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BP Medical Program

BP's Medical Program offers employees a variety of options to meet their health care and maintenance needs

Copays waived for COVID-19 testing and telemedicine services

BP is committed to providing you with timely access to medical care. Effective immediately:

- All out-of-pocket costs relating to testing to COVID-19 are waived.
- All telemedicine copays are waived through at least December 31, 2020. This applies to telemedicine services offered through healthcare providers, Teladoc (Aetna) and MDLive (BCBS-IL).

These waivers apply to employees enrolled in the Standard, HealthPlus and Health+Savings options of the BP Medical Plan. HMO eligibility may vary.

BP provides employees and their families the opportunity to purchase quality health care at affordable rates. The BP Medical Program offers a variety of health care options from which to choose, including options under the BP Medical Plan and Health Maintenance Organizations (HMOs).

The BP Medical Program also includes the Employee Assistance Program (EAP). You do not have to enroll in a BP medical option to be eligible for EAP services. You and any member of your household are automatically covered in the EAP. The EAP, also known as “BP Care, Your Employee Assistance and Work Life Program,” is designed to help you manage issues that may have a negative effect on your work or personal life and is provided at no cost. For immediate EAP assistance, call 1-800-409-3687. This service is available 24 hours per day, seven days a week.

Throughout this summary there are references to the BP Medical Program and the BP Medical Plan.

- The Medical Program refers to all BP medical options, including the HMO options but excluding the BP Corporation North America Inc. Retiree Medical Plan (“the BP Retiree Medical Plan”).
- The Medical Plan (“the plan”) refers to all BP medical options except the HMO options and the BP Retiree Medical Plan.

Throughout this summary, “you” generally refers to:

- You (the eligible employee) when describing elections (e.g., how to enroll, how to change coverage).
- You or any eligible dependent when describing the provisions of the plan (e.g., eligible and ineligible expenses).

Because this document is intended as a summary of a BP benefits plan, it is not intended to describe each plan provision in full detail. More complete details are contained in the governing plan documents (including applicable insurance policies). While we intend to update this summary on a regular basis, it is possible that at any point this summary may be neither current nor complete. Further, differences between this summary and the applicable plan document are not intended. If, however, any differences are found to exist, the relevant provisions of the applicable plan document — and not the summary — will govern. Note: The BP Retiree Medical Plan is an entirely separate plan of benefits with a different summary plan description.

BP reserves the right to amend or terminate a plan at any time without advance notice.

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Eligibility and participation

Learn about the eligibility rules governing the Medical Program

Who is eligible

You are eligible to participate in the Medical Program if you are classified as a full-time, part-time or temporary employee of a participating employer. Occasional employees are only eligible to access the Employee Assistance Program (EAP).*

An eligible U.S. employee on international assignment outside of the U.S. is eligible for the Expatriate Medical Plan administered by Cigna, which includes the HealthPlus PPO Option of the BP Medical Program. In this case, you do not make a separate election to enroll in the HealthPlus Option. If you have questions, contact Cigna or the BP Benefits Center for more information.

Full-time employee: An employee assigned a position that:

- Requires full-time service as determined by BP;
- Is established to fill regular and ordinary employment requirements; and
- Is expected to continue for an indefinite period of time.

Part-time employee: An employee assigned a position that is:

- Regular and ordinary in nature;
- Expected to continue for an indefinite period of time; and
- One in which the employee works a schedule that is less than that of a full-time employee but is at least 20 hours a week.

Temporary employee: An employee assigned to a position that:

- Requires full-time or part-time (not occasional) service as determined by BP;
- Requires a regular schedule of hours; and
- Will continue for a specified period of time or until the occurrence of a specified event, such as the return to work of a regular employee or the completion of a special assignment or project.

Interns and co-ops are considered occasional employees.

* Occasional employee: For purposes of the plan, an "occasional employee" means an employee who is employed by BP for work that is irregular or infrequent in nature and which ordinarily should last no longer than four to six months, or an employee who works a regular schedule that is less than 20 hours per week and which is expected to continue for an indefinite period of time.
Eligible dependents

If you participate in the BP Medical Program, you may also enroll your eligible dependents under your medical coverage. Eligible dependents include your:

- Spouse, including a legally separated spouse.
- Common-law spouse (if you and your common-law spouse reside in a state that recognizes your common-law marriage as a legal marriage).
- Opposite-sex or same-sex domestic partner.
- Eligible dependent child.

Except for COBRA continuation and a surviving disabled dependent (as described below), you must participate in the Medical Program for your dependents to also be eligible.

An "eligible dependent child" is a child up to age 26* if he/she is:

- Your natural or adopted child (including a child placed with you for adoption);
- A child for whom you have legal guardianship;
- A child of your spouse/domestic partner; or
- A grandchild who lives with you in a regular parent/child relationship for at least half the year and receives at least 50% of his/her financial support from you. This includes only a grandchild related to you by blood, marriage or domestic partnership whose parents do not live with the child and for whose daily care and guidance you are legally responsible.

* An eligible covered child who is totally and permanently disabled at the time he/she turns age 26 can continue to be covered as long as approved by the claims administrator.

Disabled Dependent Children

Health coverage for your fully disabled dependent child may be continued past the maximum age for a dependent child.

Your child is considered fully disabled if:

- He or she is not able to earn his or her own living because of mental retardation or a physical disability which started prior to the date he or she reaches the maximum age for dependent children under your plan; and
- He or she depends chiefly on you for support and maintenance.

Proof that your child is fully disabled must be submitted to the claims administrator no later than 31 days after the date your child reaches the maximum age under your plan.

Coverage will cease on the first to occur of:

- Cessation of the disability.
- Failure to give proof that the disability continues.
- Failure to have any required exam.
- Termination of dependent coverage as to your child for any reason other than reaching the maximum age under your plan.

The claims administrator will have the right to require proof of the continuation of the disability. The claims administrator also has the right to examine your child as often as needed while the disability continues, at its own expense. An exam will not be required more often than once each year after two years from the date your child reached the maximum age under your plan.

Your dependent does not qualify as an eligible dependent if he/she is:

- On active duty in the military.
- Covered as a BP employee or retiree in a BP-sponsored medical plan.
- Covered as a dependent of another BP employee or retiree in a BP-sponsored medical plan.
Special rules apply if your spouse/domestic partner is also an eligible BP employee. You may do either of the following:

- Each of you may enroll for "You only" coverage if no other dependents are covered.
- One of you may enroll in a coverage level that includes dependents, with the other covered as one of your dependents. "You only" coverage is not available for the spouse/domestic partner covered as a dependent.

In order for a same-sex spouse to be covered as a spouse under the plan, the marriage must have been conducted in a state that recognizes the legality of your same-sex marriage, and you will have to submit a copy of the marriage license from that state. Note that civil union ceremonies are specifically not permitted to be treated as marriages under federal law. If you participated in a civil union only, your partner must be treated as your domestic partner by the plan, and premiums for him/her must be made on an after-tax basis.

For the EAP, your eligible dependents include any member of your household, regardless of relationship or whether he/she qualifies as an eligible dependent under the BP Medical Program. In addition, a child who does not reside with you is an eligible dependent for the EAP if he/she is enrolled in your BP Medical Program coverage.

**Domestic partners**

There are two alternative methods for qualifying your same-sex or opposite-sex domestic partner as an "eligible dependent":

- Alternative "A": Register your domestic partnership or civil union in accordance with registration requirements in the state in which you and your domestic partner or civil union partner reside. Your registration date is the first date you can enroll your partner as a domestic partner under the BP Medical Program; or
- Alternative "B": Satisfy each of the following requirements for at least six full months before signing a Domestic Partner Affidavit. The date you are first eligible to sign the affidavit is the date your partner will be considered your domestic partner for plan purposes.
  - Be each other's sole domestic partner and intend to remain so indefinitely;
  - Reside together in the same principal residence and intend to remain so indefinitely;
  - Be emotionally committed to one another, share joint responsibilities for the partnership's common welfare and be financially interdependent;
  - Be at least 18 years old, of legal age and mentally competent to enter into contracts;
  - Not be related by blood closer than would bar marriage under applicable law where you live; and
  - Not be legally married to, nor the domestic partner of, anyone else.

**Note:** Some HMOs may impose more restrictive criteria. Contact the HMO directly for more information. Also, under the Medical Plan, and pursuant to federal law, a civil union must be treated by the plan the same as a domestic partnership.

Your domestic partner will cease being an eligible dependent as of the date you cease to satisfy any of the above conditions. If your domestic partnership ends, call the BP Benefits Center immediately.

Publication date: April 2020
Who is not eligible

Regardless of your employee classification, you are not eligible to participate in the BP Medical Program if you are:

- An employee residing in Hawaii (who must be a participant in Kaiser Hawaii).
- An occasional employee.
- A member of a collective bargaining unit (union), unless your collective bargaining agreement provides that you are eligible to participate.
- Not classified as an employee on a participating employer's payroll, even if reclassified as a common-law employee by any third party.
- An employee on an unpaid leave of absence not approved by BP.

Note that if an employee is not eligible, the employee's family members are also not eligible.

Occasional employee: For purposes of the plan, an "occasional employee" means an employee who is employed by BP for work that is irregular or infrequent in nature and which ordinarily should last no longer than four to six months, or an employee who works a regular schedule that is less than 20 hours per week and which is expected to continue for an indefinite period of time.

Note: If you are an employee of BP Products North America Inc. employed in GBS Americas, or an eligible dependent of such person, you are eligible for the BP Medical Program; however, your benefits are described in a separate Summary Plan Description.

An employee's classification in BP's payroll records controls eligibility regardless of whether the individual is later reclassified. An employee's classification is determined at the time of hire. If later changed, the new classification will only apply prospectively, regardless of the actual hours worked under the initial classification.

Publication date: April 2020
Learn more about how to enroll in the BP Medical Program

To enroll in a BP Medical Program option, contact the BP Benefits Center. There are two ways to access the BP Benefits Center:

<table>
<thead>
<tr>
<th><strong>Online</strong></th>
<th><strong>By phone</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The BP Benefits Center online:</td>
<td>Through the BP Benefits Center:</td>
</tr>
<tr>
<td>I <a href="http://www.bp.com/lifebenefits">http://www.bp.com/lifebenefits</a></td>
<td>I Within the U.S.: 1-800-890-4100</td>
</tr>
<tr>
<td>You can:</td>
<td>I Outside the U.S.: +1-312-843-5290</td>
</tr>
<tr>
<td>I Enroll in BP health and protection benefits.</td>
<td>You can speak to a Participant Services Representative (available Monday – Friday, 7:00 A.M. – 7:00 P.M., Central time) to:</td>
</tr>
<tr>
<td>I Change or reset your BP Benefits Center password.</td>
<td>I Get answers to your questions about BP's benefits.</td>
</tr>
<tr>
<td>I View your coverage details.</td>
<td>I Change all dependent information, including Social Security number or Medicare-eligibility status.</td>
</tr>
<tr>
<td>I Find out which network providers are located near your home or work.</td>
<td>I Make changes to your current coverage based on qualifying status changes or relocation.</td>
</tr>
<tr>
<td>I Review and/or request a change in your current coverage.</td>
<td></td>
</tr>
<tr>
<td>I Change most dependent information, including name, birth date and relationship.</td>
<td></td>
</tr>
</tbody>
</table>

When you enroll, you can elect coverage for yourself and your eligible dependents. Your coverage choices are:

I You only.
I You + spouse/domestic partner.
I You + child(ren).
I You + family.

If you elect anything other than "You only" coverage, only those eligible dependents you enroll are covered. Be sure to review your dependents carefully to be sure all the eligible dependents you want to cover are included and that each of the dependents you enroll meets the requirements for dependent eligibility. If you have questions about the eligibility of your dependent(s), contact the BP Benefits Center.

You can enroll:

I **When you first become eligible.** If you do not enroll within 30 days of your initial eligibility (generally your date of hire or the date you change or transfer into an eligible position), you will be automatically enrolled into the following default coverage: "You only" coverage in the Health+Savings Option with the Health Savings Account (HSA). You will not be able to change this coverage until you enroll during a future enrollment opportunity (i.e., annual enrollment or a qualifying status change). If you do enroll within 30 days into any available option, you must submit appropriate documentation if you are electing coverage for a dependent.

I **During annual enrollment.** The choices you make during each annual enrollment period — generally held each February — are effective for the next plan year (i.e., April 1 to March 31). You must submit appropriate documentation if you are adding coverage for a dependent.

I **If you have a qualifying status change.** If you experience a qualifying event, such as marriage or the birth of a child, you may make changes to your benefits that are consistent with the event. You are not allowed to change your reimbursement option (Debit Card vs. Streamline) under the Health Care Flexible Spending Account. **Note:** You cannot use the HCFSA Debit Card outside the U.S. You must make changes within 30 days of the qualifying status change. If you do not enroll within 30 days of a qualifying event, you may not enroll again until the next annual enrollment. For more information on qualifying status changes, review the "Life Events" tab on the LifeBenefits website or contact the BP Benefits Center. You must submit appropriate documentation if you are adding coverage for a dependent.*

If you are enrolling during a 30-day enrollment window, once you have confirmed your elections, you may not change your elections during the remainder of the plan year unless you have a subsequent qualifying status change. This restriction applies even if you are still within the 30-
day election period.

For the rules related to enrolling in the HealthPlus and Health+Savings Options, refer to the BP Wellness Program detailed elsewhere in the SPD.

All coverage under the Medical Program is based on the truthfulness of statements made by you and your dependents. Coverage may be terminated, including retroactively, if such statements are found to be false, and intentional falsehoods will be considered a violation of the BP Code of Conduct, subjecting you to disciplinary actions, up to and including termination of employment.

* Special rules on switching between the Health Care Flexible Spending Account and the Health Savings Account can limit your ability to enroll in certain medical options in the middle of a plan year. Click here for the rules.

