PERFORCE

2022 Employee Benefits Guide

Table of Contents

PERFORCE

Welcome to Perforce Software

At Perforce Software, we are committed to offering you a comprehensive benefit program to meet your personal, family and financial needs. Because you will need to make some very important decisions regarding your health and welfare coverage, we urge each employee and their family members to read this benefit booklet thoroughly. Detailed information can be found on the carrier websites or are located in ADP>Resources>Tools/References. Carrier contact details and web addresses can be found at the end of this summary document. If you need more information, have a question, need assistance in ADP, or have any other concern, contact the HR department at contact-hr@perforce.com.

Perforce Software 2022 Employee Contributions

PPO Medical Plan (BCBSMN)	Monthly Employee Contribution
Employee Only	$104.00
Employee and Spouse/Domestic Partner	$270.00
Employee and Child(ren)	$280.00
Employee and Family	$380.00
High Deductible Health Plan (BCBSMN)	**Monthly Employee Contribution**
Employee Only	$35.00*
Employee and Spouse/Domestic Partner	$166.00*
Employee and Child(ren)	$126.00*
Employee and Family	$268.00*
Dental Plan (Delta Dental of MN)	**Monthly Employee Contribution**
Employee Only	$5.00
Employee and Spouse/Domestic Partner	$22.00
Employee and Child(ren)	$26.00
Employee and Family	$44.00
Vision Plan (VSP)	**Monthly Employee Contribution**
Employee Only	$1.00
Employee and Spouse/Domestic Partner	$3.00
Employee and Child(ren)	$3.00
Employee and Family	$6.00

*Employees enrolled in the High Deductible Health Plan receive a monthly employer contribution to his/her Health Savings Account in the amount of $60 for Employee Only coverage and $120 for Employee and Spouse/Domestic Partner, Employee and Child(ren) and Family coverage.

Perforce provides the following benefits at no cost to employees:

- Basic Life and AD&D
- Short and Long-Term Disability
- Employee Assistance Program
- Travel Assistance
- Health Advocate

PPO & High Deductible Medical Plan Overview

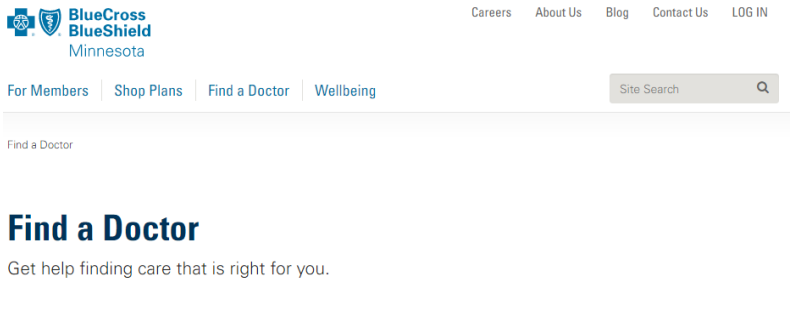
	BCBS of MN Choice Plus PPO 750	BCBS of MN HDHP HSA 2800
	In-Network	In-Network
Deductible	$750 Individual $1,500 Family	$2,800 Individual $5,600 Family
Out-of-Pocket Maximum	$5,000 Individual $10,000 Family	$2,800 Individual $5,600 Family
Office Visit	$30 copay Primary Care & Specialist	0% after ded.
Preventive Care Services	No Charge	No Charge
Lab and X-ray	20% after ded.	0% after ded.
Urgent Care	$30	0% after ded.
Emergency Room	$150 copay, waived if admitted, then 20% after ded.	0% after ded.
Inpatient Hospital	20% after ded. Pre-auth. Required	0% after ded.
Outpatient Surgery	20% after ded.	0% after ded.
Chiropractic Care	$30 20 visits per year	0% after ded. 20 visits per year
Outpatient Mental Health Copay	$30 copay	0% after ded.
Prescription Drug Copays *30 day supply*		
Preventive/Contraceptives	No Charge	No Charge
Tier 1	$10 copay	0% after ded.
Tier 2	$35 copay	0% after ded.
Tier 3	$60 copay	0% after ded.
Specialty	20% coinsurance up to a maximum of $400.00.	0% after ded.

This is only a brief overview of benefits. Exclusions and limitations may apply.
Please refer to the Evidence of Coverage for more information.

How to Find a Doctor with Blue Cross Blue Shield of MN

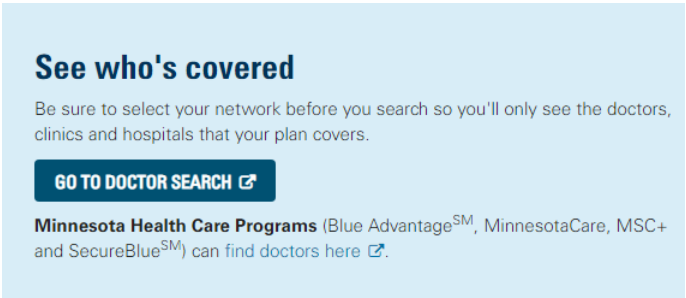
<u>If you are not a member yet:</u>

Go to
https://www.bluecrossmn.com/find-a-doctor



Scroll down to

'GO TO DOCTOR SEARCH'

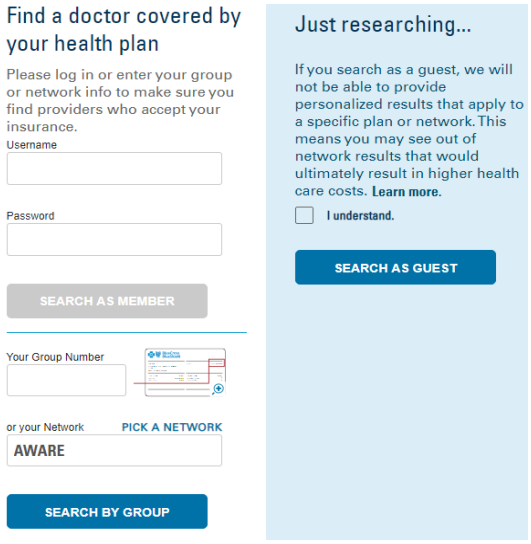


Search as a *Guest* and under the

"Pick a Network" select:

AWARE (inside Minnesota)

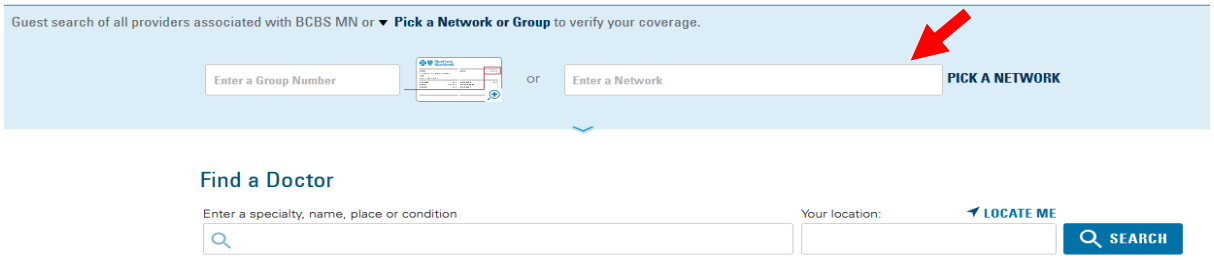
Blue Card PPO (outside Minnesota)



Find a Doctor

Search by specialty, name, place,

or condition and your location.



BCBS High Deductible Health Plan and Health Savings Account

A Health Savings Account plan is a medical benefit designed to provide premium savings on your monthly contributions and limit your overall exposure to medical related costs. When you enroll in the BCBS of MN High Deductible Health Plan, you are eligible to open a special tax-advantaged savings account to pay qualified medical expenses for you and your family.

There are several advantages to a Health Savings Account:

- Money contributed to the plan through payroll deduction with pre-tax dollars reduces your gross taxable income
- Money contributed to the plan with after-tax dollars are tax-deductible
- You can use money in your account to pay for current or future IRS-qualified medical expenses as well as deductibles, co-insurance, prescriptions, vision and dental care
- HSA funds earn interest tax free, and when used for IRS-qualified medical expenses are also free from tax
- Unused funds will roll over year to year. There's no "use or lose it" penalty.
- The HSA is individually owned. If you leave the company or change medical plan types, the money in your account remain yours—there is no "use it or lose it" provision
- Potential to build more savings through investing—you can choose from a variety of HSA self-directed investment options with no minimum balance required
- Additional retirement savings—after age 65, funds can be withdrawn for any purpose without penalty.
- Perforce Software contribution into your Health Savings Account

If electing the Blue Cross Blue Shield HDHP for the first time, you will be sent a debit card and an account number that is linked to your HSA account. Once activated, you can use your debit card to pay for qualified medical expense, to the extent of your account balance. You will also be able to have online access to your account through the FlexToday website. Contact HR for more information about the high deductible plan and the HSA account.

Perforce Software HSA Contributions

If you select the individual HSA medical plan, Perforce will contribute up to $720 annually into your personal Health Savings Account. If you select the family coverage HSA medical plan, Perforce will contribute up to $1,440 annually into your Health Savings Account. Contributions will be allocated each pay period.

IRS HSA Contribution Limits for 2022:

- Single $3,650
- Family $7,300
- If you are age 55 and over, you may contribute an extra $1,000 catch up contribution.

Dental Benefits

Perforce Software offers a dental plan through Delta Dental of MN. The chart below is a brief outline of the plan.

Dental Plan Networks

Our 2022 dental plan networks include:

- Delta Dental PPO
- Delta Dental Premier
- Out-of-Network

Members can search for network dental providers by:

1. Going to www.deltadentalmn.org/ Find a Dentist / Get Started
   - Select the network option from Delta Dental or Delta Dental Premier coverage options.
2. Call Customer Service at 1-800-553-9536

Delta Dental Plan Benefit Summary

	Delta Dental PPO	Delta Dental Premier	Out-of-Network
Diagnostic & Preventive	100%	100%	80%
Basic Restorative Services	80%	80%	60%
Endodontics	80%	80%	60%
Periodontics	80%	80%	60%
Oral Surgery	80%	80%	60%
Major Restorative	50%	50%	50%
Prosthetic Repairs/Adjustments	50%	50%	50%
Prosthetics and Implants	50%	50%	50%
Orthodontics (Per covered dependent child)	50%	50%	50%
Annual/Individual Deductible	$25	$25	$50
Annual/Family Deductible	$75	$75	$150
Annual Maximum	$1,500	$1,500	$1,500
Lifetime Orthodontic Maximum	$1,500	$1,500	$1,500
Deductible Waived for:	Diagnostic & Preventive and Orthodontic Services		
Sealants	Covered under Basic Restorative		
Waiting Periods	None		

This is only a brief overview of benefits. Exclusions and limitations may apply.

Please refer to the Summary Plan Description (SPD) for more information.

Vision Benefits

Vision benefits are provided through Vision Service Plan (VSP). We encourage you to use a participating VSP provider to maximize your vision benefits. You'll get the highest level of care, including a WellVision Exam® – the most comprehensive exam designed to detect eye and health conditions. Plus, when you see a VSP provider, you'll have lower out-of-pocket costs and your satisfaction is guaranteed.

Out of network benefits are available if you use a non-VSP provider. However, you will be reimbursed a lesser benefit based on the type of service you receive.

