendar year) **Contact Lens Evaluation, Fitting Fees and Contact Lenses**	100% after $15 copay	Up to $210
Elective Contacts[3] (once per calendar year) **Contact Lens Evaluation, Fitting Fees and Contact Lenses**	Up to $135	Up to $105

(1) Special frames and tinted lenses will cost more.

(2) Necessary contacts—required after cataract surgery; to correct extreme acuity problems that cannot be corrected with glasses; for certain conditions of anisometropia and keratoconus.

(3) Elective contacts—for any other reason than stated above and are covered instead of lenses and frames.

Employee Assistance Program (EAP)

At some time during the course of your employment, you or a family member may experience a personal difficulty. Problems arising from illnesses, day care issues, loss of a loved one, relationship conflicts or financial difficulties can affect your life at home and at work. Through the Employee Assistance Program (EAP), you and your immediate family members can receive confidential counseling and referrals at no cost to you. Any help you receive is completely confidential and not shared with BMC.

The EAP is designed to provide an assessment of the problem and often a referral to a local resource for follow-up counseling. BMC provides the first six visits with a counselor at no cost to you. After that, your visits may be covered by your medical insurance.

When to Use the EAP

Counseling is available through the EAP for personal difficulties such as:

- Family or marital problems
- Parenting concerns
- Emotional difficulties such as depression, anxiety and guilt
- Drug and alcohol dependence
- Grief over the death of a loved one or other losses
- Conflicts at work
- Job stress
- Crisis situations
- Questions about legal or financial concerns
- Questions about child or elder care

How to Use the EAP

If you need assistance, you can call 1-800-955-6422 and speak to an EAP counselor. Sometimes a telephone call is all it takes. However, if you need additional counseling, you can schedule an appointment with an EAP counselor. BMC will pay for up to six counseling sessions each year. The EAP can also provide referrals to other providers or community sources if you need additional assistance.

In addition to traditional counseling sessions either in person or over the phone, our Employee Assistance Program includes the following additional benefit:

Financial Services

- One-half hour initial consultation with a selected plan financial counselor on up to three new financial counseling topics each plan year related to credit repair, debt management or debt consolidation.

The EAP website (mylifevalues.com); (Username: BMC, Password: EAP) also includes various other resources and educational materials on health and wellness topics, mental health, stress, substance abuse and daily life management. It also features a discount center where you can take advantage of Aetna's pre-negotiated discounts on a wide variety of products and services nationwide.

Life, Accident Insurance

BMC Software provides you with a firm foundation of income protection benefits. In addition, you can supplement your company-provided coverage to further protect your income should you die or become disabled. Life and Accidental Death and Dismemberment (AD&D) insurance is administered by Liberty Mutual. Business Travel Accident Insurance is administered by AC Newman & Co.

Basic Life Insurance

Benefits: Two times your annual base salary, rounded to the next highest $1,000*

Maximum Benefit: $2 million

**If you are working at age 70, your benefit will be reduced by 35%; at age 75, it will be reduced by 50%.*

Understanding Imputed Income

The IRS considers the value of life insurance over $50,000 to be taxable income. This value is referred to as "imputed income." If you have coverage over $50,000, you will see the value of such coverage reported on your annual W-2 statement. It will also be subject to FICA taxes and is reflected each payroll period on your paycheck stub as "GTL," which stands for "group term life."

Accessing Living Benefits

This important benefit is provided at no cost to you and is designed to help a terminally ill employee receive part of his or her life insurance benefits for medical expenses and ongoing care.

Payment of this benefit is subject to approval by Liberty Mutual and certification by a doctor that your life expectancy is less than 12 months.

In general, the benefit pays up to 80% of the value of your basic life insurance coverage, with a maximum of $500,000. You will receive the money in a single lump-sum payment.

Supplemental Life Insurance

Depending on your individual needs, you can purchase additional life insurance for yourself and your family. The amounts of coverage you can purchase are listed below:

EMPLOYEE	One to five times your annual base salary (combined maximum with basic life insurance is lesser of seven times base salary or $2 million).
SPOUSE/DOMESTIC PARTNER	You can purchase life insurance for your spouse/domestic partner in $25,000 increments—up to the lesser of your total life insurance amount or $250,000. If you do not purchase supplemental employee life insurance, you can still purchase spouse/domestic partner life insurance.
CHILDREN*	You can purchase life insurance for your eligible children in the amount of $5,000, $10,000 or $15,000. Please note: Coverage amount for newborn children 14 days through six months of age is $1,000.

**If you purchase life insurance for your children, the coverage amount you select will apply to each of your eligible children. For example, if you have a son and a daughter and select $10,000 as your dependent life insurance amount, both of your children will have dependent life insurance in the amount of $10,000.*

Evidence of Insurability

The amount of supplemental employee and spouse life insurance coverage elected determines whether you and your spouse/domestic partner are required to show evidence of insurability (EOI).

Evidence of Insurability is Required:

AT EMPLOYMENT	If coverage amounts elected are greater than $500,000 when combined with basic life insurance amount (employee) or greater than $25,000 (spouse/domestic partner).
AT ANNUAL ENROLLMENT	For any amounts if coverage was not elected at time of employment, or for any increase in coverage if coverage was elected at time of employment.

Need Help Filing for Benefits?

For assistance filing a life insurance claim, speak with a Benefits Representative by calling Your Benefits Resources at 1-877-BMC-4849.

Supplemental AD&D Insurance

This benefit is paid if an accident causes a death. Benefits also are paid if a serious injury is suffered. Such benefits are paid as follows:

- If, as the result of an accident, the person dies within 365 days of the accident, the beneficiary will receive AD&D benefits equal to 100% of the insurance amount—in addition to life insurance benefit.
- If the person injured is in an accident and suffers the loss of a limb and/or eyesight, the beneficiary will receive a portion of the full benefit amount, based on the extent of the loss, as indicated below:

LOSS	BENEFIT
Both hands or both feet or both eyes, or one hand and one foot, or one hand and one eye, or one foot and one eye	100% of insurance amount
One hand or one foot or one eye	50% of insurance amount

A complete list of loss events and benefits is available online on the Your Benefits Resources website (www.yourbenefitsresources.com/bmc), click on **Main Menu**, then **Your Benefits Resources**, then hover over **Knowledge Center** and select **Plan Information**. The Life and Accident Insurance benefits are described in the Life Insurance Certificate of Coverage.

WHO YOU CAN COVER	LEVEL OF COVERAGE
Employee	One to five times your annual base salary (maximum benefit of $500,000)
Employee + Family	• 50% of employee amount for your spouse or domestic partner • 15% of employee amount for each child

Business Travel Accident

This plan provides a benefit if you are accidentally injured while traveling on behalf of BMC Software. BMC provides this benefit at no cost to you.

LOSS	BENEFIT
Life	Up to two times your annual base salary (maximum benefit of $1.5 million)
Both hands or both feet or both eyes, or one hand and one foot, or one foot and one eye, or one eye and one hand, or both speech and hearing	100% of life insurance benefit
One hand or one foot or one eye; or speech or hearing	50% of life insurance benefit
Thumb and index finger of same hand	25% of life insurance benefit

Global Emergency Services

Increased business travel means increased instances of illness or injury while away from home. With one phone call, you can get immediate emergency travel assistance when you travel on BMC business more than 100 miles from home or to any foreign country.