Publication date: April 2020
When coverage begins

Find out when your coverage is effective

The date your medical coverage begins depends on when you enroll.

<table>
<thead>
<tr>
<th>If you enroll ...</th>
<th>Your coverage begins ...</th>
</tr>
</thead>
<tbody>
<tr>
<td>When you first become eligible (and within your 30-day enrollment window).</td>
<td>On your eligibility date (usually your date of hire or the date you transfer into an eligible position), but only if you are actively at work on that day. Otherwise, coverage will begin on the first day you are actively at work.</td>
</tr>
<tr>
<td>During annual enrollment.</td>
<td>The first day of the new plan year (April 1 following the end of annual enrollment).</td>
</tr>
<tr>
<td>When you have a qualifying status change and make the change within 30 days of the qualifying event.</td>
<td>On the date of the qualifying status change.</td>
</tr>
</tbody>
</table>

Publication date: April 2020
Paying for coverage

By enrolling, you authorize BP to take payroll deductions on a before-tax basis to cover the cost of coverage. Deductions will begin as soon as administratively possible. Deductions are taken retroactively to the effective date of your coverage as long as you timely enroll. If your pay is not sufficient to take deductions for contributions (for example, if you are on an unpaid leave of absence) you will be billed directly by the BP Benefits Center, which you must pay within 30 days of receipt for coverage to take effect.

“Before-tax deductions” means that your taxable pay is lower — and so is the amount you pay for Social Security tax, Medicare tax, federal income tax and, in most areas, state and local income tax. BP benefits that are based on the amount of your pay (such as life insurance, and savings plan and retirement plan benefits) are not affected when you make before-tax contributions.

If you enroll an eligible spouse, domestic partner or dependent who is not considered your spouse or dependent for federal tax purposes (on your IRS Form 1040), you will experience two consequences required by tax law.

1. Your contributions will be taken on an after-tax basis rather than a before-tax basis.
2. You will have imputed income reported by BP to the applicable tax authorities. The value reported is based on the value of coverage that is not paid by you.

Publication date: April 2020
When you can change coverage

Normally the choices you make during enrollment stay in effect for the entire plan year (April 1 – March 31). However, if you experience a qualifying status change during the plan year, that event may allow — or require — you to change your existing coverage elections.

You can make changes to your benefits within 30 days of the qualifying status event. (Note: You have 60 days to notify the BP Benefits Center of a divorce or loss of dependent status for purposes of your former eligible dependent electing COBRA coverage.) Any changes you make must be consistent with your qualifying status change. If you do not make your change within 30 days of the event, you must wait until the next annual enrollment period to make any changes.

To make your changes, log on to the BP Benefits Center online or call the BP Benefits Center and speak with a representative. Note: If you are enrolling a dependent, you will need to provide proof of his/her eligibility for coverage.

Qualifying status changes that require action

There are some qualifying status changes that require you to make changes to your coverage. The chart below provides a summary of the rules/requirements associated with these qualifying status changes:

<table>
<thead>
<tr>
<th>You must disenroll a dependent within 30 days if you ...</th>
<th>Restrictions/notes ...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need to <strong>remove</strong> an individual who is no longer an eligible dependent due to:</td>
<td>You may not switch medical or dental options.</td>
</tr>
<tr>
<td>- Legal divorce or annulment.</td>
<td></td>
</tr>
<tr>
<td>- End of a domestic partnership.</td>
<td></td>
</tr>
<tr>
<td>- Death of spouse/domestic partner/child.</td>
<td></td>
</tr>
<tr>
<td>- Child no longer meeting the eligibility requirements.</td>
<td></td>
</tr>
</tbody>
</table>

Although leaving BP will end your eligibility for coverage, you do not need to take action to notify the BP Benefits Center. You will, however, need to elect COBRA timely if you wish to continue your coverage(s).

If your covered dependent loses eligibility and you do not notify the BP Benefits Center of the event within 30 days:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>- You will not be refunded any contributions for dependent coverage. Once you notify the BP Benefits Center of the loss of eligibility, your contribution will change as of the date of notification.</td>
<td></td>
</tr>
<tr>
<td>- You are liable for claims incurred.</td>
<td></td>
</tr>
<tr>
<td>- The plan administrator may impose sanctions against you — including potential loss of your coverage.</td>
<td></td>
</tr>
<tr>
<td>- No COBRA coverage will be offered to your former eligible dependent (solely for COBRA purposes, notice will be considered to be timely if the BP Benefits Center is notified up to 60 days following the event date).</td>
<td></td>
</tr>
<tr>
<td>- BP may take remedial action against you with respect to your employment.</td>
<td></td>
</tr>
</tbody>
</table>
Qualifying status changes that allow, but do not require, you to enroll yourself and your eligible dependents

The chart below provides a summary of the rules/requirements associated with qualifying status changes that allow, but do not require, you to make changes to your coverage:

<table>
<thead>
<tr>
<th>If you want to make an enrollment change, you must contact the BP Benefits Center within 30 days if ...</th>
<th>Restrictions/notes ...</th>
</tr>
</thead>
<tbody>
<tr>
<td>You are rehired in the same plan year.</td>
<td>If you are rehired within the same plan year, your previous BP Medical Program coverage will be reinstated to the options in which you were enrolled before you left.</td>
</tr>
</tbody>
</table>

- You want to **enroll** yourself in coverage, or **add** an eligible dependent to your coverage if you are already enrolled because:
  - You are newly eligible.
  - Marriage.
  - Your establishment of your domestic partnership.
  - Birth/adoption/legal guardianship of your child.
- You or an eligible dependent experiences a non-voluntary loss of eligibility under another (non-BP) plan (including moving outside an HMO’s service area).

| You return from a leave of absence where you did not maintain coverage while on leave. | If you were on medical leave/family medical leave/military leave and return during the same plan year, you will be re-enrolled in the same benefits in which you participated before the leave unless you experienced a qualifying status change between the date you went on leave and the date you return. If you choose to change your elections when you return, you need to enroll within 30 days of returning to work. |

<table>
<thead>
<tr>
<th>Your spouse/domestic partner’s employer’s plan does not have an April 1 plan year start date.</th>
<th>If you already have coverage but are adding an eligible dependent, you may not switch BP Medical Program options.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your child becomes eligible again under the BP plan (for example, the child is newly eligible under federal health care reform rules).</td>
<td>If you already have coverage but are adding an eligible dependent, you may switch BP Medical Program options.</td>
</tr>
<tr>
<td>You are in a BP HMO or PPO and you move outside the HMO or PPO service area.</td>
<td>You may elect another BP Medical Program option. If this occurs, you are eligible to participate in the BP HealthPlus and Health+Savings Options for the remainder of the plan year without earning wellness points. However, during the next annual enrollment period, you and your covered spouse/domestic partner must each earn wellness points to remain eligible for the HealthPlus and Health+Savings Options in subsequent years.</td>
</tr>
</tbody>
</table>

If you want to disenroll yourself and/or a covered dependent as the result of one of the events below, you must contact the BP Benefits Center within 30 days of the event ...

| Restrictions/notes ... |
|------------------------------------------------|------------------------|
| Marriage, if you/your dependents will be covered under your new spouse’s employer’s plan. | |
| Establishment of a domestic partnership, if you/your dependents will be covered under your new domestic partner’s employer’s plan. | |
| Birth/adoption/legal guardianship, if you and/or your dependents will be covered under your spouse’s/domestic partner’s employer’s plan. | |
| Employment-related change of spouse/domestic partner or your child’s other parent allowing you or your dependent to become covered under the non-BP plan. | |
Special rules on switching between the Health Care Flexible Spending Account and the Health Savings Account

If you have a mid-year qualifying status change that would otherwise allow you to change your BP medical option and:

- You are not enrolled in the Health+Savings medical option (i.e., you are enrolled in the HealthPlus or Standard medical option, an HMO, or you are not enrolled in a BP medical option), and:
  - You are not participating in a Health Care Flexible Spending Account (HCFSA), you may enroll in the Health+Savings option if you wish, with or without making contributions to a Health Savings Account (HSA).
  - You are participating in an HCFSA, you may not enroll in the Health+Savings option. You may enroll in another BP medical option if available, or drop your BP medical coverage, if such a drop in coverage is consistent with the qualifying status change.
- You are enrolled in the Health+Savings medical option, you may enroll in another BP medical option if available (i.e., HealthPlus or Standard), or drop your BP medical coverage, but you may not participate in the HCFSA for the remainder of the plan year. This applies even if you had not contributed to an HSA while you were enrolled in the Health+Savings medical option and have a zero HSA balance.

When coverage begins/ends after a qualifying status change

Changes in coverage due to a qualifying status change take effect as follows:

<table>
<thead>
<tr>
<th>If you ...</th>
<th>The change in coverage takes effect on ...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enroll.</td>
<td>The date the qualifying status change occurs.</td>
</tr>
<tr>
<td>Add a new dependent:</td>
<td></td>
</tr>
<tr>
<td>- Within 30 days of acquiring the dependent.</td>
<td>- The date the qualifying status change occurs.</td>
</tr>
<tr>
<td>- After 30 days of acquiring the dependent, provided you have You + spouse/domestic partner, You + child(ren), or You + family coverage.</td>
<td>- The date you contact the BP Benefits Center to enroll the dependent.</td>
</tr>
<tr>
<td>Drop coverage for an individual who is no longer an eligible dependent.</td>
<td>The last day of the month in which the qualifying status change occurs.</td>
</tr>
<tr>
<td>Drop coverage for you or an otherwise eligible dependent within 30 days of the qualifying status change.</td>
<td>The last day of the month in which the qualifying status change occurs.</td>
</tr>
</tbody>
</table>

Publication date: April 2020
When coverage ends

Your coverage under the Medical Program ends on the earliest of the following dates:

- The last day of the month in which your employment ends for any reason.
- The last day of the month in which you are no longer an eligible employee.
- The last day of the month in which you drop coverage due to a qualifying status change.
- The last day of the month for which your last contribution was made within the required time period.
- The last day of the month in which you die.
- The date BP terminates the Medical Program.
- The date you begin an unpaid leave of absence not approved by BP.

Coverage for your covered dependents ends on the earlier of the following dates:

- The last day of the month in which your coverage ends.*
- The last day of the month in which you drop the dependent’s coverage due to a qualifying status change.
- The last day of the month in which your covered dependent is no longer eligible for coverage under the Medical Program, whether or not you report your dependent’s change in eligibility status.
- The date you begin an unpaid leave of absence not approved by BP.

* An eligible covered child who is totally and permanently disabled at the time he/she turns 26 can continue to be covered after the death of the parents, provided the applicable contribution continues to be paid.

After BP Medical Program coverage would otherwise end, you and your covered dependents may be eligible to continue medical coverage under the:

- Medical Program through COBRA (see Leaving BP); or
- BP Retiree Medical Plan (see the separate retiree medical information available on LifeBenefits for details).

For the EAP, if you initiated your first EAP counseling session and then leave BP or are no longer eligible, you may complete all three sessions related to the initial issue you consulted the EAP about if the sessions are completed within the same calendar year. You may also be eligible to continue coverage under COBRA.

Publication date: April 2020
How the BP Medical Program works

The medical options available to you are based on your address of record. Depending on where you live, you can select one of the following:

1. One of the following Aetna-administered medical options:
   - A PPO Option, if your address of record is within an Aetna Choice POS II network area (see the PPO Options (HealthPlus and Standard) summary chart), or
   - An Out-of-Area (OOA) Option, if your address of record is outside an Aetna Choice POS II network area (see the Out-of-Area (OOA) Options (HealthPlus and Standard) summary chart), or
   - The Health+Savings PPO Option, if you're interested in a high-deductible health plan with a Health Savings Account (HSA) and your address of record is within an Aetna Choice POS II network area (see the Health+Savings PPO Option summary chart), or
   - The Health+Savings Out-of-Area (OOA) Option, if you're interested in a high-deductible health plan with a Health Savings Account (HSA) and your address of record is outside an Aetna Choice POS II network area (see the Health+Savings Out-of-Area (OOA) Option summary chart).

2. A Health Maintenance Organization (HMO), if available in your area. (See How HMOs work).

A summary of options available to you is on BP Benefits Center online.

**Note:** If you are a U.S. rotator, medical coverage for you and your family within the U.S. will be provided under one of the above options that you elect. Provided you do not elect a Health+Savings option, additional medical coverage (for yourself only) outside the U.S. will be provided under the Expatriate Medical Plan administered by Cigna International. Refer to the current Rotator Supplement and the Expatriate Medical Plan Summary Plan Description for more information.

**Note:** Behavioral health services are now covered the same as other medical services.
PPO Options (HealthPlus and Standard) summary chart

The PPO Options are available only if you live in an area where the Aetna Choice POS II network is available. In addition to the options described below, you may want to consider the Health+Savings PPO Option.

If you participate in an Out-of-Area Option, see the Out-of-Area (OOA) Options (HealthPlus and Standard) summary chart or the Health+Savings Out-of-Area (OOA) Option summary chart.