	In-Network	Out-of-Network
Eye Exam Every calendar year	$10 copay	$45 copay
Lenses Every calendar year	No Charge Deductible waived	-
Single Vision Lenses	Included	Up to $30
Bifocal Lenses	Included	Up to $50
Trifocal Lenses	Included	Up to $65
Frames Every calendar year	• $150 allowance for a wide selection of frames • $170 allowance for featured frame brands • 20% savings on the amount over your allowance • $150 Walmart/Sam's Club frame allowance • $80 Costco frame allowance	Up to $70
Lens Enhancements	• Standard progressive lenses $0 • Premium progressive lenses $95 - $105 • Custom progressive lenses $150 - $175 • Average savings of 30% on other lens enhancements • lens enhancements • Every 12 months	varies
Contact Lenses Every calendar year	$130 allowance for contacts; copay does not apply Contact lens exam (fitting and evaluation) up to $60	Up to $60

This is only a brief overview of benefits. Exclusions and limitations may apply.

Please refer to the Evidence of Coverage for more information.

To find a provider, visit www.VSP.com.

Life and AD&D Benefits

Perforce Software provides Basic Life and Accidental Death & Dismemberment (AD&D) Insurance to full-time employees through The Standard Insurance. There is no employee cost for this benefit.
If death occurs while you are covered under the plan, your beneficiary will receive a life insurance benefit in the amount of $50,000. In the event of an accidental death, an additional benefit equal to your life insurance amount will be given to your beneficiary. Benefits reduce by 35% at age 65, by 50% at age 70 and end at retirement.

The Standard Voluntary Life and AD&D

In addition to Basic Life Insurance, you are eligible to purchase additional Voluntary Life and AD&D insurance for you and your eligible dependents. This coverage is 100% paid by you. The guaranteed issue is $150,000 for new hire enrollees and $30,000 for spouse. Rates are included in the ADP benefit enrollment profile or contact HR for more information.

Benefit Amounts	Employee: $10,000 increments up to $300,000 (not to exceed 5x base annual earnings) Spouse: $5,000 increments up to $150,000 Children: $10,000
Benefit Reductions	Benefits reduce by 35% at age 65, by 50% at age 70, and end at retirement
Portability	Allows you to continue your coverage if you leave employment, subject to certain restrictions
Conversion	Allows you to apply for an individual policy, subject to certain restrictions
Initial Enrollee Guarantee Issue	Benefits elected beyond your first 30 days of employment, or in excess of the amounts listed below will require an evidence of insurability to be submitted before coverage is issued: Employee: $150,000 Spouse: $30,000

This is only a brief overview of benefits. Exclusions and limitations may apply.

Please refer to the Evidence of Coverage for more information.

Disability Benefits

Short Term Disability

Perforce Software provides Short Term Disability coverage through The Standard. There is no employee cost for this benefit.

Disability benefits are paid to covered employees who become injured or suffer an illness and cannot perform the duties of their job. Benefits paid under this policy would be subject to income tax at time of claim. Your disability benefit through The Standard integrates with California State Disability, Worker Compensation plans, and Social Security and is reduced by income received from these other sources.

Short Term Disability	
Elimination Period	7 days
Maximum Benefit Period	25 weeks
Benefit Amount	60% of your pre-tax salary up to $2,308 per week

This is only a brief overview of benefits. Exclusions and limitations may apply.

Please refer to the Evidence of Coverage for more information.

Long Term Disability

Perforce Software provides Long Term Disability (LTD) through The Standard. There is no employee cost for this benefit. You are eligible for Long Term Disability benefits after 180 days of total disability

Long Term Disability	
Elimination Period	180 days or until the expiration of employer sponsored short term disability benefits
Benefit Amount	60% of your pre-tax salary up to $10,000 per month
Benefit Duration	To age 65 Benefits are reduced by Social Security, workers compensation, and/or state disability benefits

This is only a brief overview of benefits. Exclusions and limitations may apply.

Please refer to the Evidence of Coverage for more information.

Group Accident Insurance

Perforce Software offers an Accident plan through The Standard. This benefit is 100% employee paid. In the event of a covered accident, your Accident insurance will pay a benefit directly to you. You can use this money wherever you need it most-whether that's to help with your deductible, copays and other medical bills, or your daily expenses while you recover. See plan summary for full details.

Let's say your teenage daughter gets injured during tryouts for her school basketball team and goes to urgent care for treatment. Diagnosis: dislocated elbow and fracture of the forearm and wrist. Although Surgery isn't necessary, she will need follow-up appointments and physical therapy.

You'd get an additional 25% if your child is injured while participating in an organized athletic activity – whether it's football practice, a soccer game, or dance class.

BENEFITS PAID TO YOU

Urgent Care Visit	$50
X-ray	$50
Dislocated Elbow	$800
Arm Fracture	$550
Wrist Fracture	$550
Physician Follow-up Appointment	$50
Physical Therapy Appointment (2 visits)	$100
SUBTOTAL	$2,150
Youth Organized Sports Benefit (25% of subtotal)	**$538**
Total paid directly to you	$2,688

Imagine that you survive a serious car accident. After a trip to the ER, you stay in the hospital for several days while you recover. In the weeks following the accident, you have a follow-up appointment at a clinic in another city and physical therapy.

You'd get an additional $500 because you were injured in a care accident. Because you drove more than 100 miles one way for your follow-up appointment, you'd receive an extra $150. If your car accident occurred more than 100 miles away from your home and a family member who resides with your traveled to be near you while you were in the hospital, we'd pay additional benefits to help cover lodging expenses.

BENEFITS PAID TO YOU

Ambulance	$300
Emergency Room Visit	$150
CAT Scan	$200
Hospital Admission Benefit	$1,000
5-Day Hospital Confinement ($200 per day)	$1,000
Right Leg Fracture	$4,000
Knee Cap Fracture	$1,100
Pelvis Fracture	$2,400
Physician Follow-up Appointment	$50
Physical Therapy Appointment	$50
SUBTOTAL	$10,250
Automobile Accident Benefit	**$500**
Transportation Benefit	**$150**
Lodging (4 days)	**$700**
Total paid directly to you	$11,600

Monthly Rates

Coverage for...	Monthly Premium
You	$7.55
You and your spouse	$11.74
You and your children	$14.46
You, your spouse, and your children	$22.56

Critical Illness Insurance

Perforce Software offers a Critical Illness plan through The Standard. This benefit is 100% employee paid. Critical Illness insurance can make a big difference in your ability to pay out-of-pocket expenses associated with a serious illness. It pays a lump-sum benefit directly to you upon diagnosis of a covered illness, regardless of your treatment costs or what's covered by your medical insurance. Elect coverage in an amount of your choosing: $10,000 or $20,000. See plan summary for full details.