Emergency travel assistance is provided by Assist America. A global network of Assist America's emergency medical dispatch-certified personnel are on call 24-hours-a-day, 365-days-a-year to help you with a wide range of assistance services at no cost to you. Services include:

- Medical consultation and evaluation
- Hospital admission guarantee
- Emergency medical evacuation
- Critical care monitoring
- Prescription replacement assistance
- Medically supervised transportation home upon discharge
- Emergency message service
- Transportation for a friend or family member to join hospitalized patient
- Care for minor children
- Emergency room trauma counseling
- Assistance in the return of a vehicle
- Legal and interpreter referrals

All services must be arranged and paid for by America Assist.

How To Use This Service

Before you travel, be sure you have your:

- Assist America Global Emergency Services wallet card with BMC reference number
- BMC medical and/or prescription ID card(s)

During a medical emergency, call 911 in the U.S. or local emergency services, and then call the Assist America Operation's Center as soon as possible (once your situation is no longer life threatening). Once you are under the care of a physician or medical facility, your BMC medical coverage applies.

Flexible Spending Accounts

You can set aside before-tax money throughout the year in a flexible spending account (FSA) to pay for anticipated health care and/or dependent care expenses. You'll not only build a balance of funds to pay expected medical, dental, vision and dependent care bills incurred during that calendar year, but you'll also lower your taxes.

There are two types of flexible spending accounts associated with health care expenses—a regular Health Care Spending Account and a Limited Use Flexible Spending Account. If you select the Aetna PPO, the Kaiser HMO or opt out of BMC medical coverage, you are eligible to contribute to the Health Care Flexible Spending Account. If you select the Aetna HSA Plan, you are eligible for the Limited Use FSA. The Limited FSA can be used to pay eligible dental, vision and other nonmedical expenses.

Health Care FSA

If you enroll in the Aetna PPO Plan or the Kaiser HMO Plan, you can make before-tax contributions to the Health Care FSA which can be used to pay for eligible medical, dental, prescription drug and vision care expenses, health care supplies and certain over the-counter (OTC) medications (only with a prescription). Such expenses may include:

- Copayments
- Deductibles
- Prescription medications
- Insulin and diabetic supplies
- Charges for services or supplies that are not covered (or not fully paid) by your health plan, such as braces, hospital bills and speech therapy

You can contribute from $240 to $10,000 each year to the Health Care FSA. Your deduction per pay period is based on 24 pay periods for the year. If you join BMC during the year, deductions for your elected contribution amount are divided evenly among the pay periods remaining in the year at the time you enroll.

Eligibility for Health Care FSA reimbursements is limited to you and your legal spouse and children. Federal law prohibits the use of FSA funds for reimbursement of expenses for your domestic partner and your partner's children.

Limited Use FSA

This FSA is available only if you enroll in the Aetna HSA medical plan. You can contribute from $240 to $2,500 each year to the Limited FSA. A Limited Use FSA gives you the option to use before-tax money to pay for nonmedical expenses without tapping into your HSA funds, which you may be accumulating for retirement. There are two ways to use the Limited Use FSA.

1) Before you meet your Aetna HSA medical plan deductible, your Limited Use FSA funds are available only for certain nonmedical expenses, including:
   - Dental care and orthodontia, such as fillings, X-rays, braces, caps and mouth guards (not oral surgery)
   - Vision care, including eyeglasses, contact lenses, solutions and supplies, and LASIK eye surgery
2) After you meet your deductible, your Limited Use FSA funds are available for all FSA-qualified health care expenses incurred after the date you met your deductible, including coinsurance and copayments—just like a Health Care FSA.

Find more information on the Limited Use FSA on the Benefits Resources website (www.yourbenefitsresources.com/bmc). Select **Other Benefits**, then **Your Spending Account**.

The Limited FSA is available only if you enroll in the Aetna HSA medical plan.

Dependent Care FSA

Your before-tax contributions to the Dependent Care FSA can help you pay for dependent daycare expenses that allow you (or you and your spouse or domestic partner) to work. However, under Internal Revenue Code rules, reimbursement is not available for dependent care of a child of your domestic partner. If you're married and your spouse does not work, you are not eligible for this program—unless your spouse is disabled or is a full-time student.

For the purposes of this plan, the IRS defines eligible dependents as:

- Your child(ren) under age 13

  OR

- Other dependents (such as a spouse, parent, brother, sister or child over age 13) who spend at least eight hours in your home each day and are incapable of self-care

Dependent care expenses are for services such as professional day care; they do not include medical expenses for dependents.

Generally, you and your spouse can contribute from $240 up to $5,000 annually to the Dependent Care FSA ($2,500 if you are married and file separate tax returns). Your deduction per pay period is based on 24 pay periods for the year. If you join BMC during the year, deductions for your elected contribution amount are divided evenly among the pay periods remaining in the year at the time you enroll.

Reimbursable expenses include:

- Day care expenses
- In-home services provided by a babysitter, nursing aid or attendant
- Services provided by a housekeeper or maid, if that person is responsible for the care of an eligible dependent during the day
- Services provided by a licensed day care facility for children or adults
- Care provided outside your home

Expenses incurred for dependent day care while the employee is on an unpaid leave and expenses for overnight camp are ineligible for FSA reimbursement.

Special Note: *When you request reimbursement from your Dependent Care FSA and when you file your federal income tax return, you will need to provide your caregiver's Social Security or tax identification number.*

Using Your Flexible Spending Account

Use It or Lose It

It's important that you carefully estimate your anticipated health care and dependent care expenses so that you can elect the most appropriate level of annual contributions. In compliance with the Internal Revenue Service Code, any money not used by the end of the year must be forfeited—the "use it or lose it" concept.

Health Care FSA

If you have a Health Care FSA, you can use the money in that account to pay for out-of-pocket expenses. Use the Your Spending Account card like a debit card or file a claim. To view your balance, see the Your Spending Account (YSA) page on the Your Benefits Resources website (yourbenefitsresources.com/bmc). Select **Other Benefits**, then **Your Spending Account**.

Expenses paid using the Your Spending Account debit card do not require you to submit a paper claim. Substantiation of your expense(s) may be required at any time, so keep all receipts and/or Explanation of Benefit forms. YSA will notify you if itemized receipts or additional documentation is required to validate your purchase. You'll have 90 days to provide the requested documentation.

Special Note

To get help estimating how much to contribute, use the Flexible Spending Account Estimator on Your Benefits Resources.

Check your spending account or Health Savings Account balances online on Your Benefits Resources. Select **Other Benefits**, then **Your Spending Account**.

Limited Use FSA/Health Savings Account

You will use a single debit card to access funds from both your Health Savings Account and from your Limited Use FSA, if you contribute to this account. Expenses paid from your Limited Use FSA may require substantiation. Expenses paid from the Health Savings Account do not require substantiation. View your Health Savings Account or Limited FSA balance on the Your Benefits Resources website (www.yourbenefitsresources.com/bmc). Select **Other Benefits**, then **Your Spending Account**.

If you have a Health Savings Account and contribute to a Limited Use Flexible Spending Account, here's how the YSA card works to pay for eligible expenses:

When you use the YSA card to pay for...	Funds are taken from your...
Dental and vision care expenses*	Limited Use Flexible Spending Account
Medical services and prescription drugs	Health Savings Account

** You can begin paying for eligible medical services and prescription drugs with your Limited Use FSA once you reach the Aetna HSA deductible for the year and call 1-877-BMC-4849 and speak with a representative of Your Spending Account, the new administrator for Flexible Spending Accounts and the Health Savings Account.*

Direct Deposit

When you file a claim, you can choose to have your reimbursement sent to you in a check or directly deposited into your checking or savings account. Complete the online direct deposit authorization form, available on the Your Benefits Resources website (www.yourbenefitsresources.com/bmc). Select **Other Benefits**, then **Your Spending Account**.