<table>
<thead>
<tr>
<th>HealthPlus PPO Option 2020/2021 Plan Year</th>
<th>Standard PPO Option 2020/2021 Plan Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network</td>
<td>Out-of-Network&lt;sup&gt;a,b&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>Network</td>
</tr>
<tr>
<td></td>
<td>Out-of-Network&lt;sup&gt;a,b&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

### General information

- **Plan year deductible<sup>c,d</sup>**
  - HealthPlus: $300/person; $900/family maximum
  - Standard: $600/person; $1,800/family maximum
  - HealthPlus: $900/person; $2,700/family maximum
  - Standard: $1,800/person; $5,400/family maximum

- **Plan year out-of-pocket maximum<sup>c,d</sup>**
  - HealthPlus: $3,000/person; $6,000/family maximum
  - Standard: $5,000/person; $12,000/family maximum
  - HealthPlus: $8,000/person; $16,000/family maximum
  - Standard: $12,000/person; $24,000/family maximum

- **Lifetime maximum benefit**
  - HealthPlus: None
  - Standard: None
  - HealthPlus: None
  - Standard: None

### Prescription drug (administered by Express Scripts)

- Prescription drug plan year deductible (separate from and in addition to your medical plan deductible)
  - HealthPlus: No separate deductible
  - Standard: $75/person; $225/family

- FDA-approved women’s contraception and generic and OTC bowel prep medications for colonoscopy
  - HealthPlus: 100%; no deductible or copay
  - Standard: 100%; no deductible or copay

*Note: Prescriptions purchased at an out-of-network pharmacy are covered only if a network pharmacy is not available.*

#### Retail Pharmacy Network (up to a 30-day supply)

- **Generic**
  - HealthPlus: 100% after $5 copay
  - Standard: 100% after $5 copay

- **Brand name (preferred)**
  - HealthPlus: 100% after $25 copay
  - Standard: 80% covered — you pay 20% ($25 minimum; $50 maximum)

- **Brand name (non-preferred)**
  - HealthPlus: 100% after $45 copay
  - Standard: 60% covered — you pay 40% ($45 minimum; $100 maximum)

- **Brand name (when generic is available)**
  - HealthPlus: Brand name copay plus the difference in cost between the brand name and the equivalent generic
  - Standard: Brand name coinsurance plus the difference in cost between the brand name and the equivalent generic

#### Home Delivery Program (up to a 90-day supply)

- **Generic**
  - HealthPlus: 100% after $12 copay
  - Standard: 100% after $12 copay

- **Brand name (preferred)**
  - HealthPlus: 100% after $65 copay
  - Standard: 80% covered — you pay 20% ($65 minimum; $130 maximum)

- **Brand name (non-preferred)**
  - HealthPlus: 100% after $125 copay
  - Standard: 60% covered — you pay 40% ($125 minimum; $250 maximum)

- **Brand name (when generic is available)**
  - HealthPlus: Brand name copay plus the difference in cost between the brand name and the equivalent generic
  - Standard: Brand name coinsurance plus the difference in cost between the brand name and the equivalent generic

For the following covered treatments and services, the PPO Options pay...
<table>
<thead>
<tr>
<th>Doctor visits (other than preventive care)(^e)</th>
<th>100% after $20 copay, no deductible(^f)</th>
<th>60%</th>
<th>80%</th>
<th>60%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care office visit</td>
<td>Note: surgery is covered at 80% after deductible</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist office visit</td>
<td>Note: surgery is covered at 80% after deductible</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral health office visit</td>
<td>100% after $20 copay, no deductible(^f)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity services</td>
<td>100%, no deductible/copay (prenatal); 80% after deductible (post-natal)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lab and X-ray</td>
<td>80%(^f)</td>
<td>60%(^f)</td>
<td>80%(^f)</td>
<td>60%(^f)</td>
</tr>
<tr>
<td>Preventive care(^e,h)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine physicals</td>
<td>100%, no copay, no deductible</td>
<td>60%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual well-woman exams</td>
<td>100%, no copay, no deductible</td>
<td>60%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mammograms (routine)</td>
<td>100%, no copay, no deductible</td>
<td>60%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gestational diabetes screening</td>
<td>100%, no copay, no deductible</td>
<td>60%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prostate Specific Antigen (PSA) tests (routine)</td>
<td>100%, no copay, no deductible</td>
<td>60%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colorectal screenings (routine)</td>
<td>100%, no copay, no deductible</td>
<td>60%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well-child care (routine)</td>
<td>100%, no copay, no deductible</td>
<td>60%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency services(^e)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency room (applies to facility charges only)(^f)</td>
<td>80% after $150 copay, no deductible</td>
<td>80% after $150 copay, no deductible</td>
<td>80% after $150 copay, no deductible</td>
<td>80% after $150 copay, no deductible</td>
</tr>
<tr>
<td>Ambulance</td>
<td>80%</td>
<td>80%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent care facility (applies to facility charges only)</td>
<td>100% after $30 copay, no deductible</td>
<td>60%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient services (services provided other than in a doctor’s office)(^e)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient surgery facility</td>
<td>80%</td>
<td>60%(^g)</td>
<td>80%</td>
<td>60%(^g)</td>
</tr>
<tr>
<td>Hospital outpatient services</td>
<td>80%</td>
<td>60%(^g)</td>
<td>80%</td>
<td>60%(^g)</td>
</tr>
<tr>
<td>Service</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
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<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>Doctor/surgeon and related professional fees</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral health outpatient treatment (other than office visit)</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Lab</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>X-ray</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Radiation therapy/chemotherapy</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Inpatient hospital services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Room and board (semi-private room)</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Inpatient behavioral health stay, including residential treatment and partial hospitalization</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Doctor hospital visits</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Lab and X-ray</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Alternatives to inpatient hospital care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled nursing facility (up to 60 days/plan year)</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Home health care (limited to 120 visits/plan year)</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Hospice care</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Outpatient private duty nursing (up to 70 shifts/plan year)</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Other covered services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractic care (including lab/X-ray provided by a chiropractor); up to 20 visits/plan year</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Contraceptive administration (includes coverage for all contraceptive devices including the associated office visit)</td>
<td>100%, no deductible</td>
<td>60%</td>
<td>100%, no deductible</td>
<td>60%</td>
</tr>
<tr>
<td>Durable medical equipment, orthotics, consumable medical supplies</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Prosthetic appliances (including external breast prostheses, wigs)</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Breast pumps and supplies (electronic breast pump limited to one per 36 months)</td>
<td>100%, no deductible</td>
<td>60%</td>
<td>100%, no deductible</td>
<td>60%</td>
</tr>
<tr>
<td>Lactation consultation</td>
<td>100%, no deductible/copay for first 6 visits; then primary care/specialist copay applies (deductible and coinsurance apply if not part of office visit)</td>
<td>60%</td>
<td>100%, no deductible/copay for first 6 visits; then 80% after deductible</td>
<td>60%</td>
</tr>
<tr>
<td>Infertility treatment (limited to diagnostic testing and corrective surgery)</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
</tbody>
</table>
Benefits are subject to recognized charge limits.  
You may need to pay the full amount and submit a claim for reimbursement to Aetna.

Covered network expenses do not apply to the plan year out-of-network deductible or out-of-pocket maximum, and covered out-of-network expenses do not apply to the plan year deductible or out-of-pocket maximum.

Precertification penalties and amounts above recognized charges do not apply to the plan year deductible or out-of-pocket maximum. Office visit copays, emergency room/urgent care facility copays and prescription drug expenses do not apply to the plan year medical deductible; however, they do apply to the plan year out-of-pocket maximum.

Unless otherwise noted, benefits paid at 80% or 60% are paid after the plan year deductible has been met.

The office visit copay covers lab and X-ray charges performed in a doctor's office and billed as part of the visit. When these services are not performed at the time of the office visit, performed at another network facility or performed by a network entity other than the doctor's office, you must first meet your deductible and then the expense, if covered, would be paid at 80%.

For facility charges and non-emergency admissions, reimbursement is limited to 60%, with a maximum allowed amount of 1.5 times the Medicare Fee Schedule for that area.

For additional information about covered preventive care benefits, see the Preventive care section of this SPD or contact Aetna Member Services at 1-866-436-2606.

Non-facility charges for emergency services incurred in the emergency room are paid at applicable network levels.

Precertification required; benefits may be reduced or denied if precertification not obtained.

The visit/plan year limit applies to total of both network and out-of-network visits.

Deductible waived for diabetic insulin pumps and tubing.

The following in-network services require precertification: cardiac imaging (including non-urgent outpatient diagnostic heart catheterizations and echo stress tests); cardiac rhythm implantable devices; sleep studies; high-tech radiology (e.g., MRI/MRA, CT scans, PET scans and nuclear imaging).

Speech therapy is subject to medical review if one of the following circumstances exist: developmentally delayed due to an injury or sickness (other than a functional nervous disorder); diagnosis of chronic otitis media; or a congenital defect for which corrective surgery has been performed.

Publication date: April 2020
How the PPO Options work

The PPO Options are network-based options that utilize the Aetna Choice POS II network. BP offers three PPO Options: HealthPlus, Standard and Health+Savings.

The Health+Savings Option is a high deductible health plan (HDHP) that offers comprehensive medical coverage when you need it. This plan costs less per paycheck than for other medical options in exchange for having a higher deductible amount. You must meet the deductible before the Option pays any benefits, other than certain preventive care.

When you enroll in the Health+Savings Option, you’re automatically enrolled in a Health Savings Account (HSA), a tax-preferred account that you will own and which will help you save for future health expenses. See Health Savings Account (HSA) for more details about how HSAs work.

In the HealthPlus and Health+Savings PPO Options, you receive lower-cost health care services once you meet the plan’s deductible. However, in order to be eligible for the HealthPlus and Health+Savings Options, you and your covered spouse/domestic partner are each required to earn a minimum of 1,000 wellness points by completing various wellness activities associated with the BP Wellness Program.* To learn more about the available activities in the BP Wellness Program and their associated points, visit the Wellness section of LifeBenefits.

The PPO Options give you a choice when it comes to getting medical care. You can go to:

- **Any network provider.** That is, any licensed doctor, nurse, therapist, hospital, lab or other health care facility that has been designated as part of its network — and receive a higher level of benefit for a covered service. It is your responsibility to confirm that a provider or facility is part of the Aetna Choice POS II network.
  
  * If a provider practices at multiple locations, he/she may not be considered an in-network provider at each location. Confirm with your provider that he/she is in the network at the location you intend to visit before receiving care. If you use a network provider for an expense that is not covered under a PPO Option, the provider may charge you for the provider’s undiscounted rates unless you have signed a waiver prior to receiving the treatment or service(s) agreeing to pay for non-covered services.

- **Any out-of-network provider.** That is, any licensed doctor, nurse, therapist, hospital, lab or other health care facility that has not been designated as part of its network — and receive a lower level of benefit. (Note: A provider will still be considered out-of-network if the provider is an Aetna NAP provider but not in the Aetna Choice POS II network. See National Advantage Program (NAP) for more information.)

Whether you see a network provider or an out-of-network provider, each PPO Option covers a broad range of medical services and supplies once you meet your deductible, as well as preventive care services that don’t require you to meet your deductible. Each PPO Option also includes a Prescription Drug Program, administered by Express Scripts, Inc. (ESI). In the Health+Savings PPO Option, you must meet your medical plan deductible before you receive plan coverage for all formulary brand preventive prescriptions and all non-preventive prescriptions.

* New hires or newly eligible employees in their initial year of coverage under HealthPlus or Health+Savings are not required to accumulate 1,000 wellness points until the following calendar year.
Primary doctors

Under the HealthPlus and Health+Savings PPO Options, you will pay lower office visit copays for network providers who are considered primary doctors than for those who are considered specialists. Under the Health+Savings PPO Option, you must meet your medical plan deductible before copays are applicable.

Primary doctors are:

- Family practitioners.
- General practitioners.
- Internists.
- Pediatricians.
- Obstetricians/Gynecologists (OB/GYNs).

When you enroll in a PPO, you are not required to designate a primary doctor or have your primary doctor's referral to see a specialist.

How to choose a network provider

To learn more about the providers who participate in the Aetna Choice POS II Network, access BP's custom DocFind website or call Aetna Member Services at 1-866-436-2606.

Keep in mind that network providers occasionally change, so you will want to make sure the provider you choose is still in the network and at the location you would like to visit before you make an appointment. For the most up-to-date information, including whether a provider is accepting new patients, call the provider.

If Aetna determines in a particular case that there is no viable Aetna Choice POS II network provider option available, Aetna may treat a non-network provider as if it were an in-network provider until a viable Choice POS II network provider becomes available. In order for this special treatment to apply, the alleged provider deficiency must be raised with Aetna Member Services in advance of treatment and Aetna must agree with the special treatment.

If your dependents live away from home

To determine whether your dependents will be able to access the PPO network providers, you must call the Aetna Member Services Center. If the representative determines that your dependent(s) do not have access to PPO Option network providers, you may enroll yourself and all your eligible dependents in the OOA Option by calling the BP Benefits Center. You must contact the BP Benefits Center each annual enrollment period to elect this option or another OOA option if your dependent continues to live away from home.

If you elect a PPO Option and your covered dependent seeks care from out-of-network providers, those expenses will be subject to the PPO out-of-network deductible and the lower out-of-network benefit level.
Transition care benefits

If you are receiving treatment for a pregnancy or undergoing an active course of treatment from an out-of-network provider (either before coverage begins or if your provider decides to leave the network during the plan year), you may be eligible for transition care benefits. Transition care benefits are paid at the higher, network level of benefits for a limited period of time so you can complete an active course of treatment. At the end of that time, you will have the choice of seeing a network provider and receiving the higher, network level of benefits or continuing to see your out-of-network provider at the lower, out-of-network level of benefits.

If any of the following circumstances exist, you may qualify for transition coverage:

- Patient is confined to an inpatient facility.
- Patient has completed 27 weeks of pregnancy and has begun receiving prenatal care.
- Patient is in a post-operative period.
- Patient has a chronic, degenerative or disabling disease or condition.
- Patient is terminally ill and anticipated to have less than twelve months to live.
- Patient is a candidate for, or recipient of, an organ or bone marrow transplant.
- Patient is in the process of staged surgery (i.e., cleft palate repair).
- Patient is in an active course of treatment with a behavioral health provider (one visit within 30 days prior to coverage).