How it works:

John has $10,000 of Critical Illness insurance coverage. He makes an appointment with his doctor after feeling off for the past few weeks. Diagnosis: cancer, with a good prognosis but a long road ahead. Within days of making a claim, John receives his Critical Illness insurance benefit paid directly to him. As John undergoes intensive treatment over the next few months, he can use the benfit for any purpose, including to pay for things that his medical insurance does not cover. Things like the deductible, copays, child care, certain medications, time away from work, alternative treatments and a special diet.

SAMPLE OUT-OF-POCKET EXPENSES

Medical insurance deductible.....$1,300
Out-of-pocket expenses
over the course of six months.....$5,000
Lost wages.....$4,500
Alternative treatments and diets
not covered by medical plan.....$4,500

TOTAL OUT-OF-POCKET EXPENSES.....$15,300
CRITICAL ILLNESS BENEFIT.....$10,000
OUT-OF-POCKET EXPENSES.....$5,300

Costs are hypothetical. Actual costs will vary by state, cancer type, stage at diagnosis, treatments received and personal factors.

Covered Conditions

Receive 100 percent of your coverage amount for:

- Heart attack
- Stroke
- Cancer
- End stage renal (kidney) failure
- Major organ failure
- Coma
- Paralysis of two or more limbs
- Loss of sight
- Occupational HIV
- Occupational hepatitis

Receive 25 percent of your coverage amount for:

- Severe coronary artery disease with recommendation for bypass surgery
- Carcinoma in situ (cancer that has not metastasized)

Initial diagnosis and initial recommendation must occur after your coverage becomes effective.

Monthly Rates

The monthly premiums you would pay for Critical Illness insurance benfits are based on your age for both you and your spouse. The rates below are not combined rates for you and your spouse, rather they are the rates for each of you individually. Please note that you may continue your coverage past age 70.

Coverage for...	Monthly Premium
You	Flat amount of $10,000 or $20,000
Your spouse	Flat amount of $5,000 or $10,000 as long as it's not more than your coverage amount
Your child(ren) through age 25	Automatically covered at 25% of your coverage amount

Monthly Attained Age Premiums					
Coverage Amount	**Age Band**				
	<30	**30-39**	**40-49**	**50-59**	**60-70**
$5,000	$1.20	$1.90	$4.00	$8.45	$16.20
$10,000	$2.40	$3.80	$8.00	$16.90	$32.40
$20,000	$4.80	$7.60	$16.00	$33.80	$64.80

Hospital Indemnity

Perforce Software offers a Hospital Indemnity plan through The Standard. This benefit is 100% employee paid. Group Hospital Indemnity insurance can help cover unexpected out-of-pocket expenses such as copays, deductibles and out-of-network charges, as well as everyday living expenses. It pays a benefit directly to you for hospital related events, regardless of your treatment costs or other insurance coverage you might have.

How it works:

Kim is out of town on a business trip when she experiences abdominal pain and a racing heartbeat. Diagnosis: ruptured gastric ulcer. She is rushed to the hospital, admitted and taken into surgery. She ends up being hospitalized for 10 days, three of which are in a critical care unit.

Kim's husband leaves their two kids with their daycare provider and flies to be at her side. The family now faces additional costs for travel and childcare.

SAMPLE OUT-OF-POCKET EXPENSES

Medical deductible/coinsurance.....$3,000
Other non-medical expenses.....$475
Travel expenses (flights, change fees, etc.).....$350
Childcare.....$500

TOTAL EXPENSES.....$4,325
Benefit for:
Hospital admission.....$1,000
Hospital confinement (10 days x $250 per day).....$2,500
CCU admission.....$1,000
CCU confinement (3 days x $100 per day).....$300

TOTAL PAID TO YOU.....$4,800
Remaining Benefit for Other Expenses.....$475

Costs are hypothetical. Actual costs will vary by state, condition, treatments received and personal factors.

Benefits:

Waiver of Premium	Premium waived if you are confined to a hospital for more than 30 days
Hospital Admission (maximum 1 per calendar year)	$1,000 per day
Daily Hospital Confinement (maximum 15 days per stay)	$250 per day
Critical Care Unit Admission* (maximum 1 per calendar year)	$1,000
Daily Critical Care Unit Confinement* (maximum 15 days per stay)	$100 per day

*Payable in addition to the Hospital Admission and/or Daily Hospital Confinement you may be eligible to receive.

Rates

Monthly Coverage Rates for:			
You	**You and Your Spouse**	**You and Your Children**	**You, your spouse, and your children**
$13. 45	$22.35	$18.40	$32.70

Flexible Spending Account

Choose your monetary level of participation which is deducted from your paycheck on a pre-tax basis to pay for eligible medical expenses. You may elect to participate in the health care FSA, dependent care FSA, or a combination of the two. Your election is irrevocable during the plan year except in cases of a change in family or employee status.

FSA – Medical

You can elect to defer up to $2,750 of your salary to pay for unreimbursed eligible expenses into your medical FSA (subject to limit changes set by the IRS every year). Examples of qualified health care FSA expenses include deductible, copays and coinsurance charges, hearing services, vision services, eyeglasses, dental services and orthodontia.

You have until March 15th, 2023 to spend unused 2022 funds. Non-debit card reimbursement requests must be received by FlexToday no later than March 31st, 2023 to qualify for reimbursement. Perforce allows employees to carry over $550 from their FSA to the next year.