Things To Know About Flexible Spending Accounts

When making your contribution decision, take the time to carefully evaluate your personal situation, consult with your tax advisor and consider the following facts:

- Your Health Care FSA and your Dependent Care FSA must be maintained separately; you cannot transfer money between the two accounts.
- You cannot claim a tax credit or deduction for any expenses reimbursed from your accounts. However, you can claim a tax credit or deduction for any unreimbursed expenses, subject to IRS regulations. Consult with your tax advisor to determine which option is more beneficial to you.
- The list of services eligible for reimbursement can change from time to time. For complete details, see IRS Publication 502 (health care) or 503 (dependent care). See more information and a complete list of qualified health care expenses on Your Benefits Resources (www.yourbenefitsresources.com/bmc). Select **Other Benefits**, then **Your Spending Account**.
- Once you enroll in the Health Care FSA or Dependent Care FSA, you cannot change your contribution level until the next annual enrollment period, unless you have a qualifying change in family status (life event) that complies with IRS requirements (See page 6).
- If you leave the company, you can continue to file claims against your Health Care FSA balance for expenses incurred before your employment with the company ended. If you make after-tax contributions, you also may be eligible to continue your participation in the Health Care FSA under COBRA and incur reimbursable expenses until the end of the calendar year in which your employment with BMC terminated.
- If you terminate your employment with the company and do not elect to continue contributions to your Health Care FSA under COBRA or you are not eligible to do so under COBRA, you must submit any outstanding claims within 90 days of your termination.
- If you terminate your contributions to the Health Care FSA because of a qualified family status change (life event), you will be reimbursed only for claims incurred prior to the date you stopped contributions, and for any claims to be eligible for reimbursement, they must be submitted within 90 days of the status change.
- If you enroll in one or both accounts because of a qualified family status change, only expenses incurred after the enrollment date are acceptable.

If you have any questions about your participation in a flexible spending account, call Your Spending Account at 1-877-BMC-4849.

Getting Claims Help—Participant Advocacy Team

The Participant Advocacy service is available to help you resolve any conflicts you may have with your medical, dental or health care/dependent care FSA claims and carriers. Call Your Benefits Resources at 1-877-BMC-4849 and ask to speak with the Advocacy Team representative. All calls are confidential.

FSAs and HSAs Compared

The Flexible Spending Accounts (FSAs) and Health Savings Accounts (HSAs) are an affordable way to save money on health care. FSAs and HSAs operate differently. Here's how.

	DEPENDENT CARE FSA	HEALTH CARE FSA	LIMITED USE FSA	HEALTH SAVINGS ACCOUNT
Who can participate	If you anticipate eligible dependent day	If you enroll in the PPO or HMO	If you enroll in the Aetna HSA Plan	If you enroll in the Aetna HSA Plan
What happens to unused contributions	Subject to the "use it or lose it" rule; you forfeit them at the end of the year			Any unused contributions remain in your account for future health care expenses.
Contribution type	Before-tax contributions			
How much can I contribute	Contribute from $240 to $5,000 per year	Contribute from $240 to $10,000 per year	Contribute from $240 to $2,500 per year	Individual: $3,100 Family: $6,250 If you are 55 or older, you can deposit up to an additional $1,000.
What expenses are eligible	Any eligible dependent day care expenses – as qualified by the IRS and incurred during the year	A full range of qualified medical expenses – as qualified by the IRS and incurred during the calendar year	Dental and vision expenses only (until you meet your deductible) and a limited range of expenses after you meet your deductible) – as qualified by the IRS and incurred during the calendar year.	A full range of qualified medical expenses – as qualified by the IRS
When can I change the contribution amount	The amount you contribute cannot change during the year unless you have a qualified status change (life event).			Change contribution amounts anytime
When are expenses reimbursed	All eligible expenses are reimbursed when you file a claim. However, reimbursements can only be made as funds become available from payroll deductions.	All eligible expenses are reimbursed when you use your debit card or file a claim up to the full amount of your annual contribution, regardless of the actual amount of money that has been deposited into your account through payroll deductions.	All eligible expenses are reimbursed when you use your debit card or file a claim up to the full amount of your annual contribution, regardless of the actual amount of money that has been deposited into your account through payroll deductions.	All eligible expenses are reimbursed when you file a claim or use your debit card. However, reimbursements can only be made as funds become available from payroll deductions or company contributions are deposited.

Financial Benefits

BMC 401(k) Plan

Wealth accumulation and financial security during retirement are top long-range objectives for most people. The BMC Software, Inc. Savings and Investment Plan (a 401(k) plan) gives you a distinct head start on reaching your financial goals. When you enroll in the plan, you elect to defer a certain percentage of your pay as a contribution to the plan. Your contributions may be made on a before-tax basis, after-tax basis, or through Roth 401(k) contributions. The plan's combination of before-tax savings, company matching contributions and wide range of investment alternatives makes it one of the most attractive savings opportunities available.

You are eligible to enroll in the BMC 401(k) Plan on your date of hire. Once your new hire information is submitted to Fidelity and an account is set up, you can enroll at anytime. You will see the change in your deductions in one to two pay periods.

To enroll in the BMC 401(k) Plan go to Fidelity NetBenefits® (www.netbenefits.com) or call 1-866-546-4424.

Enrolling in Your BMC 401(K) Plan

Log on to www.netbenefits.com or call Your Benefits Resources at 1-877-BMC-4849, (option Savings and Investments), or Fidelity directly at 1-866-546-4424 to enroll, to make your "catch-up"contribution election and/or to change any existing election.

Allow one week from your date of hire before calling. If you are a current participant, the changes will take effect within one to two pay periods.

Your Contributions

You can contribute between 1% and 35% of your plan earnings into a before-tax or Roth account, up to the annual IRS dollar limit (for 2012 this limit is $17,000). In addition, you can contribute up to 10% of your plan earnings into an after-tax account. Plan earnings generally include all elements of cash compensation (such as base salary, bonuses, overtime and commissions) and exclude equity compensation, allowances, prizes, awards and disability pay. If you are age 50 or older or will reach age 50 during the calendar year, you can make "catch-up" contributions to your account in addition to your regular contributions, up to the annual IRS dollar limit (for 2012 this limit is $5,500).

Please Note: The total of all contributions to your account cannot exceed $50,000. This includes any before-tax, Roth, after-tax and company matching contributions made to the plan (excluding catch-up contributions).

Your Account — Your Choice

The BMC 401(k) Plan allows you to make tax-advantaged contributions three different ways—to a before-tax account, a Roth 401(k) account or to an after-tax account. If you are wondering which contribution type is better for you—tax-deferred savings now (through the before-tax contributions), tax-free in the future (through the Roth feature) or defer taxes on earnings on after-tax money—look at the chart below. You can go to Fidelity NetBenefits® (www.netbenefits.com) for more information on all of these options. You may also want to consult with a personal tax advisor about the path that might be best for you.