If you think you may qualify for transition coverage benefits, you should call Aetna Member Services to request a review of your situation. Once a review is completed, you will be notified in writing whether or not your request for coverage under transition coverage provisions is approved.
What the PPO Options pay

Network providers

Network providers have agreed to offer covered services at contracted rates. This means that the dollar amount you pay for your share of covered expenses is generally lower when you use a network provider. When you see a network provider:

1. Covered office visit expenses are covered at:
   - 100% after you pay a copay, with no deductible, by the HealthPlus PPO Option.
   - 80% after the deductible by the Standard PPO Option.
2. Under both PPO Options, in-network preventive care is covered at 100% with no copay and no deductible.
3. Emergency room facility charges are paid at 100% after a copay, with no deductible, by both PPO Options.
4. For both PPO Options, most other covered in-network services are paid at 80% of the contracted rate for other covered expenses after you meet the individual or family plan year deductible, and you pay the remaining portion of the charges (the coinsurance).
5. Once you meet the plan year network out-of-pocket maximum, the PPO Options pay 100% of the contracted rate for covered expenses for the rest of the plan year. **Note:** Under the HealthPlus PPO, copays will still apply as they are not subject to the out-of-pocket maximum.

See the PPO Options (HealthPlus and Standard) summary chart for more information.

Out-of-network providers

If you see an out-of-network provider, the PPO Options generally pay 60% of recognized charges for all covered expenses (except chiropractic care and ambulances services, which are covered at 80% of recognized charges) after you meet the individual or family plan year deductible. You pay the remaining percentage (the coinsurance) and any costs above recognized charge limits. (See Recognized charge limits.) **Note:** Eligible claims incurred in an emergency room facility will be covered at the applicable in-network benefit level.

Once you meet the plan year out-of-network out-of-pocket maximum, the PPO Options pay 100% of recognized charges for most covered expenses for the rest of the plan year. **Note:** Emergency room copays will still apply as they are not subject to the out-of-pocket maximum.
Deductibles

You pay the first portion of contracted or recognized charges for most covered expenses incurred by you and each covered dependent during the plan year before the plan begins paying benefits.

Each PPO Option has separate network and out-of-network medical coverage plan year deductibles. These deductibles are exclusive of each other. This means your covered network expenses count only toward meeting the network medical deductible. Network expenses do not count toward meeting the out-of-network medical deductible.

Similarly, covered out-of-network expenses count toward meeting the out-of-network medical coverage deductible, but do not count toward meeting the network medical deductible.

In addition, the Health+Savings PPO Option has two separate deductibles for network expenses, and two more for out-of-network expenses. Under the Health+Savings option, the lower deductibles apply **only** if you have You Only coverage. The higher deductibles apply if you have You + Spouse, You + Child(ren) or You + Family coverage, even if only one family member incurs medical expenses during the year. Under the Health+Savings option, the lower You Only deductibles would not apply to any covered individual in your family if you have You + Spouse, You + Child(ren) or You + Family coverage.

If you participate in the HealthPlus and Standard PPO options, any medical expense that counts toward an individual's deductible automatically counts toward the family deductible. This means that once you meet the family network or out-of-network deductible for the plan year, no other covered family member is required to meet his/her individual network or out-of-network medical deductible (as applicable) for that plan year before benefits are paid.

If you participate in the HealthPlus PPO Option, there is no separate plan year deductible for prescription drugs. Prescription drug expenses do not apply to the medical plan deductible.

If you participate in the Standard PPO Option, you pay a separate plan year deductible under the Prescription Drug Program. Medical expenses do not apply to the deductibles under the Prescription Drug Program and vice versa.

If you participate in the Health+Savings PPO Option, there is no separate plan year deductible for prescription drugs. Prescription drug expenses do apply to the medical plan deductible. You must meet the plan year deductible before the plan starts to pay most expenses, including those for formulary brand preventive and non-preventive prescription drugs.

Expenses excluded from the deductibles

The following expenses do not apply to the medical coverage plan year deductibles under the various PPO Options as indicated:

<table>
<thead>
<tr>
<th>Under the HealthPlus and Standard PPO Options</th>
<th>Under the Health+Savings PPO Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visit copays.</td>
<td>Expenses for diabetic insulin pumps and tubing.</td>
</tr>
<tr>
<td>Emergency room/urgent care facility copays.</td>
<td>Penalties for noncompliance with precertification provisions.</td>
</tr>
<tr>
<td>Prescription drug expenses.</td>
<td>Expenses not covered by the PPO Option.</td>
</tr>
<tr>
<td>Expenses for diabetic insulin pumps and tubing.</td>
<td>Charges above recognized charge limits.</td>
</tr>
<tr>
<td>Penalties for noncompliance with precertification provisions.</td>
<td></td>
</tr>
<tr>
<td>Expenses not covered by the PPO Option.</td>
<td></td>
</tr>
<tr>
<td>Charges above recognized charge limits.</td>
<td></td>
</tr>
</tbody>
</table>

Publication date: April 2020
Copays/coinsurance

Network providers

A “copay” is a fixed dollar amount you pay in lieu of a deductible and coinsurance at the time you receive medical services. When you see a network provider, copays apply to:

<table>
<thead>
<tr>
<th>Office visits for non-preventive care under the HealthPlus and Health+Savings PPO Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Note: If you use either the Westlake or Cherry Point Clinics, you will pay a reduced office visit copay.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Note: Under the Health+Savings PPO Option only, you must satisfy the applicable individual or family deductible first before the office visit copay will apply for these services. (The individual deductible applies if you have You Only coverage. The family deductible applies if you have You + Spouse, You + Child(ren) or You + Family coverage.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The office visit copay includes:</td>
</tr>
<tr>
<td>- The doctor office visit.</td>
</tr>
<tr>
<td>- Diagnostic laboratory tests or X-rays performed in a doctor’s office and billed as part of the visit.</td>
</tr>
<tr>
<td>- Injections administered in a doctor’s office as part of the visit (including allergy injections).</td>
</tr>
</tbody>
</table>

The office visit copay does not apply to:

<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visits if a surgical procedure as defined by Aetna is performed as part of the visit (for example, if a mole is removed or a broken bone is set during the office visit).</td>
</tr>
<tr>
<td>Prenatal maternity-related office visits (except for the first office visit to confirm the pregnancy). These visits are included in the delivery charge. However, post-natal maternity services are covered at 80% after the deductible.</td>
</tr>
<tr>
<td>Routine and diagnostic laboratory tests or X-rays performed:</td>
</tr>
<tr>
<td>- In a doctor’s office, but not at the time of the visit.</td>
</tr>
<tr>
<td>- In a facility other than the doctor’s office.</td>
</tr>
<tr>
<td>- By an entity other than the doctor’s office.</td>
</tr>
</tbody>
</table>

(Ask your doctor whether the lab facilities he/she uses are in the network.)

| - Chiropractic visits. |

<table>
<thead>
<tr>
<th>Emergency room facility charges</th>
</tr>
</thead>
</table>

Under the HealthPlus and Standard PPO Options, both network and out-of-network emergency room facility charges are covered at 80% after a copay, with no deductible.

Under the Health+Savings PPO Option, both network and out-of-network emergency room facility charges are covered at 80% after a copay, after the deductible.

<table>
<thead>
<tr>
<th>Urgent care facility charges under the HealthPlus and Health+Savings PPO Options</th>
</tr>
</thead>
</table>

Under the HealthPlus PPO Option, network urgent care facility charges are covered at 100% after a copay, with no deductible.

Under the Health+Savings PPO Option, network urgent care facility charges are covered at 100% after a copay, and after the deductible is met.

When you use a network provider, eligible preventive care expenses are covered at 100% with no copay and no deductible. See Preventive care for details.

Most other covered services received from network providers (including non-preventive care office visits and urgent care facility charges under the Standard PPO Option) are paid at 80% of the contracted rate after you meet the individual or family plan year deductible, and you pay the remaining portion of the charges (the coinsurance).
Out-of-network providers

When you see an out-of-network provider for a covered expense, you typically pay a larger share of the cost. Most covered services received from out-of-network providers are paid at 60% of recognized charges after you meet the individual or family plan year deductible, and you pay the remaining portion of the charges (the coinsurance). You are responsible for paying any charges above the recognized charge limits.

Note: Eligible claims incurred in an emergency room facility will be covered at the applicable in-network benefit level.

You are also responsible for filing claim forms when you see out-of-network providers. (See How to file a claim.)
**Out-of-pocket maximums**

You pay a certain amount of covered expenses each plan year before the PPO Options begin paying 100% of contracted or recognized charges for most covered services. This is your medical coverage plan year out-of-pocket maximum.

Each BP PPO Option has separate network and out-of-network medical coverage plan year out-of-pocket maximums. These maximums are exclusive of each other. This means that covered network expenses — including the network deductible — count only toward meeting the network medical out-of-pocket maximum. Network expenses do not count toward meeting the out-of-network medical coverage out-of-pocket maximum. Similarly, covered out-of-network expenses — including the out-of-network deductible — count toward meeting the out-of-network medical out-of-pocket maximum, but do not count toward meeting the network medical out-of-pocket maximum.

In addition, each Health+Savings PPO Option has two separate out-of-pocket maximum amounts for network expenses, and two more for out-of-network expenses. Under the Health+Savings option, the lower out-of-pocket maximum amounts apply only if you have You Only coverage. The higher out-of-pocket maximum amounts apply if you have You + Spouse, You + Child(ren) or You + Family coverage, even if only one family member incurs medical expenses during the year. Under the Health+Savings options, the lower You Only out-of-pocket maximum amounts would not apply to any covered individual in your family if you have You + Spouse, You + Child(ren) or You + Family coverage.

Under the HealthPlus and Standard PPO options, any medical expense that counts toward an individual's out-of-pocket maximum automatically counts toward the family out-of-pocket maximum. For example, once you meet the family plan year network out-of-pocket maximum, no other covered family member is required to meet his/her individual network out-of-pocket maximum for that plan year before plan benefits are paid at 100%.

The expenses that apply to the out-of-pocket maximum vary depending on the option in which you are enrolled.

<table>
<thead>
<tr>
<th>If you are enrolled in this option...</th>
<th>The following expenses apply to the option’s medical out-of-pocket maximum...</th>
<th>The following expenses do not apply to the option’s medical out-of-pocket maximum and are payable by you even after the out-of-pocket maximum has been met...</th>
</tr>
</thead>
<tbody>
<tr>
<td>HealthPlus PPO or Standard PPO Option</td>
<td>l Deductibles.</td>
<td>l Charges above the recognized charge limits.</td>
</tr>
<tr>
<td></td>
<td>l Coinsurance.</td>
<td>l Penalties for noncompliance with precertification provisions.</td>
</tr>
<tr>
<td></td>
<td>l Office visit copays.</td>
<td>l Expenses not covered by the PPO Option.</td>
</tr>
<tr>
<td></td>
<td>l Emergency room/urgent care facility copays.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>l Expenses under the Prescription Drug Program.</td>
<td></td>
</tr>
<tr>
<td>Health+Savings PPO Option</td>
<td>l Deductibles.</td>
<td>l Charges above the recognized charge limits.</td>
</tr>
<tr>
<td></td>
<td>l Coinsurance.</td>
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<tr>
<td></td>
<td>l Expenses under the Prescription Drug Program.</td>
<td></td>
</tr>
</tbody>
</table>

Publication date: April 2020
Important plan provisions

The HealthPlus and Standard Options include special plan provisions. These important features include preventive care, recognized charge limits, precertification requirements and more. More information about each of these features is outlined in this section.

- Preventive care
- Emergency care
- Recognized charge limits
- Aetna's National Advantage Program (NAP)
- Transplant services
- Precertification requirements
- Coverage while traveling
Preventive care

The HealthPlus, Standard and Health+Savings Options provide coverage for the following preventive care services:

- Routine physicals (once per calendar year).
- Routine well-child care.
- Annual well-woman exams.
- Routine mammograms.
- Routine Prostate Specific Antigen (PSA) tests.
- Colorectal screenings.
- Routine hearing and vision chart exams (once per year).
- Preventive items or services with an “A” or “B” rating from the United States Preventive Services Task Force.
- Immunizations pursuant to the Advisory Committee on Immunization Practices (“ACIP”) recommendations.
- Preventive care and screenings that are provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”).
- Gestational diabetes screening.

Routine physicals are covered annually. All other screenings and tests are covered based on age, gender and medical history. Preventive care benefits are subject to age restrictions/limitations as determined under the claims administrator’s guidelines. For additional information about benefits for covered preventive care services, contact the member services number on your medical ID card.

Routine physicals and well-child care include the following services:

- Doctor’s exam.
- Immunizations.
- Vision chart and hearing screenings performed in a doctor’s office.

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Emergency care

No matter where you are, if you have a medical emergency — that is, a sudden and unexpected change in your physical or mental condition which, if not treated immediately, could result in a loss of life or limb, significant impairment of a bodily function or permanent dysfunction of a body part — you should go to the nearest emergency room to get the care you need.

Emergency medical condition

An emergency medical condition is a recent and severe medical condition, including (but not limited to) severe pain, which would lead a prudent person possessing an average knowledge of medicine and health, to believe that his or her condition, illness or injury is of such a nature that failure to get immediate medical care could result in:

- Placing your health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Examples of medical emergencies include heart attack, stroke, severe bleeding, serious burns and poisoning. It can sometimes be difficult to determine when urgent situations are true emergencies. If you need help determining whether your situation is a true emergency, you can consult a doctor who will be able to tell you what steps to take. You can also contact Aetna's 24-Hour NurseLine at 1-800-556-1555 to speak with a registered nurse.

Emergency services

“Emergency services” means, with respect to an emergency medical condition:

- A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient.

Under all PPO Options, you receive the higher, network level benefits for emergency services — even if you see an out-of-network provider. You do not need prior authorization for the treatment of an emergency medical condition, even if the services are provided by an out-of-network provider. Care provided by an out-of-network provider will be paid at no greater cost to you than if the services were performed by a network provider. You may receive a bill for the difference between the amount billed by the out-of-network provider and the amount paid by Aetna. If an out-of-network provider bills you directly for an amount beyond your cost share for the treatment of an emergency medical condition, you are not responsible for paying that amount. Please send the bill to the address listed on the back of your member ID card and Aetna will resolve any payment dispute with the provider over the amount. Make sure your member ID number is on the bill.