If you elect the Blue Cross Blue Shield HDHP/HSA Plan, your FSA account usage will change

HSAs and FSAs are both tax-advantaged accounts designed to help you pay for qualified medical expenses. The IRS governs the use of an FSA if an employee is enrolled in an HSA plan.

You may still contribute to an FSA through payroll deduction. However, you are limited to using your FSA funds to pay for qualified dental and vision expenses only, for you, your spouse and eligible dependents. Qualified medical expenses must be paid for with your HSA funds.

FSA – Dependent Care

With a dependent care FSA, you can defer up to $5,000 of your salary to pay for eligible day care expenses. Examples of qualified Dependent Care FSA expenses include the cost of child or adult dependent care, cost for an individual to provide care either in or out of your house, nursery schools and preschools (excluding kindergarten). You have until March 15th to submit reimbursements for expenses that have occurred on the previous plan year. Non-debit card reimbursement requests must be received by FlexToday no later than March 31st to qualify for reimbursement.

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ELIGIBLE MEDICAL EXPENSES

Eligible expenses are services and treatments that are medically necessary and prevent or treat illness or disease. You can include the expenses of your spouse and eligible dependents (up to age 26), even if they are not covered under your employer's group health plans. To be eligible for reimbursement, your expenses must be incurred -- services actually received -- by you or your eligible dependents during the plan year while you are/were an active participant and your claim must be made according to the requirements of your employer's plan.

The following is list of some of the many eligible medical, dental and vision expenses:

Adaptive Equipment (Crutches, Canes, Grab Bars, Wheelchairs, etc.)
Ambulance Services
Body Scans & Medical Diagnostic Services
Breast Pump & Lactation Supplies
Childbirth Classes
Christian Science Practitioner Fees
Co-payments, Coinsurance & Deductibles
C-PAP and BiPAP Devices and Supplies

Dental Services & Treatments

Bridges	Cleanings	Crowns
Dentures	Fillings	Implants
Root Canals	Sealants	X-Rays

Doula Services * (Not for post-partum/healthy baby care.)

Eye Care Services, Products & Treatments

Contact Lenses (Corrective)	Prescription Glasses
Sunglasses (Rx/Corrective)	Vision/Lasik Surgery

Fertility Enhancement

Artificial Insemination	In Vitro Fertilization
Ovulation Monitors	Pregnancy Tests

Hearing Aids & Batteries
Homeopathic Care (Licensed health care professional fees.)
Immunizations/Flu Shots/Vaccinations
Insulin, Related Supplies & Equipment
Laboratory Fees
Lactation Consultant
Medical Alert ID Bracelets/Necklaces
Medical Information Plans & Records Fees

Medical Service Professional Fees

Acupuncturists	Chiropractors	Dentists
Eye Doctors	Oral Surgeons	Orthodontists
Osteopaths	Pediatricians	Podiatrists
Physicians	Psychiatrists	Psychologists

Nurse & Midwife Services * (Not for post-partum/healthy baby care.)
Orthodontia Treatments (Eligible after services are received.)
Orthotic Inserts, custom or over the counter
Prescription Medications
Prosthetics (Including Post-Mastectomy Prosthetic Bras.)
Speech Therapy
Travel, medical-related

2021 mileage reimbursement rate is $16/mile (2020 was $.17) plus parking and toll-fees. Claim must include to/from information, mileage and include documentation of the related expenses. Does not include trips to the pharmacy or grocery store.

Vasectomy & Vasectomy Reversal

Over the counter medications, Menstrual Supplies and Personal Protective Equipment are ELIGIBLE as of 01/01/2020

The CARES Act of 2020 allows Over the Counter Drugs and Medications as FSA-eligible medical expenses and added Menstrual Supplies as eligible medical expenses, both retroactively effective as of 1/1/2020. In March 2021, the IRS announced that Personal Protective Equipment (PPE) are eligible medical expenses retroactive to 01/01/2020.

This includes:

- OTC Medications such as Advil®, Tylenol®, Flonase®, Prilosec®, Rolaids®, Zyrtec®, Zantac®, and many, many more!
- PPE such as Face Masks, Hand Sanitizers, Alcohol Wipes, Medical-grade Gloves, Sanitizing Wipes, etc.
- Menstrual supplies such as Tampons, Pads, Cups, Liners, Sponges and similar products used for menstruation.

MORE INFORMATION ON THE NEXT PAGE

* Licensed health care professional fees and medical-grade products. See LMN next page.
** Does not include lotions or other products that contain sunscreen or SPF protection.

Eligible Over The Counter (OTC) Medications & Products (No Rx)

ACE® Bandages	Contact Lens Solutions	Hearing Aid Batteries	Ovulation/Pregnancy Kits	**Menstrual Supplies**
Advil®	Cortizone®	Home Medical Test Kits	Prenatal Vitamins	• Tampons
Alcohol Wipes	CPAP Supplies	Ice or Heat Pads/Packs	Prep. H®	• Pads
Antiarthritics Supplements	Denture Care Products	Incontinence Products	Prilosec®	• Liners
Band-Aids® & Bandages	Desitin®	Lamisil®	Reading Glasses	• Cups
Benadryl®	Diabetic Supplies	Maternity Belts & Hose*	Sunscreen (SPF 15+)**	• Sponges
Betadine®	Excedrin®	Monistat ®	Surgical Stockings	**Hygiene Products**
Blood Pressure Monitors	**Face Masks**	Nasal/Sinus Rinse Supplies	Theraflu®	• Betadine
Braces & Supports	Fertility Monitor	Nebulizers & Inhalers	Thermometers	• Epsom Salts
Breast Pumps & Supplies	First Aid Kits	Neosporin®	Tinactin®	• **Hand Sanitizers**
Commit®	**Gloves (Medical-grade)**	Nicoderm®	Tylenol®	• Hydrogen Peroxide
Compression Hosiery/Socks*	Hand Sanitizers	Orajel®	Walkers & Wheelchairs	• Rubbing Alcohol
Condoms	Heart Rate Monitor (non-sports)	Orthotic Shoe Inserts	Zyrtec®	

SPECIAL EXPENSES

Eligible if prescribed/recommended by your Physician to treat a specific medical condition:

Allergy Products (LMN)

Birth Control & Contraceptives (Rx)

Cord Blood Banking (LMN)
Eligible only if there is an immediate medical need. Storage limited to the first 12 months or less, prorated for plan year.