	BEFORE-TAX CONTRIBUTIONS	AFTER-TAX CONTRIBUTIONS	ROTH CONTRIBUTIONS
Tax Treatment of Contributions	Contributions reduce taxable income.	Contributions are deducted after taxes and therefore do not reduce current taxable income.	Contributions are deducted after taxes and therefore do not reduce current taxable income.
Tax Treatment of Earnings	Earnings grow tax-deferred until taken as a distribution.	Earnings grow tax-deferred until taken as a distribution.	Earnings grow tax-deferred until taken as a distribution.
Tax Treatment of Distributions, If Not Rolled Over	Distributions are fully taxable at the time of withdrawal.	Distributions of the after-tax contributions are not taxable; however, the earnings on the contributions are taxable at the time of withdrawal.	Distributions are not taxable as long as you are at least 59½ years old and it has been at least 5 years since your first year of Roth 401(k) contributions.
Early Withdrawal Penalties	Distributions taken before age of 59½ are subject to a 10% tax penalty unless you terminate service after attainment of age 55.	Earnings withdrawn prior to age 59½ are subject to a 10% excise tax.	Distributions of Roth earnings taken before age 59½, or with less than 5 years from the first contribution, are subject to at 10% tax penalty.
In-Service Withdrawal	In-service withdrawal options are only a loan or hardship withdrawal prior to age 59½.	After-tax contributions and earnings may be taken as an in-service withdrawal.	In-service withdrawal options are only a loan or hardship withdrawal prior to age 59½.
Contribution Limit (2012)	$17,000 (combined with Roth contributions)	10% of pay (coordinates with other contributions and match to not exceed $50,000 in 2012)	$17,000 (combined with before-tax contributions)
Catch-Up Contribution Limit (age 50 or older)	$5,500 (combined with Roth catch-up)	N/A	$5,500 (combined with before-tax catch-up)

Company Contributions

BMC helps your retirement savings grow by matching your before-tax or Roth 401(k) contributions. BMC matches 100% of every dollar you contribute, up to 5% of your eligible pay each pay period.

Please Note: *Company matching contributions are made each pay period with your payroll contributions. There is no company match on after-tax or catch-up contributions.*

The "BMC 401(k) Deferral Calculator" is available on Fidelity NetBenefits® (www.netbenefits.com). Click on **401(k)**, then **Plan Information**. This tool can help you determine your maximum contribution amount and help you maximize company contributions to your account. If you plan to contribute more than 5% of your eligible earnings, note that as soon as your contributions reach the annual IRS dollar limit ($17,000 in 2012), your contributions and matching contributions will end. In addition, when you reach the annual IRS dollar limit on plan earnings ($250,000 in 2012), your participation for the year will stop.

Check your year-to-date contributions by reviewing your pay stubs or by going online to Fidelity NetBenefits and running a year-to-date statement. You can change your contribution rate at any time.

Vesting

You are always 100% vested in your own contributions and in any earnings on those contributions. You will be 100% vested in the company matching contributions and earnings when you have reached two years of service.

BMC matches 100% of every dollar you contribute, up to 5% of your eligible pay each pay period.

Loans & Withdrawals

The BMC 401(k) Plan includes a loan provision, allowing you to borrow money from your account. If you are in need of funds that aren't readily available elsewhere, you can borrow up to 50% of your vested account balance or $50,000, whichever is less, minus the highest outstanding loan balance during the last 12 months. BMC 401(k) Plan participants who take loans from the plan will be responsible for associated administration fees.

Under limited circumstances, you can make withdrawals from the plan. You can make withdrawals at any time on your after-tax contributions made to the plan after January 1, 2008. You can make withdrawals at any time on rollover funds from prior employer plans that you deposited into the BMC 401(k) Plan. In case of financial hardship, you may be eligible for a special hardship withdrawal of funds from your 401(k) account if you have previously borrowed money from your account.

Your Investment Choices

To help you meet your financial goals, the plan offers you a range of investment options, including conservative, moderately conservative and aggressive options. The plan also offers the Fidelity Freedom K Funds®, each one offering a blend of stocks, bonds and short-term investments within a single fund. Each Freedom Fund's asset allocation is based on the number of years until the fund's target retirement date. The Freedom Funds are designed for investors who want a simple approach to investing for retirement.

If you do not choose an investment election, your contributions will default to the Fidelity Freedom K Fund that has a target retirement date closest to the year you might retire based on your current age, assuming retirement at age 65, until you provide further investment instruction. You can learn more by contacting Your Benefits Resources at 1-877-BMC-4849, (option Savings and Investments), or Fidelity directly at 1-866-546-4424. For those who prefer a more hands-on approach to managing their account, the plan provides an individual brokerage option that permits purchases of a wide range of mutual funds plus individual stocks and bonds.

The Fidelity Portfolio Advisory Services (PAS)—an optional feature—puts your 401(k) account under professional investment management. There is an annual fee to maintain the account, and it varies based on your account balance.

Employee Stock Purchase Plan (ESPP)

The BMC Employee Stock Purchase Plan (ESPP) enables eligible employees to purchase shares of BMC Software stock at a 15% discount off the fair market value. Your ESPP is a qualified plan under Section 423 of the Internal Revenue Service Code. This means that for stock purchased under the plan, all income taxes are deferred until you sell your shares. Upon sale, a portion of your gain will be taxed at the more favorable capital gains tax rate, provided you hold the stock for at least two years after the start of the offering period. There are two purchase offerings each year, one beginning January 1 and one beginning July 1.

Enrollment for the ESPP occurs twice a year before the beginning of a new enrollment window. Enrollment runs from May 15 to June 15 and from November 15 to December 15. To participate in the plan, you must be regularly scheduled to work more than 20 hours each week. You can enroll in the ESPP during the first enrollment window following your date of hire. When you are first eligible to participate, you will receive an e-mail with an ESPP Welcome Guide from Your Benefits Center at Fidelity Investments. If you do not receive the e-mail, call Your Benefits Resources at 1-877-BMC-4849, (option Savings and Investments), or Fidelity directly at 1-866-546-4424.

ESPP PURCHASE PRICE EXAMPLE	
Average Share Price at the Beginning of the Offering Period	$50
Average Share Price on the Last Day of the Offering Period (purchase date)	$55
Share Price of ESPP (lesser of two above prices)	$50
15% Discount Amount	$7.50
Your Discounted Purchase Price	$42.50

This represents a purchase price 23% lower than the current share price!

(Employee Stock Purchase Plan continues on page 43)

ESPP (continued)

You can contribute up to 10% of eligible compensation (base pay, overtime, commissions and bonuses). Or, instead of a percentage, you can elect to contribute a specific dollar amount per pay period. Please note that either election (a percentage or a specific dollar amount) must equal at least $25 per pay period. However, if you wish for your deductions to be taken from all of your pay, including overtime, commissions and bonuses, you must elect a percentage. Your total contributions cannot exceed $21,250 per calendar year. Your contribution election must remain in place through the entire six month offering period. You can elect to withdraw accumulated contributions in the middle of an offering period; however, no purchase will be made for you at the end of the period, and you must actively re-enroll if you wish to rejoin the ESPP.

Your contribution election will automatically carry over into each subsequent purchase offering period unless you change it, opt out of the plan or make a withdrawal. If you end your participation and later wish to rejoin the ESPP, you must actively re-enroll during the enrollment window of a future offering period.

Any income taxes on the gains on the shares purchased through the ESPP are deferred until you sell your shares. Upon sale, a portion of your gain will be taxed at the more favorable capital gains tax rate, provided you hold the stock for at least two years after the start of the offering period. If you hold your shares less than two years, your gains will be subject to ordinary income tax rates. Please review the BMC ESPP Prospectus, located on the Fidelity NetBenefits website (**www.netbenefits.com**), under Plan Information & Documents, for more information on the tax implications of the sale of your shares purchased through the ESPP. You can also read **IRS Publication 525** — Taxable and Nontaxable income, or consult with your tax advisor.