Under all OOA Options, your cost may be lower if you use Aetna's National Advantage Program (NAP). See Aetna's National Advantage Program (NAP) for more information. You do not need prior authorization for the treatment of an emergency medical condition.

Under both the PPO and OOA Options, if you are admitted to the hospital, you or someone on your behalf is required to certify your hospitalization within 48 hours (or two business days) of your emergency admission. Instructions on how to contact your claims administrator are provided on your medical option ID card.

Publication date: April 2020
**Recognized charge limits**

Benefits under the HealthPlus, Standard and Health+Savings Options are based on recognized charge limits.* These Options do not cover otherwise eligible expenses above recognized charge limits — they are your responsibility. For example, if you incur a $200 doctor expense, but only $180 of the charge is within recognized charge limits, only $180 will be considered an eligible expense under the plan.

Recognized charge limits do not apply to:

- Eligible expenses provided by a network provider under the PPO Options.
- Eligible charges from participating NAP hospitals and doctors under the OOA Options. NAP providers can be found by using BP’s custom DocFind website. (See Quick links on the LifeBenefits site.)

The recognized charge for a service or supply is the lower of:

- What the provider bills or submits for that service or supply; and
- The charge the claims administrator determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made, billed or coded.
  - For non-facility charges:
    - PPO Options: The 85th percentile of the Prevailing Charge Rate, for the Geographic Area where the service is furnished.
    - OOA Options: Twice the 95th percentile of the Prevailing Charge Rate, for the Geographic Area where the service is furnished.
  - For facility charges:
    - PPO Options: 150% of the Medicare Fee Schedule for the Geographic Area where the service is furnished. Aetna will determine the usual charge level if a Medicare fee is not applicable.
    - OOA Options: Aetna uses the charge Aetna determines to be the usual charge level made for it in the Geographic Area where it was furnished.

As used above, Geographic Area and Prevailing Charge Rates are defined as follows:

- **Geographic Area:** This means an expense area grouping defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three-digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three-digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three-digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three-digit zip codes, the grouping never crosses state lines.

- **Prevailing Charge Rates:** These are rates reported by FAIR Health, a nonprofit company, in their database. FAIR Health reviews and, if necessary, changes these rates periodically. Aetna updates its systems with these changes within 180 days of receiving them from FAIR Health.

* You may be accustomed to seeing the term "reasonable and customary (R&C)," however Aetna uses the term "recognized charge." Recognized charge works in the same manner as reasonable and customary.

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Publication date: April 2020
Aetna’s National Advantage Program (NAP)

The National Advantage Program (NAP) offers you access to Aetna-contracted rates for many hospital and doctor expenses that would otherwise be billed at the provider's normal rate. These include:

- For the PPO Options, eligible expenses provided by providers who are not Choice POS II network providers but who are Aetna NAP providers.
- For the OOA Options, eligible expenses provided by a provider who is an Aetna NAP provider.

You may save money with the NAP because the contracted rate is generally lower than the provider's normal charge. In addition, you should not be billed by the provider for the difference between the provider's normal charge and the contracted rate (i.e., no balance billing).

In order to qualify for Aetna’s contracted NAP rates, the expense must be covered under the plan and the provider must submit the charge to process at the contracted amount before you pay for services. It is therefore important to remind the provider to submit the claim to Aetna directly before you pay.

The NAP network consists of many of Aetna’s directly contracted hospitals, ancillary providers and doctors, as well as hospitals, ancillary providers and doctors accessed through vendor arrangements where Aetna does not have direct contractual arrangements. NAP-participating doctors include primary care doctors, obstetricians, gynecologists, radiologists, anesthesiologists, pathologists and other specialists.

NAP ancillary providers include:

- Acute rehabilitation facilities.
- Ambulatory surgical centers.
- Dialysis centers.
- Freestanding hospices.
- Infusion centers.
- Nursing care agencies.
- Skilled nursing facilities.
- Substance abuse facilities.

Certain claims are not eligible for a NAP discount, including:

- Small hospital or ancillary provider claims (currently below $151) that require manual intervention to obtain a discount.
- Claims involving Medicare or Coordination of benefits (COB) when the plan is not primary.
- Claims that have already been paid directly by the plan participant before the provider has submitted the claim to Aetna at the contracted rate.
- Claims that are not covered by the plan.

To learn more about the providers who participate in the NAP, contact Aetna Member Services or access BP’s custom DocFind website.
Transplant services

The Institutes of Excellence (IOE) network is the claims administrator’s network for transplants and transplant-related services, including evaluation and follow-up care. This is a network of facilities that have demonstrated success at performing these highly specialized procedures.

For the PPO Options:

- The network level of benefits is paid for treatment received at a facility designated by the plan as an IOE for the type of transplant being performed. Each IOE facility has been selected to perform only certain types of transplants.
- Services obtained from a facility that is not designated as an IOE for the transplant being performed will be covered as out-of-network services and supplies, even if the facility is a network facility or IOE for other types of services.

The National Medical Excellence (NME) Program coordinates transplants and other specialized care that may not be available in your local area. If you are referred to a facility that is more than 100 miles from your home or you are required to remain within a certain radius of the treating facility that is farther than your home, the NME Program will help pay certain travel and lodging expenses for you and a companion.

If you or one of your covered family members could be a potential transplant candidate, contact the claims administrator to learn more about this program.

Out-of-country care

The National Medical Excellence (NME) Program coordinates care when an Aetna plan participant develops an urgent or acute illness when traveling outside of the United States. Coordination of some or all of the following may apply:

- Assessment of the urgent or acute care facility’s appropriateness for the required care;
- Transfer of the plan participant to a more appropriate acute care facility for stabilization;
- Transfer of the plan participant back to the United States; and
- Transfer of the plan participant to his/her home.

Publication date: April 2020
Precertification requirements

The decision to receive care is between you and your provider. If you do not precertify care when you are required to do so, your benefits will be reduced, or in some instances, not paid at all.

- If you are in a PPO Option and you use a network provider for covered medical care, the provider will take care of precertification for you.
- If you use a NAP provider, confirm that the provider is obtaining precertification on your behalf; otherwise contact Aetna directly for precertification. (The NAP Program is a discount program and does not guarantee precertification.)
- In all other instances, you are responsible for obtaining any required precertification.

Precertification is not required for expenses incurred while you are outside the United States.

It is a good idea to provide a family member, friend and/or your doctor with the precertification instructions. That way, they will be able to make the precertification call for you in case you cannot. Even if you rely on someone else to make the call for you, it is your responsibility to follow up to be sure the call was made. Precertification is required for the following services:

- **Inpatient admissions.** Non-emergency hospital (including hospitalization for mental health/substance abuse treatment), skilled nursing facility, and hospice admissions must be precertified by calling the claims administrator at the toll-free precertification number shown on your medical option ID card (at least 10 days in advance for Aetna).

- **Maternity stays.** Precertification of maternity care is not required. If your doctor recommends an extended stay beyond 48 hours for a vaginal delivery or 96 hours for a Caesarean section, the additional days must be precertified with the claims administrator within 48 hours (or two business days). If the mother is discharged before the baby is allowed to go home, the baby’s extended stay must also be precertified.

- **Hospitalization due to a medical emergency.** You must certify by calling the claims administrator within 48 hours (or two business days) of your emergency admission.

- **Enhanced clinical review (NOTE: Applies only to Aetna PPO Options).** Certain services (listed below) are subject to enhanced clinical review through a separate independent company. This company uses medical specialists and diagnostic tools to review your doctor’s request, applying national medical standards, with the initial review accomplished typically within 24 hours of the request. Your doctor should submit a request for clinical review for the following services:
  - Cardiac imaging, including non-urgent outpatient diagnostic catheterization and echo stress tests.
  - Cardiac rhythm implantable devices.
  - Sleep studies.
  - High-tech radiology, including MRI/MRA, CT scan, PET scan and nuclear imaging.
  - Outpatient interventional pain management.
  - Hip and knee replacements (inpatient and outpatient).

Responsibility for obtaining preauthorization of the above services is shared by the patient (or the parent plan participant, if a child), the referring physician and the facility rendering the service. In-network physicians have been engaged regarding this requirement and should be aware of the process.

- **Outpatient medical services.** Some outpatient procedures, including outpatient hospice care, home health care and private duty nursing and, in some circumstances, outpatient rehabilitation services require precertification. Additionally, if your doctor recommends an intensive outpatient program for psychiatric, eating disorder care and/or substance abuse care that is generally two or more hours per day, precertification is required. If your doctor recommends these outpatient services, you or your doctor should call the toll-free precertification number shown on your medical option ID card in advance to make sure the procedure is covered by the plan.

- **Partial hospitalization or a day program.** Outpatient care focused on psychiatric, eating disorder care and/or substance abuse care that is generally four or more hours per day and includes individual, group and family therapies must be precertified in advance by calling the claims administrator at the toll-free precertification number shown on your medical option ID card.

- **Electroconvulsive therapy treatment (ECT).** ECT is systematic use of electric shocks to produce convulsions. Care must be
Precertified in advance by calling the claims administrator at the toll-free precertification number shown on your medical option ID card.

- **Psychological testing.** Psychological testing must be precertified by calling the claims administrator at the toll-free precertification number shown on your medical option ID card.

- **Biofeedback.** Biofeedback must be precertified by calling the claims administrator at the toll-free precertification number shown on your medical option ID card.

- **Outpatient detoxification.** Outpatient detoxification must be precertified by calling the claims administrator at the toll-free precertification number shown on your medical option ID card.

See Process for formal benefit claims and appeals if you receive an adverse benefit determination with respect to your request for precertification.

**Precertification penalties**

If you do not precertify care (including behavioral health care) when you are required to do so, your benefits will be reduced or, in some instances, not paid at all. Specifically, the following penalties will apply:

- **If you do not call to precertify.** All expenses related to care that has not been precertified are reviewed by the claims administrator. Benefits will not be paid for any expenses (including room and board) that were not medically necessary. A $300 penalty will be deducted from any benefits that are otherwise payable.

- **If you call to precertify, but the claims administrator determines that your admission, proposed treatment or expense is not medically necessary:** No benefits will be paid.

- **If you call to precertify additional hospital days beyond those initially precertified, but the claims administrator determines that those additional days are not medically necessary:** No benefits will be paid for the additional days.

Because PPO network providers are responsible for obtaining precertification of care for you, precertification penalties do not apply under the BP PPO Options for eligible care received from a network provider. However, if you are intending to receive an in-network level of benefits, it is your responsibility to confirm that each provider or facility you use is in the Aetna Choice POS II network. If a provider practices at multiple locations, he/she may not be considered an in-network provider at each location. Confirm with the provider that he/she is in the network at the location you intend to visit before receiving care.

Publication date: April 2020
Coverage while traveling

Eligible medical expenses incurred while traveling within or outside the U.S. are covered. Under all HealthPlus, Standard and Health+Savings Options, you may need to pay the provider in full and submit a claim for reimbursement from your claims administrator.

If you receive medical or behavioral health care or purchase prescription drugs within or outside the U.S. (other than from a PPO network provider, if you are enrolled in a PPO Option), submit a claim to the claims administrator for reimbursement.

If you purchase any prescription medication from a non-network pharmacy, submit a claim to Express Scripts, Inc. (ESI).

Publication date: April 2020
Alternatives to physician office visits

Walk-in clinic visits

Covered expenses include charges made by walk-in clinics for:

I Unscheduled, non-emergency illnesses and injuries;
I The administration of certain immunizations administered within the scope of the clinic’s license; and
I Individual screening and counseling services to aid you:
   ° to stop the use of tobacco products;
   ° in weight reduction due to obesity;
   ° in stress management. The stress management counseling sessions will help you to identify the life events which cause you stress (the physical and mental strain on your body.) The counseling sessions will teach you techniques and changes in behavior to reduce the stress.

Unless specified above, not covered under this benefit are charges incured for services and supplies furnished:

I In a group setting for screening and counseling services.

Important Notes:

I Deductibles, copays and/or coinsurance will apply where applicable. Refer to the applicable summary chart for more information.
I Not all services are available at all walk-in clinics. The types of services offered will vary by the provider and location of the clinic.
I For a complete description of the screening and counseling services provided on the use of tobacco products and to aid in weight reduction due to obesity, refer to the Preventive care and Expenses covered under the BP Medical Plan sections in this SPD for a description of these services. These services may also be obtained from your physician.

Walk-in clinic

Walk-in clinics are free-standing health care facilities. They are an alternative to a physician’s office visit for treatment of:

I Unscheduled, non-emergency illnesses and injuries;
I The administration of certain immunizations; and
I Individual screening and counseling services.

It is not an alternative for emergency room services or the ongoing care provided by a physician.

Neither:

I An emergency room; nor
I The outpatient department of a hospital;

shall be considered a walk-in clinic.

Publication date: April 2020
Teladoc provides you with 24/7 telephonic access to a national network of U.S. board-certified doctors when enrolled in an Aetna medical plan. There is no additional cost to you for this service. You can call a physician from anywhere — home, work or on the road. Teladoc doctors diagnose non-emergency medical problems, recommend treatment, and can even call in any necessary prescription(s) to your pharmacy.

Teladoc is intended to treat minor non-emergency conditions such as:

- Respiratory infections
- Ear infections
- Urinary tract infections
- Allergies
- Colds and flu
- Sore throat

How to use Teladoc

2. Complete your medical history.
3. Request a consultation and a U.S. board-certified physician will call you back within one hour.
4. Pay online. Teladoc visits generally cost less than a regular office visit, with costs not exceeding $40.