Egg/Sperm/Embryo Storage (LMN)
Eligible only during active fertility treatment. Storage limited to the first 12 months or less, prorated for plan year.

Guide and Disability Support Service Animals (LMN)

Gym Memberships & Fitness Programs (LMN)
The cost of gym memberships, fitness classes and home exercise equipment can be eligible if purchased at the direction of your Physician to treat a specific medical condition, such as obesity. For home fitness equipment, the Physician will also need to document the need for the equipment and why other activities were not advisable.

Humidifiers and Air Purifiers (LMN)
Unless it is a medical product (i.e. Vicks®) it is only eligible if recommended (LMN) to treat a specific medical condition. If affixed to your home, the eligible expense is reduced by the increase in the value of your home due to the product.

Language and/or Learning Disability Expenses (LMN)
Therapy, tuition and tutoring fees paid to special schools and specially trained teachers for an individual with a disability.

Lice Treatment (Rx required for medications, LMN for professional services)

Licensed Massage Therapist (LMN)

Orthopedic Shoes (Rx/LMN, only excess cost of special form eligible.)

Ultrasound, Pre-natal (For diagnostic purposes only.) (LMN)

Vitamins, Herbals, Botanical and Biological Products (Rx)

Weight Loss Programs (LMN)

Not Generally Eligible

As a rule, expenses are not eligible if you don't owe the provider, or if the expenses are cosmetic in nature or not medically necessary. For example:

- Cosmetic services and products such as Botox®, Rogaine® & teeth whitening.
- Foods & food products are not eligible unless it does not satisfy nutritional needs, is prescribed (Rx) to treat a specific condition and limited to the cost exceeding the cost of a normal diet.
- Infant diapers.
- Insurance Premiums & Student Health fees.
- Interest, Missed Appointment and Late fees.
- Life Coaching, Career Counseling, Family, Marriage and/or Parental Counseling are not eligible unless it is primarily for medical care to treat a specific medical condition or diagnosis.
- Medications imported from foreign countries are generally not eligible. Medications received and used in foreign countries are only eligible if they could be legally obtained in the United States.
- Medications and services that are not legal and eligible per the FDA/Federal Law, regardless of their status under State Laws.
- OTC products and medications are limited to purchases of a 90-day supply in any 90-day period.
- Personal use items such as clothes, soap, tissues, hygiene products, etc. In some cases, the excess cost of a special form may be eligible if prescribed (Rx) to treat a specific condition, such as the excess cost to purchase allergen-free bedding.
- Preferred Provider (PPO) discounts.
- Prepaid services, including pre-paid Orthodontic treatment, medical practice membership and retainer fees are not eligible.
- Sunglasses are not eligible unless the lenses are Rx/Corrective.
- Swim/Ski goggles are not eligible, even with prescription lenses.
- Toothpaste & toothbrushes are not eligible, even if prescribed.

"Physician," Prescription (Rx) & Letter of Medical Necessity (LMN) The term "Physician" refers to a licensed Medical Doctor (M.D./N.D./D.O.) as well as Physician Assistants and Nurse Practitioners who are licensed to write script for prescription medications in your State. "LMN": A letter of medical necessity is required from your Physician including the specific medical diagnosis and treatment plan. "Rx": A formal prescription "script" from your Physician is required for this product. All Rx must be updated annually if/as needed for consideration in future years. Stress relief is not a valid diagnosis for massage therapy. Vitamins, herbs and homeopathic remedies recommended by a health professional, such as a Chiropractor or Acupuncturist, to treat a medical condition as diagnosed by a Physician will require documentation of the Physician's diagnosis and the letter of medical necessity from the health professional.

This list is subject to change. This is a brief introduction and does not guarantee the payment of benefits. Some Employer Plans limit the expense types that are eligible for reimbursement as well as the eligibility of dependents. The use of categories, brand names or registered trade names does not indicate an endorsement, recommendation or limitation. For specific information about your Employer's plan, please refer to the Summary Plan Description (SPD). The SPD provides important information such as eligibility, benefits, eligible expenses, the claims procedures and claims filing deadlines.

Commuter Benefits

Perforce Software offers employees a Qualified Transportation Benefit Plan (Section 132 Plan). This program allows you the opportunity to payroll-deduct pre-tax dollars to pay for eligible transportation expenses. The use of pre-tax dollars reduces your taxable income based on the amount of money you defer. Eligible transportation expenses include parking expenses, transit pass expenses, and commuter highway vehicle (vanpool) expenses.

The qualified maximum amount you may contribute to the account cannot exceed $270 monthly for parking expenses and/or $270 monthly for Transit and Commuter Highway Vehicle Expenses for 2021 Qualified Transportation Plan. Refer to the Flex Today Commuter Benefit flyer for more information or visit www.flextoday.com.

COMMUTER CHOICE – Tax Savings for Commuters

When you participate in Commuter Choice, your contributions are taken off the top of your pay, before taxes are calculated. When you use your Commuter benefits, they are tax-free which reduces your taxes and increases your take-home pay. The savings could but up to 20%-40% of the cost of your commuting expense. See the example below:

Tax Savings Illustration	Paycheck Total Earnings	Pre-Tax Commuter	Taxable Earnings	Federal Taxes	Soc Sec/ Medicare	State/ Local	Net Paycheck	After-Tax Commuter	Take Home Pay	Monthly Tax Savings	Annual Tax Savings $600*
Before	$3,000	$0	$3,000	-$545	-$170	-$227	$2,058	-$120	$1,938		
After	$3,000	$-120	$2,880	-$515	-$163	-$214	$1,988	$0	$1,938	$50	

* Illustration demonstrates 42% (maximum) tax savings. Your actual savings will depend upon your income, location and personal/family tax situation.