To enroll in the ESPP or to manage your account, log on to Fidelity NetBenefits (**www.netbenefits.com**) or call Your Benefits Resources at 1-877-BMC-4849, (option Savings and Investments), or Fidelity directly at 1-866-546-4424. You can manage all elements of your ESPP account online: enrollment, withdrawals, change contribution rates or sale of purchased shares.

Please Note: All sales of BMC Software stock through the ESPP are subject to the BMC Software Securities Trading Policy, which prohibits the buying and selling of stock at certain times, including scheduled blackout periods. The status of the Trading Window is posted on BMC's intranet home page. Certain employees of BMC are subject to additional restrictions and must receive approval from the legal department before executing a transaction. If you have any questions about our Insider Trading Policy, please contact the legal department.

Paid Time Off & Holidays

BMC recognizes that in order to do your work well, you also need time away from work to refresh and renew. That's why BMC offers you paid time off from work.

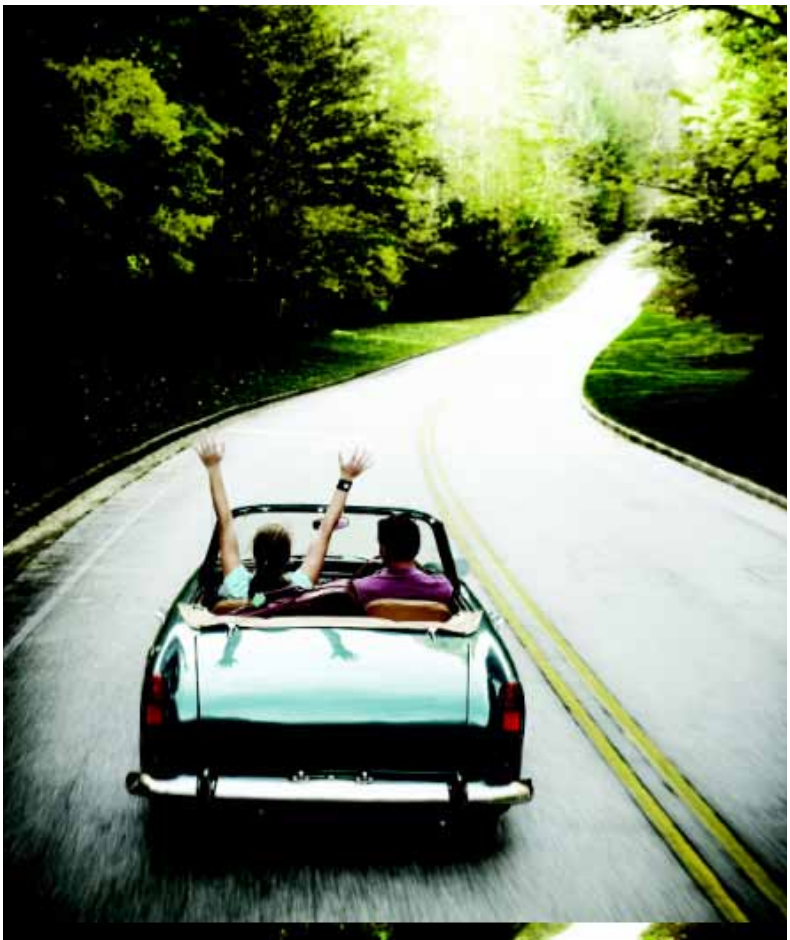
How PTO/Vacation Works

Our Paid Time Off (PTO)/Vacation program provides each eligible employee an amount of paid time off based on length of service, employment status and hours worked per week. PTO/Vacation provides employees with control and flexibility and may be used for any reason, such as personal travel to care for a family member, for personal business or just a day off. Depending on your reason for taking time off under the PTO/Vacation program, you may also be eligible for FMLA leave. See page 48 for more information.

During the first partial calendar year of BMC employment, eligible full-time employees will accrue (earn) the pro-rata equivalent of 15 days per year, calculated on a daily basis (.041 days of vacation time per calendar day). Beginning in the first full calendar year after your hire date, PTO eligibility is as follows:

YEARS OF SERVICE	ANNUAL ACCRUAL	DAILY ACCRUAL
1 to 4	15 days	.041
5 to 9	20 days	.055
10	25 days (maximum)	.068

Exempt employees can use vacation time in full-day or half-day increments. Non-exempt employees can use vacation time in hourly increments.



PTO/Vacation Eligibility

Part-time employees working between 20 and 40 hours per week are eligible for a prorated amount of PTO hours based on the percentage of hours worked. For example, if you have less than five years of service and work 24 hours a week (60% of the work week) you will be eligible for nine days of vacation time annually (60% of the full time allowance of 15 days). Part-time employees working less than 20 hours per week do not receive any PTO/vacation time.

Carry-Over

You must use your PTO/Vacation time during the current calendar year unless you are a California employee. Unused PTO/Vacation not taken by December 31 will be lost. California employees may carry over unused accrued PTO/Vacation, up to the maximum days available in a calendar year based on years of service.

If you are unable to complete your previously scheduled and approved vacation by December 31, because of heavy workload or another business reason, management may, at its discretion, grant an extension through January of the following year.

Termination

If you leave BMC for any reason, voluntary or involuntary, you will be paid for unused vacation time you earned to date. California employees will be paid for PTO/Vacation time earned to date plus any accrued PTO/Vacation time carried over from the prior year, subject to the maximum accrual amount.

Questions about PTO payouts at termination should be directed to Ask-HR at 1-713-918-2ASK (2275) or 1-800-811-6367 or log a help desk ticket at ASKHR Help Desk Ticket.

Holidays

BMC schedules nine holiday days each year in the U.S. In addition, employees receive one floating holiday of their choice. You can view the holiday schedule on the HR – U.S. Country Site under the Global People Portal on the BMC intranet.

All full-time and part-time employees are eligible for holidays. Holidays can't be carried over into the next year, and employees do not receive pay for unused holidays, although some employees who are required to work on scheduled holidays may be eligible for substitute time off agreed to in advance with the manager. Employees on a leave of absence are not eligible for holiday pay.

Part-time employees must be scheduled to work on the holiday to receive holiday pay. Employees who record their time using Oracle Time and Labor (OTL) should enter the hours they would have normally worked on the timesheet as "holiday" (not to exceed 8 hours).

Sick Time

Full-time employees scheduled to work 40 or more hours per week are eligible for sick time benefits. You may use sick time for personal illness, injury or for personal doctor or dentist appointments when you can't schedule them around work hours. You may be required to provide medical documentation to support your need to be out of the office.

If you will be off work longer than three business days due to illness, you should file an FMLA claim with Liberty Mutual for your leave. If your illness extends to five business days or longer, you must file a disability claim with Liberty Mutual. See pages 48-49 for more information on FMLA and disability benefits.

Other Paid Leave

In addition to PTO and holidays, you may be eligible for other forms of paid leave.

Bereavement or Funeral Leave

In the event of a death in your immediate family (your spouse, domestic partner, child, stepchild, parent, sibling, step-sibling, grandparent, mother-in-law or father-in-law, or brother-in-law or sister-in-law), you will eligible for paid time off. Full-time employees are eligible for three business days off, and part-time employees are eligible for leave for the scheduled work hours that fall within the three-day leave period. You will receive full pay and benefits for the bereavement leave.

Please call your manager immediately to inform him or her of your loss and impending absence. If your absence will last longer than the leave granted above, you may request additional time off in the form of unpaid leave or PTO/Vacation time.

Jury Duty

Your pay and benefits continue while you are on jury duty. You also may keep any payments made by the court for jury duty service. Please notify your manager as soon as possible after you receive notice to report for jury duty. Your manager may ask you to provide a copy of your jury duty summons.