Teladoc is available beginning April 1, 2016 to those enrolled in an Aetna medical plan.

Publication date: April 2020
Effective April 1, 2019, the Enhanced Aetna Concierge program is available to participants in Aetna-administered medical plans. This program helps you manage your healthcare by putting you at the center of it all. Resources are available to help you 24/7.

This program puts a team of benefits specialists at one location at your disposal, waiting to resolve all of your healthcare coverage questions and concerns. When you call, you'll be assigned a personal concierge as a single point of contact until your situation is resolved. Your concierge can call upon other team members as needed — doctors, nurses, pharmacists, dietitians, behavioral health specialists, social workers, well-being specialists, network provider specialists and more — to consult with you about your coverage.

The BP Enhanced Aetna Concierge team can do many things for you:

- Schedule appointments with your doctor.
- Coordinate care approvals for an upcoming surgery or procedure.
- Help set coverage goals that are right for you.
- Work with you to help resolve claim inquiries or billing issues.
- Check in with you to see how you're doing, both routinely when convenient and urgently if needed.
- Connect you to healthcare resources in your community.

How to reach Enhanced Aetna Concierge

You can call 1-866-436-2606 at any time. Concierge specialists are available 8:00 am to 8:00 pm Monday-Friday, and 8:00 am to 4:30 pm Saturday, Central time. Additional support is available 24/7/365.
Prescription drug coverage

The medical plans all offer prescription drug coverage. Under the HealthPlus, Standard and Health+Savings Options, the Prescription Drug Program is administered by Express Scripts (ESI).

In general, the program offers prescription drug benefits two ways:

- **For short-term prescriptions**, you must fill your prescription at any Express Scripts network retail pharmacy, unless one is not available in the area.
- **For longer-term maintenance prescriptions**, you must use the home delivery service.

When you participate in either option, you will receive a separate ESI prescription drug ID card. Each time you fill a prescription at an ESI network retail pharmacy, simply show your ID card so the pharmacist knows you are covered under the program.

- If you are a participant in the HealthPlus Option, there is no separate prescription drug deductible. You only pay your applicable prescription drug copay.
- If you are a participant in the Standard Option, you must meet the separate prescription drug deductible before the plan pays a benefit. Once you meet the separate prescription drug deductible, you will pay a copay for generic drugs, or the applicable coinsurance for preferred or non-preferred brand name drugs.
- If you are a participant in the Health+Savings Option, there is no separate prescription drug deductible. You pay your applicable prescription drug copay after you satisfy the medical plan deductible.

When you use home delivery, you must submit information to ESI. (See Home delivery program for more information.)

Prescription drugs usually fall into one of two basic categories — generic and brand name. Regardless of where you choose to fill your prescription, the program covers three levels of medications: generic drugs, brand name preferred drugs and brand name non-preferred drugs.

- **Generic drugs** have the same active ingredients as brand name drugs and are subject to the same Food and Drug Administration (FDA) standards for quality, strength and purity as their brand name counterparts. Not all brand name drugs have generic equivalents. Typically, your pharmacist will fill your prescription with a generic drug, if available, unless you or your doctor specify otherwise.
- **Brand name drugs** are drugs patented by the FDA and subject to an exclusivity agreement, which allows the company to be the sole manufacturer of the drug for a certain number of years. Brand name drugs include preferred drugs and non-preferred drugs.
  - Preferred drugs are drugs that Express Scripts considers preferred choices, based on their effectiveness and cost, and are on ESI's formulary drug list.
  - Non-preferred drugs are those that are not on ESI's formulary drug list.

A formulary is a list of recommended prescription medications that is created, reviewed and continually updated by a team of physicians and pharmacists. The Express Scripts formulary contains a wide range of generic and brand name preferred products that have been approved by the Food and Drug Administration (FDA). The formulary applies to medications that are dispensed in a retail pharmacy or mail service setting. The formulary is developed and maintained by Express Scripts and is available online or a paper copy may be requested. Formulary designations may change as new clinical information becomes available.

If a prescription drug does not have a generic equivalent available, you will be charged the brand name copay (preferred or non-preferred, depending on the drug). Please note that the information on the formulary drug list is not BP-specific, and not all of the preferred drugs covered may be listed nor does BP cover all the drugs that may be listed. If you do not see your drug listed, contact Express Scripts for coverage information.

<table>
<thead>
<tr>
<th>Prescription Drug</th>
<th>HealthPlus Option</th>
<th>Standard Option</th>
<th>Health+Savings Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rx Deductible</td>
<td>Retail(\text{a})</td>
<td>Retail(\text{a})</td>
<td>Retail(\text{a})</td>
</tr>
<tr>
<td></td>
<td>Home Delivery</td>
<td>$75/person; $225/family</td>
<td>No separate Rx deductible; Rx subject to medical plan deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Copay(\text{b})/Coinsurance</td>
<td>Deductible, then</td>
</tr>
<tr>
<td>Generic</td>
<td>$5 copay</td>
<td>$5 copay</td>
<td>Deductible, then</td>
</tr>
<tr>
<td></td>
<td>$12 copay</td>
<td>$12 copay</td>
<td></td>
</tr>
</tbody>
</table>

The most up-to-date information is available online at http://hr.bpglobal.com/lifebenefits/Core.
Prescriptions purchased at an out-of-network pharmacy are covered only if a network pharmacy is not available.  

You always pay the lesser of the actual cost of your prescription or the copay. All brand name non-sedating and low-sedating antihistamines — even if on the formulary drug list — are subject to the brand name non-preferred drug copay.

Prescription drugs are covered (subject to plan exclusions and limitations) under the Prescription Drug Program if they:

- Require a prescription for dispensing;
- Are FDA indicated for an approved diagnosis;
- Are medically necessary; and
- Are not experimental in nature.

If you participate in a Standard Option and have not met the plan year prescription drug deductible, you pay 100% of the negotiated cost of the medication (if applicable) at a network pharmacy — or the billed charges if a network pharmacy is not available — until the deductible is met. After that, you pay only the applicable copay or coinsurance.

Expenses that are not applied to the separate Standard Option Prescription Drug Program deductible include:

- Copays.
- Prescriptions filled at a retail pharmacy after the two-fill limit on maintenance medication is reached.
- Prescriptions filled at a non-network pharmacy when an ESI network pharmacy is available.
- Prescriptions not covered under the Prescription Drug Program.

Inpatient care and your prescription benefit

Prescription drugs received while you are an inpatient at an extended care facility/skilled nursing facility are payable under the Prescription Drug Program (and not under the medical coverage provisions of the plan). Because you have no control over whether a network pharmacy is used, coverage is provided even when the prescription drugs are obtained from a non-network pharmacy. Whether a network or non-network pharmacy is used, you may need to pay for the prescription drug up front and then file a claim for reimbursement.

Prescriptions covered without deductibles or copays

The following prescriptions are 100% covered without a need to pay a medical or prescription drug deductible or pay any copays:

- FDA-approved women’s contraception.
- Generic preventive prescriptions (applies to the Health+Savings Options only)
Retail pharmacy network

To use your prescription drug benefit, present your prescription drug ID card when you have your prescription filled.

You must fill your prescription drug at an ESI network pharmacy unless one is not available in the area. No benefit is provided if you use a non-participating pharmacy when an ESI network pharmacy is available. In addition, if you use a non-participating pharmacy when an ESI network pharmacy is available, eligible expenses incurred at the non-participating pharmacy do not count toward the Standard Option’s prescription drug deductible. These restrictions do not apply if you are outside the ESI network area — there is no ESI network pharmacy within a 40-mile radius of your home or work location — or outside the United States.

You may fill maintenance medications (for example, medication for high blood pressure or for high cholesterol) twice through a retail pharmacy. After that, refills must be filled through ESI’s home delivery program to receive benefits under the Prescription Drug Program.

If there is no participating pharmacy within a 40-mile radius of your home or work location, you can go to any pharmacy, have your prescription filled and pay the full cost for it. You will then need to file a claim with ESI and submit it with your original itemized receipt for reimbursement based on plan limitations.

If you are outside the United States, you can go to any pharmacy, have your prescription filled and pay the full cost for it. You will then need to file a claim with ESI and submit it with your original itemized receipt. If you are enrolled in the Standard Option, you must first meet the Prescription Drug Program plan year deductible before you receive any reimbursement. ESI will reimburse you for your cost, less the appropriate copay or coinsurance. In processing your claim incurred while traveling abroad, ESI uses the conversion rate posted on www.oanda.com as of the date the prescription was filled.

If you are enrolled in the Health+Savings Option, you may use your PayFlex Card® (your HSA debit card) to pay for eligible prescription drug expenses at a participating retail pharmacy. **Note:** You cannot use the HSA debit card outside the U.S.

Publication date: April 2020
Home delivery program

If you live in the United States you can order up to a 90-day supply of maintenance medication for chronic conditions, such as asthma or high blood pressure, through ESI's home delivery program. The home delivery program is not available if you live outside the United States.

Certain prescription drugs — such as diet medications, growth hormones and topical tretinoin products — are available only through the home delivery program and are available only if they are medically necessary. Anabolic steroids, tretinoin, weight loss management, photo-aged skin products and erectile dysfunction drugs are available only through the home delivery program, subject to plan limits.

To order a prescription through the home delivery program, complete and return an order form (available from ESI or the LifeBenefits website). Return the form, your prescription from your doctor as well as:

- If you participate in the HealthPlus Option, any appropriate copay.
- If you participate in the Standard Option, any remaining Prescription Drug Program deductible (up to the cost of the prescription) and appropriate copay or coinsurance amount. You may contact ESI to determine your remaining deductible.
- If you participate in the Health+Savings Option, any remaining Medical Plan Program deductible (up to the cost of the prescription) and appropriate copay or coinsurance amount. You may contact Aetna to determine your remaining deductible.

Typically, a pharmacist at the home delivery program facility will fill your prescription with a generic drug, if available, unless your doctor specifies otherwise. In addition, the pharmacist may contact your doctor if your prescription is unclear or incomplete, or to ask if a substitution or change may be made to the prescription he/she has written. ESI pharmacists will not make any changes to your prescription unless authorized by your doctor.

You will receive your medication approximately 14 days from the date ESI receives your order with the correct payment. If you need your medication sooner, ask your doctor to write two prescriptions:

- One for up to a 30-day supply to be filled immediately at a retail pharmacy that participates in the ESI network.
- Another that you can send to the home delivery program for an additional supply.

To order a refill from ESI's home delivery program, contact ESI online or via phone. You may also detach the refill slip, complete the patient order form and mail the request to ESI with the correct payment.

If you are enrolled in the Health+Savings Option, you may use your PayFlex Card® (your HSA debit card) to pay for eligible prescription drug expenses you incur through the home delivery program. **Note:** You cannot use the HSA debit card outside the U.S.

Publication date: April 2020
Specialty pharmacy

If you use a specialty medication, the Prescription Drug Program offers an enhanced level of service for medications that are not available through a retail pharmacy. You may receive these medications through Accredo Pharmacy, a special mail order pharmacy affiliated with ESI that is designed to service your unique needs and deliver your medication to your doorstep.

Examples of diseases or conditions for which drugs may be obtained through Accredo Pharmacy include but are not limited to, multiple sclerosis, rheumatoid arthritis, HIV/AIDS, cancer, hepatitis B & C, hemophilia and growth hormone deficiency. Certain drugs such as Insulin, Immitrex, Epinephrine and Glucagon are not considered specialty drugs.

**Note:** Effective April 1, 2020, certain designated specialty medication will be covered only through Accredo Pharmacy. This change does not affect medications supplied by an emergency room, or during an inpatient hospital stay. However, if any of these medications are obtained from an outpatient clinic, a home infusion company, a doctor’s office, or from another pharmacy, they will not be covered.

Accredo will contact you if the medication you’re taking can be supplied or is required to be supplied through the Accredo program. As an Accredo patient, you will have access to a team of specialists who will work closely with you and your physician throughout your course of therapy.

After you have successfully taken the medication for a six-month period and your physician has deemed that the ongoing dosage and medication are appropriate for your condition, you may begin to receive a 90-day supply from Accredo for the applicable home delivery copay or coinsurance. Until that time, you will receive a 30-day supply each month from Accredo at the applicable retail level copay or coinsurance.

**Copays for specialty medications**

Copays for certain specialty medications will vary depending on the amount of available assistance provided by manufacturers of the particular medication. If you have questions regarding the amount of your copay, please contact ESI.

Your out-of-pocket maximum calculations will reflect your copay amount and not include any financial assistance provided to you by manufacturers of your medications.

Publication date: April 2020
Drugs not covered

The Prescription Drug Program does not pay benefits for:

- Any drug that can be purchased legally without a prescription.
- Hair growth agents.
- Homeopathic drugs.
- Injectable cosmetics.
- Nutritional supplements.
- Smoking cessation agents (gum and patches) (covered only for employees and eligible dependents who are enrolled in a HealthPlus Option and participate in a smoking cessation program sponsored by StayWell).

In addition, the following expenses are covered under the medical provisions of the HealthPlus, Standard and Health+Savings Options and are not payable through the Prescription Drug Program:

- Prescriptions administered during a hospital stay (treated as part of the hospital expense).
- Injectables provided at a doctor’s office (treated as a part of the office visit expense).

See Expenses not covered under the BP Medical Plan for all other limitations and exclusions.

Publication date: April 2020
A note about Medicare and prescription drug coverage

If you are eligible for Medicare, you are eligible to enroll in a Medicare Part D plan that offers prescription drug coverage. There is a late enrollment penalty if you do not enroll in Medicare Part D coverage when you are first eligible unless you have “creditable coverage” under an employer group health plan. (You must enroll in a Medicare Part D plan within 63 days of losing creditable coverage to avoid the late enrollment penalty.)