Commuter Choice offers two benefit options:

Mass-Transit You can set aside up to $270 per month pre-tax to pay for transportation by train, light-rail or by a public or subscription bus or the costs of an eligible vanpool. An eligible vanpool transports 7 or more adults, including the driver, for the majority of the commute.

Parking You can set aside up to $270 per month pre-tax to pay for your parking expenses at or near your primary, long-term business location, or parking at or near a "park and ride" or similar location if you use mass-transit

Eligible Expenses Your personal work-related commuting expenses are eligible if they are incurred while you are an active participant in your Commuter benefits. An expense is incurred when you receive the services. Commuter expenses during vacations or holidays are not eligible. However, parking expenses during your short-term vacation are eligible if required to "hold your spot." Other examples of ineligible expenses include expenses paid for your spouse and dependents and the normal commuting expenses you pay to drive your personal vehicle to work, such as toll-fees and gasoline.

www.FlexToday.com • Ph 1-800-995-5373 • Email – Flex@FlexToday.com

MetroPass

Minneapolis commuters have access to the metro transit pass MetroPass. This allows unlimited transit use throughout the twin cities metro transit lines subsidized by Perforce. Sign up during enrollment or contact HR for more information.

Employee Assistance Program

Your Employee Assistance program is offered by The Standard. You, your dependents (including children to age 26) and all household members can contact master's-degreed clinicians 24/7 by phone, online live chat, email and text. There's even a mobile EAP app. Receive referrals to support groups, a network counselor, community resources or your health plan. If necessary, you'll be connected to emergency services. Counseling is available on issues such as relationships, job pressures, family conflicts, substance abuse, stress, depression, grief, and loss.

WorkLife Services

WorkLife Services are included with the Employee Assistance Program. Get help with referrals for important needs like education, adoption, travel, daily living and care for your pet, child or elderly loved one.

Online Resources

Visit workhealthlife.com/Standard3 to explore a wealth of information online, including videos, guides, articles, webinars, resources, self-assessments and calculators.

Contact EAP

888.293.6948
TDD: 800.327.1833
24 hours a day, seven days a week
workhealthlife.com/Standard3

Travel Assistance

Travel Assistance is available when you travel more than 100 miles from home or internationally for up to 180 days for business or pleasure. It offers aid before and during your trip, including:

- Passport, visa, weather and currency exchange information, health hazards advice and inoculation requirements
- Emergency ticket, credit card and passport replacement, funds transfer and missing baggage
- 24/7/365 phone access to registered nurses for
- health and medication information, symptom decision support, and help understanding treatment options
- Emergency evacuation to the nearest adequate medical facility and medically necessary repatriation to the employee's home, including repatriation of remains
- Connection to medical care providers, interpreter services, a local attorney, consular office or bail bond services
- Return travel companion if travel is disrupted due to emergency transportation services or return dependent children if left unattended due to prolonged hospitalization
- Logistical arrangements for ground transportation, housing and/or evacuation in the event of political unrest and social instability; for more complex situations, assists with making arrangements with providers of specialized security service

Contact Travel Assistance

800.527.0218

assistance@uhcglobal.com

www.standard.com/travel

HealthAdvocate

If you need assistance with healthcare-related issues and/or medical billing issues, you can contact Health Advocate at:

Phone: 866-695-8622

Email: Answers@HealthAdvocate.com

Website: www.HealthAdvocate.com/members

Phone App: iPhone & Android "Health Advocate Smart Health"

Your Health Advocate benefit is being offered by your employer, at no cost, for you and covers eligible employees, their spouses, dependent children, parents and parents-in-law.

We're here to help when you need it most.

Here's how.

Find the right doctors

We can also find the right hospitals, specialists and other leading providers, anywhere in the country.

Schedule appointments

Our experts can expedite appointments, arrange second opinions and transfer medical records.

Assist in the transfer of medical records

We'll also handle the details of transferring X-rays and lab results.

Work with insurance companies

Our team works on your behalf to obtain appropriate approvals for needed services.

Resolve benefits issues

We'll do the legwork to resolve insurance claims and billing issues, untangle medical bills and coordinate benefits.

Weigh your medical care options

Use your online MedChoice Support™ tool to help you make informed decisions.

Get your questions answered

We help you become informed about test results, treatments and medications.

Medical Bill Saver

Skilled negotiators can help lower your out-of-pocket costs on uncovered medical or dental bills over $400.

24/7 support

866.695.8622

Visit us online at:
HealthAdvocate.com/members

HealthAdvocate℠

Health Advocate is not affiliated with any insurance company or third-party provider and does not provide medical care or recommend treatment.

PrivacyArmor by Allstate

Get complete identity protection with PrivacyArmor Plus so you can focus on what matters most.

Your identity is made up of more than your Social Security number and your bank accounts. That's why PrivacyArmor Plus does more than monitor your credit reports and scores. We safeguard your personal information, the data you share, and the relationships you treasure. And now PrivacyArmor Plus is better than ever. We've teamed up with Allstate to provide the next generation of protection. Our new proprietary tools stay one step ahead — allowing us to catch fraud as it happens. In the event of wrongdoing, you have a dedicated Privacy Advocate® available 24/7 to fully manage your recovery and restore your identity.