Job Abandonment

It is important to keep your manager informed of the reason for your leave and the length of time you will be away from work. If you do not notify BMC of your leave and you are absent for three consecutive days, BMC will consider that you have abandoned your position and voluntarily resigned.

Disability Benefits

Short- & Long-Term Disability

BMC's sick time and disability programs work together to help pay your household expenses if you become disabled and cannot work. BMC pays 100% of the cost of this coverage, and enrollment is automatic.

The chart shown below illustrates your benefits under our sick time and disability programs.

ABSENCE PERIOD	PROGRAM	PROGRAM ADMINISTRATOR	PROGRAM BENEFIT*
First five business days (Week 1)	Sick time **(see page 46)**	BMC Payroll	100% of base salary
Weeks 2 and 3	Short-term disability	Liberty Mutual	100% of base salary
Weeks 4 through 6	Short-term disability	Liberty Mutual	75% of base salary
Weeks 7 through 26	Short-term disability	Liberty Mutual	66 2/3% of base salary
Week 26 and onward	Long-term disability	Liberty Mutual	60% of total cash compensation (base salary, bonus and commission**)

** Benefits are offset by any amounts received under workers' compensation and/or a state disability plan.*
*** Updated annually*

You must apply and be approved for Short-Term Disability (STD) benefits before or immediately after you are absent for illness. You can even **start your claim** in advance of your estimated leave date if you are scheduled for surgery or childbirth.

Your STD benefits will be paid to you directly from Liberty Mutual, BMC's administrator and payment agent for STD. All statutory withholdings will be deducted, and benefits may be offset by any statutory sickness or disability benefits payable to you. During your illness absence, you will be billed directly for your portion of benefits contributions by BMC's benefits administrator, Aon Hewitt.

You can apply for STD benefits online at **www.mylibertyclaim.com** (Claimant ID # BMC2008) or by calling 1-888-408-7300. Liberty Mutual is also our FMLA administrator, so you can also file your FMLA claim (if you are eligible) at the same time you apply for your disability benefits.

In order to be approved for Long-Term Disability (LTD) benefits, you must be permanently and totally disabled and unable to perform your own occupation for the first two years of disability. After two years, the definition of disability changes and you must be unable to hold any job that is reasonably appropriate given your education level, training, or experience. LTD benefits continue until you are no longer disabled, the date you turn 65, or until your death. If you are approved for LTD benefits, you will no longer be covered under the BMC benefit plans; however you will be eligible for COBRA continuation benefits for medical, dental, vision and health care FSA coverage.

Supplemental Long-Term Disability (LTD)

You can purchase supplemental coverage of an additional 15% of total pay (base salary, bonus and commission), resulting in a combined benefit of 75% of total pay (base salary, bonus and commission). You pay the cost of supplemental LTD through after-tax payroll deductions. Due to the monthly benefit maximum of $15,000 for both basic and supplemental LTD, there will be no change in your gross LTD coverage amount if you select the supplemental option. However, your net monthly benefit will be greater with the supplemental LTD option because you will be paying for a portion of the total benefit with after-tax dollars. For more information about how tax rules apply to supplemental disability coverage, see the Group Disability Income Policy on Your Benefits Resources posted under **Plan Information**.

Please Note: *LTD benefits will be offset by Social Security, Workers' Compensation and any other statutory benefits available to you. The overall maximum benefit—a basic and supplemental insurance combined maximum—payable under this plan is $15,000 per month.*

Workers' Compensation

BMC provides all active U.S. employees with workers' compensation insurance coverage according to the state laws that apply. These laws generally provide employees who are injured on the job with compensation for medical expenses and for lost wages due to the injury. Any injury that occurs on BMC property or while on company business should immediately be reported to your manager and your local Human Resources representative. Medical expenses resulting from work-related injuries are not covered through the group health plan, but instead through the workers' compensation insurance carrier.

Family Medical Leave Act (FMLA)

The Family Medical Leave Act (FMLA) is a federal law that allows individuals up to 12 weeks leave during a 12-month period based on specified family and medical reasons for self, child, spouse or parents or to care for a newborn or newly adopted child. Additional FMLA leave benefits may be available for you if you have a family member who has been called to active military duty or who has been injured as a result of active military duty. You are eligible for FMLA if you have worked at BMC for at least 12 consecutive months and at least 1,250 hours.

FMLA runs concurrently with our sick time and disability programs, if you are eligible. All accrued PTO/Vacation time must be used during your FMLA leave if you are not receiving sick time or disability benefits. Upon expiration of your FMLA leave, reasonable efforts will be undertaken by the company to return you to the same position, or an equivalent position, held by you prior to departure, subject to the company's policy of at-will employment. To apply for FMLA, please call Liberty Mutual at 1-888-408-7300.

Work/Life Solutions

In addition to health care, income protection and saving benefits, BMC Software offers the following programs to enable you to build a customized benefits program that meets your lifestyle needs.

Group Prepaid Legal

The BMC Legal Services Plan, underwritten by Hyatt Legal Services (MetLife), offers easy access to experts regarding your legal needs. For enrolled plan members, most services are provided at no cost, while others are provided at a significantly reduced rate. Services are available online, by phone or by in person consultation. The plan can provide assistance regarding:

- Identity theft
- Family issues
- Personal property
- Estate planning
- Real estate ownership or rental

For additional information, go to Hyatt Legal Plans (www.legalplans.com) or call 1-800-821-6400.

Group Auto/Homeowner's/Property Insurance

MetLife Auto & Home® provides you with access to insurance coverage for your personal insurance needs. The program gives you access to special group rates and policy discounts. With a MetLife® home policy, you're eligible for full replacement cost coverage. It is what most people think they have, but when their home suffers losses, they find out their insurance won't really put things back the way they were. It's different with MetLife Auto & Home—you get full replacement cost, whatever the cost.

Call 1-800-GET-MET-8 (1-800-438-6388) for a free quote. BMC employees can choose from several convenient payment options, including payroll or checking account deductions. You may even receive a policy discount for selecting this type of payment method.

Pet Health Insurance

What's Covered in a VPI Pet Health Insurance Policy?

A VPI pet health insurance policy provides reimbursement coverage for your pet's eligible medical treatments, surgeries, lab fees, X-rays, prescriptions and more, so that you can make optimal health care decisions for your pet, based on your veterinarian's recommendation rather than on the cost of treatment.

Take Control of Veterinary Expenses

VPI offers you a financial solution to managing your veterinary costs by reimbursing your eligible expenses for accidents, illnesses and routine preventive care, including office visits, lab fees, X-rays, surgeries, diagnostic testing, prescriptions, hospitalization and much more.

Which Level of Coverage is Best for You?

Get the health care protection that's right for your pet by selecting the VPI Plan and one of our pet WellCare protection riders for optional routine care.

TREATMENTS	VPI PLAN	VPI PLAN WITH WELLCARE CORE	VPI PLAN WITH WELLCARE PREMIER
Accidents & Illnesses	X	X	X
MRI, CAT Scans & X-rays	X	X	X
Surgeries	X	X	X
Cancer Treatments	X	X	X
Prescription Medication	X	X	X
Hospitalization	X	X	X
Vaccinations		X	X
Heartworm, Preventive		X	X
Prescription Flea Control		X	X
Urinalysis			X
Dental or Spay Service			X

Additional information is available through MetLife at 1-800-GET-MET-8 (1-800-438-6388) or at Metlife www.metlife.com/mybenefits.