The prescription drug coverage offered under the HealthPlus and Standard Options is considered to be “creditable coverage” for purposes of Medicare Part D. Therefore, you do not need to enroll in a Medicare Part D plan while you are covered under one of these options. However, the prescription drug coverage offered under the Health+Savings Option is not considered to be “creditable coverage” for purposes of Medicare Part D.

Each year, you will be sent a notice notifying you whether the plan’s prescription drug coverage remains “creditable” for purposes of Medicare Part D.

Publication date: April 2020
The Health+Savings PPO Option is available only if you live in an area where the Aetna Choice POS II network is available; otherwise, the Out-of-Area Option is available to you.

If you participate in an Out-of-Area Option, see the Out-of-Area (OOA) Options (HealthPlus and Standard) summary chart or the Health+Savings Out-of-Area (OOA) Option chart.

### Health+Savings PPO Option summary chart

<table>
<thead>
<tr>
<th>Network</th>
<th>Out-of-Network&lt;sup&gt;h,b&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General information</strong></td>
<td></td>
</tr>
<tr>
<td>Plan year deductible&lt;sup&gt;c,d&lt;/sup&gt;</td>
<td>$1,500 if you have You Only coverage; $3,000 if you have You + Spouse, You + Child(ren) or You + Family coverage</td>
</tr>
<tr>
<td>See Deductibles for more information</td>
<td></td>
</tr>
<tr>
<td>Plan year out-of-pocket maximum&lt;sup&gt;c,d&lt;/sup&gt;</td>
<td>$3,000 if you have You Only coverage; $6,000 if you have You + Spouse, You + Child(ren) or You + Family coverage</td>
</tr>
<tr>
<td>See Out-of-pocket maximums for more information</td>
<td></td>
</tr>
<tr>
<td>Lifetime maximum benefit</td>
<td>None</td>
</tr>
</tbody>
</table>

**Prescription drug (administered by Express Scripts)**

- **Prescription drug plan year deductible** (separate from and in addition to your medical plan deductible): No separate deductible
- **FDA-approved women’s contraception and generic and OTC bowel prep medications for colonoscopy**: 100%; no deductible or copay
- **Certain generic preventive prescriptions**: 100%; no deductible or copay

**Retail Pharmacy Network (up to a 30-day supply)**

*Note: Prescriptions purchased at an out-of-network pharmacy are covered only if a network pharmacy is not available.*

<table>
<thead>
<tr>
<th>Generic – non-preventive</th>
<th>After medical deductible is met, 100% after $5 copay (deductible and copay waived for certain generic preventive)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brand name (preferred)</td>
<td>After medical deductible is met, 100% after $25 copay</td>
</tr>
<tr>
<td>Brand name (non-preferred)</td>
<td>After medical deductible is met, 100% after $45 copay</td>
</tr>
<tr>
<td>Brand name (when generic is available)</td>
<td>After medical deductible is met, brand name copay plus the difference in cost between the brand name and the equivalent generic</td>
</tr>
</tbody>
</table>

**Home Delivery Program (up to a 90-day supply)**

<table>
<thead>
<tr>
<th>Generic – non-preventive</th>
<th>After medical deductible is met, 100% after $12 copay (deductible and copay waived for certain generic preventive)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brand name (preferred)</td>
<td>After medical deductible is met, 100% after $65 copay</td>
</tr>
<tr>
<td>Brand name (non-preferred)</td>
<td>After medical deductible is met, 100% after $125 copay</td>
</tr>
</tbody>
</table>
### For the following covered treatments and services, the Health+Savings PPO Option pays

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Coverage Details</th>
<th>Copay Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Doctor visits (other than preventive care)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care office visit</td>
<td>100% after $20 copay, after deductible(^f) Note: surgery is covered at 80% after deductible</td>
<td>60%</td>
</tr>
<tr>
<td>Specialist office visit</td>
<td>100% after $30 copay, after deductible(^f) Note: surgery is covered at 80% after deductible</td>
<td>60%</td>
</tr>
<tr>
<td>Behavioral health office visit</td>
<td>100% after $20 copay, after deductible(^f)</td>
<td>60%</td>
</tr>
<tr>
<td>Maternity services</td>
<td>100%, no deductible/copay (prenatal): 80% after deductible (post-natal)</td>
<td>60%</td>
</tr>
<tr>
<td>Lab and X-ray</td>
<td>80%(^f)</td>
<td>60%(^f)</td>
</tr>
<tr>
<td><strong>Preventive care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine physicals</td>
<td>100%, no copay, no deductible</td>
<td>60%</td>
</tr>
<tr>
<td>Annual well-woman exams</td>
<td>100%, no copay, no deductible</td>
<td>60%</td>
</tr>
<tr>
<td>Mammograms (routine)</td>
<td>100%, no copay, no deductible</td>
<td>60%</td>
</tr>
<tr>
<td>Gestational diabetes screening</td>
<td>100%, no copay, no deductible</td>
<td>60%</td>
</tr>
<tr>
<td>Prostate Specific Antigen (PSA) tests (routine)</td>
<td>100%, no copay, no deductible</td>
<td>60%</td>
</tr>
<tr>
<td>Colorectal screenings (routine)</td>
<td>100%, no copay, no deductible</td>
<td>60%</td>
</tr>
<tr>
<td>Well-child care (routine)</td>
<td>100%, no copay, no deductible</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Emergency services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency room (applies to facility charges only)(^i)</td>
<td>80% after $150 copay, after deductible</td>
<td>80% after $150 copay, after deductible</td>
</tr>
<tr>
<td>Ambulance</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Urgent care facility (applies to facility charges only)</td>
<td>100% after $30 copay, after deductible</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Outpatient services (services provided other than in a doctor’s office)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient surgery facility</td>
<td>80%</td>
<td>60%(^g)</td>
</tr>
<tr>
<td>Hospital outpatient services</td>
<td>80%</td>
<td>60%(^g)</td>
</tr>
<tr>
<td>Doctor/surgeon and related professional fees</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Service</td>
<td>Inpatient hospital services&lt;sup&gt;e&lt;/sup&gt;</td>
<td>Alternatives to inpatient hospital care&lt;sup&gt;e&lt;/sup&gt;</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>----------------------------------------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td>Behavioral health outpatient treatment (other than office visit)</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Lab</td>
<td>80%&lt;sup&gt;m&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>X-ray</td>
<td>80%&lt;sup&gt;m&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>Radiation therapy/chemotherapy</td>
<td>80%&lt;sup&gt;m&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>Inpatient hospital services&lt;sup&gt;e&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Room and board (semi-private room)</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Inpatient behavioral health stay, including residential treatment and partial hospitalization</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Doctor hospital visits</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Lab and X-ray</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Anesthesia</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Alternatives to inpatient hospital care&lt;sup&gt;e&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled nursing facility (up to 60 days/plan year)&lt;sup&gt;k&lt;/sup&gt;</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Home health care (limited to 120 visits/plan year)&lt;sup&gt;k&lt;/sup&gt;</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Hospice care</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Outpatient private duty nursing (up to 70 shifts/plan year)&lt;sup&gt;k&lt;/sup&gt;</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Other covered services&lt;sup&gt;e&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractic care (including lab/X-ray provided by a chiropractor); up to 20 visits/plan year&lt;sup&gt;k&lt;/sup&gt;</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Contraceptive administration (includes coverage for all contraceptive devices including the associated office visit)</td>
<td>100%, no deductible</td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment, orthotics, consumable medical supplies&lt;sup&gt;l&lt;/sup&gt;</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Prosthetic appliances (including external breast prostheses, wigs)</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Breast pumps and supplies (electronic breast pump limited to one per 36 months)</td>
<td>100%, no deductible</td>
<td></td>
</tr>
<tr>
<td>Lactation consultation</td>
<td>100%, no deductible</td>
<td></td>
</tr>
<tr>
<td>Infertility treatment (limited to diagnostic testing and corrective surgery)</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Infertility treatment through Progyny (including IVF, IUI and fertility preservation)</td>
<td>80%, limited to 3 &quot;Smart Cycles&quot; through Progyny network</td>
<td></td>
</tr>
<tr>
<td>Sterilization (female tubal ligation)</td>
<td>100% covered, no deductible/copay; includes ancillary services</td>
<td></td>
</tr>
<tr>
<td>Sterilization (male vasectomy)</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Outpatient rehabilitation (physical/speech/occupational therapy) and cardiac rehabilitation (A combined maximum of 60 visits per plan year applies to physical,</td>
<td>80%</td>
<td></td>
</tr>
</tbody>
</table>
Benefits are subject to recognized charge limits. You may need to pay the full amount and submit a claim for reimbursement to Aetna. Covered network expenses do not apply to the plan year out-of-network deductible or out-of-pocket maximum, and covered out-of-network expenses do not apply to the plan year network deductible or out-of-pocket maximum. Precertification penalties and amounts above recognized charges do not apply to the plan year deductible or out-of-pocket maximum. Unless otherwise noted, benefits paid at 80% or 60% are paid after the plan year deductible has been met. The office visit copay covers lab and X-ray charges performed in a doctor's office and billed as part of the visit. When these services are not performed at the time of the office visit, performed at another network facility or performed by a network entity other than the doctor's office, you must first meet your deductible and then the expense, if covered, would be paid at 80%. For facility charges and non-emergency admissions, reimbursement is limited to 60%, with a maximum allowed amount of 1.5 times the Medicare Fee Schedule for that area. For additional information about covered preventive care benefits, see the Preventive care section of this SPD or contact Aetna Member Services at 1-866-436-2606. Non-facility charges for emergency services incurred in the emergency room are paid at applicable network levels. Precertification required; benefits may be reduced or denied if precertification not obtained. The visit/plan year limit applies to total of both network and out-of-network visits. Deductible waived for diabetic insulin pumps and tubing. The following in-network services require precertification: cardiac imaging (including non-urgent outpatient diagnostic heart catheterizations and echo stress tests); cardiac rhythm implantable devices; sleep studies; high-tech radiology (e.g., MRI/MRA, CT scans, PET scans and nuclear imaging). Speech therapy is subject to medical review if one of the following circumstances exist: developmentally delayed due to an injury or sickness (other than a functional nervous disorder); diagnosis of chronic otitis media; or a congenital defect for which corrective surgery has been performed.

<table>
<thead>
<tr>
<th>Service Description</th>
<th>80%</th>
<th>60%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage for autism spectrum disorders, including physical therapy/occupational</td>
<td></td>
<td></td>
</tr>
<tr>
<td>therapy/speech therapy (PT/OT/ST visit limit applies)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Applied Behavioral Analysis (ABA) (requires precertification)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TMJ (medical treatment for TMJ covered; TMJ-related dental services and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>orthodontic appliances not covered)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>80%</td>
<td>60%</td>
</tr>
</tbody>
</table>

Publication date: April 2020
How the PPO Options work

The PPO Options are network-based options that utilize the Aetna Choice POS II network. BP offers three PPO Options: HealthPlus, Standard and Health+Savings.

The Health+Savings Option is a high deductible health plan (HDHP) that offers comprehensive medical coverage when you need it. This plan costs less per paycheck than for other medical options in exchange for having a higher deductible amount. You must meet the deductible before the Option pays any benefits, other than certain preventive care.

When you enroll in the Health+Savings Option, you’re automatically enrolled in a Health Savings Account (HSA), a tax-preferred account that you will own and which will help you save for future health expenses. See Health Savings Account (HSA) for more details about how HSAs work.

In the HealthPlus and Health+Savings PPO Options, you receive lower-cost health care services once you meet the plan’s deductible. However, in order to be eligible for the HealthPlus and Health+Savings Options, you and your covered spouse/domestic partner are each required to earn a minimum of 1,000 wellness points by completing various wellness activities associated with the BP Wellness Program.* To learn more about the available activities in the BP Wellness Program and their associated points, visit the Wellness section of LifeBenefits.

The PPO Options give you a choice when it comes to getting medical care. You can go to:

- **Any network provider.** That is, any licensed doctor, nurse, therapist, hospital, lab or other health care facility that has been designated as part of its network — and receive a higher level of benefit for a covered service. It is your responsibility to confirm that a provider or facility is part of the Aetna Choice POS II network.
  * If a provider practices at multiple locations, he/she may not be considered an in-network provider at each location. Confirm with your provider that he/she is in the network at the location you intend to visit before receiving care. If you use a network provider for an expense that is not covered under a PPO Option, the provider may charge you for the provider’s undiscounted rates unless you have signed a waiver prior to receiving the treatment or service(s) agreeing to pay for non-covered services.

- **Any out-of-network provider.** That is, any licensed doctor, nurse, therapist, hospital, lab or other health care facility that has not been designated as part of its network — and receive a lower level of benefit. (Note: A provider will still be considered out-of-network if the provider is an Aetna NAP provider but not in the Aetna Choice POS II network. See National Advantage Program (NAP) for more information.)

Whether you see a network provider or an out-of-network provider, each PPO Option covers a broad range of medical services and supplies once you meet your deductible, as well as preventive care services that don’t require you to meet your deductible. Each PPO Option also includes a Prescription Drug Program, administered by Express Scripts, Inc. (ESI). In the Health+Savings PPO Option, you must meet your medical plan deductible before you receive plan coverage for all formulary brand preventive prescriptions and all non-preventive prescriptions.

* New hires or newly eligible employees in their initial year of coverage under HealthPlus or Health+Savings are not required to accumulate 1,000 wellness points until the following calendar year.
Primary doctors

Under the HealthPlus and Health+Savings PPO Options, you will pay lower office visit copays for network providers who are considered primary doctors than for those who are considered specialists. Under the Health+Savings PPO Option, you must meet your medical plan deductible before copays are applicable.

Primary doctors are:

- Family practitioners.
- General practitioners.
- Internists.
- Pediatricians.
- Obstetricians/Gynecologists (OB/GYNs).

When you enroll in a PPO, you are not required to designate a primary doctor or have your primary doctor's referral to see a specialist.