- ✓ Identity monitoring and alerts
- ✓ Full-service remediation
- ✓ Identity theft reimbursement
- ✓ iOS and Android app

How it Works

1. **Enroll in PrivacyArmor Plus:** You're protected from your effective date. Our auto-on credit monitoring alerts, and support require no additional setup.
2. **We'll do the heavy lifting:** In the event of identity theft or fraud, Privacy Advocates are available 24/7. They won't stop until you're in the clear.
3. **Get to know us:** Explore additional features in our easy-to-use portal. The more we monitor, the safer you can be.
4. **We've got your back:** Our $1 million identity theft insurance policy covers out-of-pocket costs associated with identity restoration.
5. **We're on the job:** Our human operatives see more – like when your personal information is sold on the dark web. If you've been compromised, we alert you.

Contact

MyPrivacyArmor.com
1.800.789.2720

Plans and Pricing

Privacy Armor Plus
$9.95 per person/month
$17.95 per family/month

Perforce Software, Inc. 401(k) Plan

FinDec, is our Third Party Administrator, Investment Advisor, Recordkeeper. Charles Schwab is the Platform and Bank

You can contribute to the traditional (pre-tax) and roth deferrals. Upon hire, you have immediate eligibility.

The plan has several of investment opportunities including:
-Individual Funds
-Target Retirement Date funds ranging from 2020 -2060
-Target Risk Portfolios
-Self-Directed Personal Choice Retirement Account

Deferrals are made within ADP. Register with FinDec at FinDec.com to manage your account and find more information about their services and investment choices.

Contact FinDec directly at:

- Email: support@findec.com
- Call (855) 434-6332
- 8 a.m. to 5 p.m. PDT
- Visit the website at www.findec.com

charles SCHWAB

Carrier and Policy Information

Medical

Blue Cross Blue Shield of MN
Company ID# 271195
High Deductible Group #10545125
PPO Plan Group # 10545123
(866) 873-5943
www.bluecrossmn.com

Dental

Delta Dental of MN
Policy # 100425
(800) 448-3815
www.deltadentalmn.org

Vision

Vision Service Plan (VSP)
Policy# 30044768
(800) 877-7195
www.vsp.com

Life and AD&D

The Standard
Life/ADD Policy #165004
Voluntary Life Policy #165004
(800) 628-8600
www.standard.com

Disability

The Standard
STD Policy #165004
LTD Policy #165004
(800) 368-1135 (LTD)
(800) 368-2859 (STD)
www.standard.com

Accident, Critical Illness, and Hospital Indemnity

The Standard
Accident Policy #165004
Critical Illness Policy #165004
Hospital Indemnity Policy #165004
(866) 851-2429
www.standard.com

FSA, HSA, and Commuter

FlexToday
(888) 209-7840
www.flextoday.com

Employee Assistance Plan (EAP)

WorkLife Services
(888) 293-6948
www.workhealthlife.com/Standard3

Travel Assistance

(800) 527-0218 (US & Canada)
(410) 453-6330 (call collect)
Assistance@uhcglobal.com
www.standard.com/travel

HealthAdvocate

HealthAdvocate
(866) 695-8622
answers@healthadvocate.com
www.healthadvocate.com/members

Perforce Software HR Contact

Colleen Hurst
Senior Benefits Specialist
(612) 517-2044
churst@perforce.com
contact-hr@perforce.com

PERFORCE

Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

NEWBORNS ACT DISCLOSURE - FEDERAL

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.
No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $156 per day (up to a $1,566 cap per request), until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

CONTACT INFORMATION

CONTACT INFORMATION

Questions regarding any of this information can be directed to:

Colleen Hurst
Minnesota United States 55401
612-517-2044
churst@perforce.com

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

Your Information. Your Rights. Our Responsibilities.

Recipients of the notice are encouraged to read the entire notice. Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- In these cases we never share your information unless you give us written permission:

Marketing purposes

Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

If you are receiving this electronically, you are responsible for providing a copy of this notice to any Medicare Part D-eligible dependents who are covered under the group health plan.

Important Notice from Blue Cross Blue Shield About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Blue Cross Blue Shield and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **Blue Cross Blue Shield has determined that the prescription drug coverage offered by Perforce is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15thto December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

OMB 0938-0990

MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE LANGUAGE
FOR USE ON OR AFTER APRIL 1, 2011

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Blue Cross Blue Shield coverage may be affected. If you joined a Medicare drug plan after a COBRA qualified event, your COBRA coverage may end.

If you do decide to join a Medicare drug plan and drop your current Blue Cross Blue Shield coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with [Insert Name of Entity] and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Blue Cross Blue Shield changes. You also may request a copy of this notice at any time.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE LANGUAGE
FOR USE ON OR AFTER APRIL 1, 2011

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Medicare Eligible Individual's Name:
Individual's DOB or unique Member ID:

The individual stated above has been covered under **creditable** prescription drug coverage for the following date ranges that occurred after May 15, 2006:

From: **To:**
From: **To:**

Date:
Name of Entity/Sender:
Contact--Position/Office:
Address:
Phone Number:

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**

Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131

CALIFORNIA – Medicaid	INDIANA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**MONTANA – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710

MASSACHUSETTS – Medicaid and CHIP	NEW YORK – Medicaid
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor	U.S. Department of Health and Human Services
Employee Benefits Security Administration	Centers for Medicare & Medicaid Services
www.dol.gov/agencies/ebsa	**www.cms.hhs.gov**
1-866-444-EBSA (3272)	1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMBNo.1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one–stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost–sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.1

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer–offered coverage. Also, this employer contribution –as well as your employee contribution to employer–offered coverage– is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after–tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

1 An employer – sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)	
5. Employer address	6. Employer phone number	
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above)	12. Email address	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☐ Some employees. Eligible employees are:
- With respect to dependents:
  - ☐ We do offer coverage. Eligible dependents are:
  - ☐ We do not offer coverage.

☐ If checked, this coverage meets the minimum value standard*, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid–year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

* An employer – sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36 B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Model General Notice of COBRA Continuation Coverage Rights
(For use by single-employer group health plans)

** Continuation Coverage Rights Under COBRA**

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage may pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

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

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

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Perforce, Inc., and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health 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 **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.