Tuition Reimbursement

Active, full-time employees may be reimbursed for expenses resulting from college-level studies. The maximum benefit is $5,500 per calendar year; however, to be eligible to receive reimbursement, you must receive a grade of C or better (B in the case of some graduate schools).

Expenses for academically accredited courses of a job-related degree program (undergraduate and graduate) are considered for reimbursement approval by your manager and director if the course:

- Relates to your present job;
- Prepares you for additional responsibility; or
- Relates to a future potential assignment within BMC.

Eligible expenses include tuition, textbooks and all laboratory and computer fees related to the approved course. Ineligible expenses include items such as parking, and building and library fees. In addition, all certificates and seminar-related expenses are not eligible under this program and should be reimbursed under professional development.

To obtain pre-approval for tuition reimbursement, you must complete the Tuition Reimbursement form online at Your Benefits Resources (www.yourbenefitsresources.com/bmc). Select **Other Benefits**, then **Your Spending Account**. Print the form and obtain the proper signatures before beginning your course(s). Once you have completed your course(s), submit the signed Education Assistance Approval Form (along with all additional required documentation) to Your Spending Account.

BMC Scholarship Program

Each year, BMC Software offers up to six college scholarships to sons and daughters of BMC employees. Winners are selected in conjunction with the National Merit Scholarship Corporation and receive a maximum award of $2,500 per year for up to four years of undergraduate college study.

Adoption Assistance

The company will provide financial assistance of $5,000 when you adopt a child. This assistance is intended to help you offset legal and other adoption-related expenses, such as agency fees and court costs. Reimbursement is made to active employees once the adoption is final. The request must be submitted within 30 days from the final adoption date.

For more information and to submit your claim, visit Your Benefits Resources (www.yourbenefitsresources.com/bmc). Select **Other Benefits**, then **Your Spending Account**.

Fitness Reimbursement Program

The BMC Fitness Reimbursement Program helps you improve your health or keep in shape by providing up to $225 each year to help pay for fitness activities outside your home. Requests for reimbursement of expenses incurred during a calendar year can be submitted at any time, but must be received by the program administrator by March 31 of the following year. You must be an active employee during the period you incurred expenses and on the date you submit a reimbursement request. Complete the online reimbursement form, available on Your Benefits Resources (www.yourbenefitsresources.com/bmc). Select **Other Benefits**, then **Your Spending Account**.

Plan Contact Information

PLAN	CONTACT	PHONE NUMBER	WEB SITE
All plans	Your Benefits Resources	1-877-BMC-4849	www.yourbenefitsresources.com/bmc
Medical Insurance — Aetna Plans	Aetna	1-866-214-4839	www.aetna.com
Prescription Drug Coverage for Aetna Medical Plans	Medco	1-866-577-2523	www.medco.com
Medical Insurance & Prescription Drug Coverage – Kaiser Plan	Kaiser Permanente	1-800-464-4000	www.kp.org
Dental	Aetna	1-866-214-4839	www.aetna.com
Vision	VSP	1-800-877-7195	www.vsp.com
Flexible Spending Accounts & Health Savings Account	Your Spending Account	1-877-BMC-4849	www.yourbenefitsresources.com/bmc Select **Other Benefits**, then **Your Spending Account**.
Employee Assistance Program	Aetna	1-800-955-6422 (effective January 1, 2012)	www.mylifevalues.com Username: BMC, Password: EAP
Global Emergency Travel Services	Assist America	1-800-872-1414 (within USA) 1-609-986-1234 (outside USA) Email at: medservices@assistamerica.com	www.assistamerica.com Reference Number: 01-AA-ACN-06048
401(k) Plan & Employee Stock Purchase Plan	Fidelity	1-866-546-4424	www.netbenefits.com
Short-term & Long-term Disability & FMLA reporting	Liberty Mutual	1-888-408-7300	www.mylibertyclaim.com Claimant ID: BMC2008
Group Prepaid Legal Assistance	Hyatt Legal Plans	1-800-821-6400	www.legalplans.com
Group Auto/Homeowner's/ Property Insurance	MetLife	1-800-GET-MET-8	www.metlife.com/mybenefits
Pet Health Insurance	MetLife	1-800-GET-MET-8	www.metlife.com/mybenefits (follow the pet insurance link)
Participant Advocacy — (Help with medical, dental, vision or FSA claims)	Your Benefits Resources	1-877-BMC-4849	www.yourbenefitsresources.com/bmc

Appendices

Getting Help With Eligibility & Claims

The plans have a review process that is followed whenever you submit a benefit claim or an eligibility claim. There are dedicated teams to assist you with both benefit and eligibility issues.

When you file a claim, the claims administrator reviews the claim and, in accordance with plan provisions, either approves or denies the claim (in whole or in part). The claims administrator will notify you of this action. In some situations, the plan may need an extension of time to process the claim (for example, if the plan needs additional information). In these cases, you'll be notified of the extension and the additional information needed.

Getting Eligibility Help—Claims and Appeals

If you have an issue with your claim dealing with eligibility for you or a covered dependent, Claims and Appeals can help. Claims and Appeals is a special group of Your Benefits Resources representatives dedicated to assisting you with your eligibility claims issues. Call Your Benefits Resources at 1-877-BMC-4849 for assistance. Claims and Appeals will conduct an initial review and determination.

Getting Claims Help—Participant Advocacy Team

BMC Software wants you to get the most out of your health care benefits. The Participant Advocacy service is available to help you resolve any conflicts you may have with your medical, dental or health care/dependent care FSA claims and carriers.

Definition of "Benefit Claim" & "Eligibility Claim"

A BENEFIT CLAIM is a request for a particular benefit under an option (for example, a claim for a certain type of surgery under the medical plans). A benefit claim typically includes your initial request for benefits.

An ELIGIBILITY CLAIM is a request to enroll, disenroll or change your participation in a specific option or coverage category outside of the enrollment guidelines stated in this guide. Eligibility claims are filed by calling Your Benefits Resources at 1-877-BMC-4849.

What Is Participant Advocacy?

Participant Advocacy will help you with unresolved health plan access or claims issues. The Advocate Team will research your issue and work with your health plan to resolve it on your behalf.

The Advocate Team helps ensure that your issue is given the attention it deserves and is considered fairly. However, contacting the Advocate Team does not guarantee the resolution you want—the terms of the plan still apply.

The service is available to employees enrolled in medical, vision, prescription drug, mental health care, dental and the health care/dependent care FSA plans.

How Can I Reach the Advocacy Team?

Call Your Benefits Resources at 1-877-BMC-4849 and ask to speak with an Advocate Team representative. All calls are confidential.

Before you request assistance, you must make at least one attempt to resolve the issue directly with your health plan. This attempt does not need to be in writing. If your issue is still unresolved after you've discussed it with the health plan's customer service, call Your Benefits Resources Benefits Center. If you contact the Benefits Center before talking to your health plan, your issue will not be passed on to the Advocate Team. Instead you will be directed to contact your health plan.

A Benefits Representative will review the issue to determine next steps. If the issue requires advocacy assistance, the Benefits Representative will pass your issue on to the Advocate Team to begin research. An advocate will contact you within two business days to follow up.

Have the Following Information Ready When You Call the Benefits Center

- **Issue description**
- **Health care provider**
- **Date(s) of service**
- **Claim amount**
- **Health plan's response**

COBRA: If You and Your Dependents Lose Health Care Coverage

If you lose your BMC medical, dental and vision coverage, in certain situations you may be able to continue coverage on an after-tax basis. This opportunity to continue coverage is provided by the Consolidated Omnibus Budget Reconciliation Act (COBRA), a federal law.

COBRA coverage is a temporary continuation of health care coverage when it otherwise would end because of a life event, known as a "qualifying event." After a qualifying event, COBRA continuation coverage is offered to each "qualified beneficiary." You, your spouse/domestic partner and your dependent children could become qualified beneficiaries if coverage under the health care plans is lost because of the qualifying event. You pay a monthly premium for continuation of coverage. BMC does not pay for or contribute toward the premium, so coverage is more expensive than health coverage for active employees.

COBRA applies to these plans:

- Medical insurance
- Dental insurance
- Vision insurance
- Health Care Flexible Spending Account
- Employee Assistance Program

For additional information about your rights and obligations under federal law and under BMC's group health care plans—medical (including prescription drugs), dental and vision coverage and the Health Care FSA—contact Your Benefits Resources (YBR) Benefits Center at 1-877-BMC-4849.

Coverage Options

When you or a qualified beneficiary chooses to continue coverage, coverage options include:

- Keep the same level of coverage you had as an active employee or choose a lower level of coverage
- Change coverage (if enrolled within the initial 60-day enrollment window) in either of the following circumstances:
  - During the annual enrollment period
  - If you or your dependent has a qualified status change (life event) or another change in circumstances recognized by the Internal Revenue Service (IRS) and BMC
- Enroll any newly eligible spouse or dependent child under the health care plan's rules

When You Can Elect COBRA Coverage

The following charts show how long you and your eligible dependents (qualified beneficiaries) can continue COBRA coverage.

IF YOU LOSE COVERAGE BECAUSE...	YOU CAN CONTINUE COVERAGE FOR...
You are no longer eligible due to termination of your employment or your work hours are reduced below 30 regularly scheduled hours per week	18 months
You are no longer eligible due to termination of your employment and either you or a dependent is disabled (according to the Social Security definition) at any time during the first 60 days of COBRA coverage	29 months

Ending Coverage

COBRA coverage under a group health care plan ends before the maximum continuation period if:

- You or your covered dependent fails to make timely premium payments or contributions
- You or your covered dependent become entitled to Medicare
- You or any of your covered dependents become covered under another health care plan not offered by the company
- During an extended period of COBRA coverage due to a disability (and assuming there has not been a second qualifying event), a final determination is made by the Social Security Administration that the qualified beneficiary is no longer disabled

For more information about your rights under the Employee Retirement Income Security Act of 1974 (ERISA), including COBRA, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other laws affecting group health care plans, contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area, or visit the EBSA website (www.dol.gov/ebsa/). (Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website).

Terms to Know

An understanding of these terms will help you gain a greater understanding of your benefits.

Allowable amount. The amount allowed by the plan for a given service, supply or procedure.

Annual dollar maximum. Each person can receive plan reimbursements up to a calendar-year limit. Annual dollar maximums apply as a single amount to in-network and out-of-network services combined.

Balance billing. When the allowable amount is less than a health care provider usually charges, a provider can bill the patient for the amount not paid by the plan. If this occurs with a network provider, you are not responsible for the additional amount. With a non-network provider, you are responsible for payment, and the amount of the balance bill does not apply to your out-of-pocket maximum.

Coinsurance. The portion of covered expenses the plan pays after the deductible is met. Coinsurance is expressed as a percentage.

Copayment (copay). The dollar amount you must pay for specific supplies or services.

Deductible. The portion of covered expenses you pay each calendar year before the plan begins to reimburse you for all eligible expenses.

Drug Formulary. A list of prescription drugs, both generic and brand name, that are approved by the health plan.

Health Savings Account (HSA). A before-tax account feature of a high-deductible medical plan that you use to pay your health-related expenses each year. BMC contributes to the account, and you may also make voluntary before-tax contributions each year.

High-Deductible Health Plan (HDHP). An option that provides comprehensive health care coverage for you and your family along with a tax-advantaged Health Savings Account that lets you save to pay for your current and future out-of-pocket health care expenses. The HDHP/HSA gives you greater flexibility and discretion over how you use your health care benefits.

Network provider. A doctor, hospital or other health care provider who is an active member of a particular plan's provider network.

Non-network provider. A doctor, hospital or other health care provider who is not an active member of a particular plan's provider network.

Out-of-pocket maximum. When the amount of coinsurance you pay for expenses has reached a stated annual maximum, the plan will reimburse 100% of covered expenses for the rest of the calendar year. You must still pay all required copayments (if any).

(Terms to Know continues on page 59)

Terms to Know (continued)

Preferred Provider Organization (PPO). A PPO is a managed care organization of medical doctors, hospitals and other health care providers who have contracted with an insurer or a third-party administrator to provide health care at reduced rates to the insurer's or administrator's clients.

Preventive Prescription Drug. Medications prescribed for disease prevention. To view medications that are considered preventive under the Aetna HSA plan, please see the list on Your Benefits Resources (www.yourbenefitsresources.com/bmc) under **Plan Information**.

Specialty pharmacy. A specialty pharmacy is a pharmacy that provides specialty medications. Specialty medications often require special storage and handling that most retail pharmacies cannot manage. These medications include injectable, infused and selected oral therapies. A specialty pharmacy offers these medications, and an in-house compounding pharmacy lets pharmacists create forms of medication that are not available in stores. Patients may have trouble sticking to their therapy schedule and often have side effects from their medications. This is why specialty medications require a pharmacist or registered nurse to monitor the treatment. BMC strongly recommends that all specialty medications be obtained through either the Medco or Kaiser Specialty Pharmacy services.

Usual and customary (U&C) (allowable charges). Charges that fall within an acceptable range based on the most common fees for similar services in a given local area, as determined by Aetna using Health Insurance Association of America (HIAA) rates. Additional factors such as the complexity and complications of a procedure may also be considered. If your expenses exceed the U&C charge, you will pay the excess amount. Usual and customary charges for services within the PPO network are predetermined—you should not be billed for the excess amount.

About This Guide

This information is only a summary. The provisions of the benefit plan documents, the current BMC Software, Inc. (the Company) policies, and the insurance policies as applicable will determine your actual benefits. If there is a conflict between this guide and the plan/company policies or documents, the plan/company policies or documents will govern. The Plan Administrator has the final discretionary authority to determine all issues arising under the benefit plans it administers, including issues of interpretation, eligibility, benefits and factual determination. If there is a conflict between this guide and a determination or interpretation made by the Plan Administrator, the interpretation adopted by the Plan Administrator will govern.

The discussion in this summary constitutes a projection of future benefit outcomes that may be available under the applicable benefit plans. The discussion is not a guarantee or warranty that such outcomes will in fact occur. The Company reserves the right to amend, modify or terminate its health and retirement plans at any time. Such changes may include reduction or elimination of benefits. However, no change will result in the elimination or reduction of legally vested benefits in a retirement plan. The Company's sponsorship of active health and welfare plans and retirement plans shall not in any way constitute or be construed as a guarantee or promise of continued employment.

Your receipt of compensation and certain benefits from the Company may be subject to income taxes by the federal government and certain states and/or municipalities that have an income tax. From time to time, the Company may provide you with tax-related information pertaining to its compensation and benefits programs. Taxation of income is complex and is subject to many different variables and individual circumstances. As a result, the Company cannot and does not provide any tax advice to its current or former employees. Any tax-related information that might be provided to you is solely for informational purposes. You should not rely upon any such communications in tax planning or in making any tax-related decisions. You are solely responsible for complying with your federal income tax obligations (and state and/or local income tax obligations if applicable). If you have any tax questions or concerns, you should retain a competent and qualified tax advisor to advise and assist you in complying with your tax obligations.