How to choose a network provider

To learn more about the providers who participate in the Aetna Choice POS II Network, access BP's custom DocFind website or call Aetna Member Services at 1-866-436-2606.

Keep in mind that network providers occasionally change, so you will want to make sure the provider you choose is still in the network and at the location you would like to visit before you make an appointment. For the most up-to-date information, including whether a provider is accepting new patients, call the provider.

If Aetna determines in a particular case that there is no viable Aetna Choice POS II network provider option available, Aetna may treat a non-network provider as if it were an in-network provider until a viable Choice POS II network provider becomes available. In order for this special treatment to apply, the alleged provider deficiency must be raised with Aetna Member Services in advance of treatment and Aetna must agree with the special treatment.

If your dependents live away from home

To determine whether your dependents will be able to access the PPO network providers, you must call the Aetna Member Services Center. If the representative determines that your dependent(s) do not have access to PPO Option network providers, you may enroll yourself and all your eligible dependents in the OOA Option by calling the BP Benefits Center. You must contact the BP Benefits Center each annual enrollment period to elect this option or another OOA option if your dependent continues to live away from home.

If you elect a PPO Option and your covered dependent seeks care from out-of-network providers, those expenses will be subject to the PPO out-of-network deductible and the lower out-of-network benefit level.
Transition care benefits

If you are receiving treatment for a pregnancy or undergoing an active course of treatment from an out-of-network provider (either before coverage begins or if your provider decides to leave the network during the plan year), you may be eligible for transition care benefits. Transition care benefits are paid at the higher, network level of benefits for a limited period of time so you can complete an active course of treatment. At the end of that time, you will have the choice of seeing a network provider and receiving the higher, network level of benefits or continuing to see your out-of-network provider at the lower, out-of-network level of benefits.

If any of the following circumstances exist, you may qualify for transition coverage:

- Patient is confined to an inpatient facility.
- Patient has completed 27 weeks of pregnancy and has begun receiving prenatal care.
- Patient is in a post-operative period.
- Patient has a chronic, degenerative or disabling disease or condition.
- Patient is terminally ill and anticipated to have less than twelve months to live.
- Patient is a candidate for, or recipient of, an organ or bone marrow transplant.
- Patient is in the process of staged surgery (i.e., cleft palate repair).
- Patient is in an active course of treatment with a behavioral health provider (one visit within 30 days prior to coverage).

If you think you may qualify for transition coverage benefits, you should call Aetna Member Services to request a review of your situation. Once a review is completed, you will be notified in writing whether or not your request for coverage under transition coverage provisions is approved.

Publication date: April 2020
Health Savings Account (HSA)

The Health Savings Account (HSA) is a bank account that works with the Health+Savings medical option to help you pay for your health care expenses, including any expenses before you meet your Health+Savings deductible. You, and not BP, own that account.

Administered by PayFlex (now part of Aetna), it works like the Health Care Flexible Spending Account (HCFSA) in that you can use tax-free dollars to cover the cost of eligible health care expenses. But unlike the HCFSA, unused funds at year end are kept by you, BP also may make contributions to the account, and you can invest your HSA money in investment funds to potentially grow your savings (assuming your balance is high enough). The earnings you make on your investment are tax-free. (Note: Federal regulations do not allow you or your spouse to contribute to both an HSA and BP’s HCFSA.)

You can use the money in your HSA to pay for eligible health care expenses, or you can choose to save your funds for the future. You never forfeit your contributions to the HSA. Unused money will carry over from one year to the next, helping you save for future expenses. You can keep any remaining money you have saved in your HSA year after year, even if you leave BP. So you can contribute tax-free, the money can grow tax-free and you can use the balance for eligible expenses tax-free — a triple tax advantage!

Who can contribute to an HSA

You are eligible for an HSA if you are:

- Covered by a high deductible health plan, such as the Health+Savings Option.
- Not covered under another health plan (including a plan your spouse/domestic partner may have, unless your spouse’s plan is a high deductible health plan).
- Not enrolled in a Health Care Flexible Spending Account (including an account your spouse may have with BP or a separate employer).*
- Not enrolled in Medicare.
- Not eligible to be claimed as a dependent on another person’s tax return.

* If you have participated in a Health Care Flexible Spending Account during any portion of the BP plan year, you may not switch to the Health+Savings medical option and/or contribute to the Health Savings Account during the remainder of that plan year.

How to enroll

When you enroll in the Health+Savings Option, Aetna will send your information to PayFlex, and PayFlex will set up your account. After you pass a customer identification process, you will receive a mailing with your PayFlex Card® (your HSA debit card) as confirmation that your HSA has been established. In some cases, PayFlex may request that you verify personal information (e.g., Social Security number, home address, date of birth) before opening your HSA.

To access your account information there are three options.

- Log on to the Aetna website at www.aetna.com using your Aetna login information. From here you will have Single Sign On access to your PayFlex accounts.
- You can log in directly at www.payflex.com.
- Using your Mobile App to sign in directly to PayFlex.

Your HSA Information will be accessible through any of these three options.
See the HSA Quick Reference Guide for tips on how to manage your account online.

You can start, stop and change your contribution amount at any time, as long as you don’t exceed the annual maximum. While employed at BP, you must be enrolled in the Health+Savings Option to continue contributing to your HSA.

Note that if you dis-enroll from the Health+Savings Option during a calendar year, this could have a retroactive effect on the tax-free nature of some of your HSA contributions — either made by BP or you. You should consult a tax advisor for any tax issues related to the HSA.
**BP’s contributions to your HSA**

As part of the wellbeing program mentioned earlier, if you complete and return a physician certification form showing that your physician certifies that three out of the five of your metabolic syndrome screening results are within the normal ranges, BP, through the plan, will contribute an additional $1,000 to your HSA. If you cannot meet three out of the five metabolic results, there is an alternative method for you to obtain the $1,000 contribution to your HSA. Your physician can document on your form that those areas have been discussed and are being managed, which would still qualify you for the additional plan contribution. **Your physician must check that box** in order for you to qualify for the $1,000.

If your spouse/domestic partner also completes a physician certification form and his/her physician certifies that three out of the five metabolic syndrome results are within normal ranges, he or she will also earn $1,000, for a family total of $2,000.

To qualify for the additional HSA contributions, send your family’s physician certification forms to StayWell, BP’s wellbeing program administrator.

If there is a medical reason why the above processes to obtain the $1,000 plan contribution are insufficient for you, additional reasonable alternatives will be provided to you. Please contact StayWell to discuss those alternatives, if necessary. Note that simple unavailability later in the year, either via travel or business reasons, will not be a reason to request an alternative process.

**Your contributions to your HSA**

You can contribute to your HSA through automatic payroll deductions at BP, or you can mail a deposit coupon and payment directly to PayFlex, our HSA administrator. Use the HSA Contribution Coupon to deposit new funds via check.

For the 2020 calendar year, the IRS allows up to $3,550 to be contributed for employee-only coverage and up to $7,100 for family coverage. Please note that any contributions made to your HSA by the plan for completing and returning the physician certification form count toward the maximum amount which can be contributed to your HSA during the year.

During annual enrollment, you decide how much to contribute to your HSA on a before-tax basis, up to the IRS limits, which can change annually. Your contributions will be deducted from your paychecks throughout the year.

If you’re over age 55, you’re also eligible to make an additional $1,000 catch-up contribution per year to your HSA. If your spouse is over age 55, he/she may also make an additional $1,000 contribution to an HSA, but he/she may not make that contribution to your HSA.

You should keep track of your contributions to ensure you don’t exceed these limits. If you do, the excess will be taxed as ordinary income and is subject to a penalty. To avoid penalties, make sure to contribute less than the legal limits, or withdraw any excess contributions and interest on those contributions before the tax-filing deadline. See the HSA Quick Reference Guide for information on how to keep track of your contributions online.

**Investment of your HSA**

In addition to new contributions, your HSA account can grow through any investment income on your account.

Once your balance reaches $1,000, you have the option to open an investment account for your HSA. Your investment options include Asset Allocation, Fixed Income, and Equity Funds. Each fund has a different investment goal and offers a different level of investment risk and potential return. Accounts for domestic partners and retirees will be charged small monthly fees. For more information, go to www.payflex.com. See the HSA Quick Reference Guide for tips on how to choose your investments online.

Any interest or investment earnings on your HSA account are tax-free.
Spending your HSA

Once you have enrolled, you will receive a mailing with your PayFlex Card® that makes it easy to access your HSA money. Just swipe the card at the point of service for eligible health care expenses, and the funds will be taken directly from your account. Be sure to select “credit” rather than “debit” when you use your card, because the card does not have a separate PIN.

You can use your card to pay for health care products and services, including doctor and dentist visits, hospital stays, prescriptions and hearing and vision care. You may also use your card at some discount and grocery stores, as long as they have a system that can process a health care card. Note: The merchants and providers must accept MasterCard® in order for your card to work.

If you don’t make a payment at the point you receive the service, you should wait for the claim to be processed through the claim system. The doctor’s office or other provider may send you a bill requesting payment for the difference between the billed charges and the amount covered by your health plan. You can write your HSA debit card number on the doctor’s bill and submit it as payment, or you can pay for the expense out of pocket and reimburse yourself later. You should keep your receipts for all expenses.

You can use your debit card for health care bills that have a “Patient Balance Due” if your account is active, you incurred the expense in the current plan year and you have enough funds in your account. To do this, write your debit card number on the bill from the provider in the space requesting credit card information. Make sure you keep your original statement.

To file your claim online, go to the PayFlex site, My Dashboard, via the PayFlex website at www.payflex.com. You can also complete a paper claim form and fax your claim to 1-888-238-3539 or 1-888-AET-FLEX or mail it to the following address:

PayFlex Systems USA, Inc.
P.O. Box 4000
Richmond, KY 40476-4000

You will have access to your account online through My Dashboard on PayFlex’s website at www.payflex.com. When you log in, you can track your expenses, claims and account balance, in addition to submitting claims online. See the HSA Quick Reference Guide for details on how to manage your account online.

Remember to keep all receipts and documentation for future reference or to answer any questions that may arise.

Keep in mind that you can only use your debit card up to the amount already in your HSA, even though you expect to contribute more in the future. If you do not have enough money in your HSA to pay for an eligible medical expense, you’ll need to pay for the expense by some other means. Once the money is in your HSA, you can reimburse yourself for the amount you personally paid for the expense.

Eligible expenses

You can use your HSA for eligible health care expenses for you, your spouse, or your dependents (even if they’re not covered under the Health+Savings Option), as defined by IRS Code Section 213(d).

According to current regulations, the expense must be primarily to alleviate or prevent a physical or mental defect or illness. Examples include prescriptions, doctors’ office visits, and vision and dental care. You can also use your HSA for some health care expenses not covered by your health plan, such as glasses or contact lenses, but such expenses will not count toward your deductible. For a complete list of eligible expenses, go to www.irs.gov or www.payflex.com.

Examples of expenses that do not qualify include most cosmetic surgery, health club dues, maternity clothing, and toiletries. In addition, insurance premiums are not an eligible medical expense for your HSA, though there are exceptions for long-term care coverage premiums and some types of retiree health premiums.

If you use your HSA for expenses other than eligible health care expenses, you automatically subject yourself to IRS penalties. However, the requirement to spend your HSA on eligible health care expenses no longer applies once you turn age 65 or if you become permanently disabled or die.

By law, PayFlex cannot require you to submit documentation backing up the reason for your HSA withdrawal. So it is very important that you keep your receipts as your reimbursements could be subject to a review by the IRS.
If you change medical plans or leave BP

Your HSA is “portable” — it belongs to you. This means that even if you change health plans, take a new job or retire, you can still use the money in the account to pay for eligible expenses. Remember, though, that you must be enrolled in a high deductible medical plan, not be claimed as a tax dependent by someone else and not be enrolled in Medicare to make contributions to your HSA.

If you have an HSA in one year and choose a BP medical option that doesn’t allow for HSA contributions in a future year, you can still use any balance remaining in your HSA for health care expenses. You won’t be able to make new contributions or receive any BP contributions to your HSA while you aren’t enrolled in an eligible high deductible health plan like the Health+Savings Option. As well, this may render some of the contributions to your HSA taxable. You should consult a tax advisor before taking this step.

If you leave BP, any remaining money in your HSA account is still yours. You can transfer it to another HSA account or keep it with PayFlex, paying any required administrative fees.

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What the PPO Options pay

**Network providers**

Network providers have agreed to offer covered services at contracted rates. This means that the dollar amount you pay for your share of covered expenses is generally lower when you use a network provider. When you see a network provider:

- Covered office visit expenses are covered at:
  - 100% after you pay a copay, with no deductible, by the HealthPlus PPO Option.
  - 80% after the deductible by the Standard PPO Option.
- Under both PPO Options, in-network preventive care is covered at 100% with no copay and no deductible.
- Emergency room facility charges are paid at 100% after a copay, with no deductible, by both PPO Options.
- For both PPO Options, most other covered in-network services are paid at 80% of the contracted rate for other covered expenses after you meet the individual or family plan year deductible, and you pay the remaining portion of the charges (the coinsurance).
- Once you meet the plan year network out-of-pocket maximum, the PPO Options pay 100% of the contracted rate for covered expenses for the rest of the plan year. **Note:** Under the HealthPlus PPO, copays will still apply as they are not subject to the out-of-pocket maximum.

See the PPO Options (HealthPlus and Standard) summary chart for more information.

**Out-of-network providers**

If you see an out-of-network provider, the PPO Options generally pay 60% of recognized charges for all covered expenses (except chiropractic care and ambulance services, which are covered at 80% of recognized charges) after you meet the individual or family plan year deductible. You pay the remaining percentage (the coinsurance) and any costs above recognized charge limits. (See Recognized charge limits.) **Note:** Eligible claims incurred in an emergency room facility will be covered at the applicable in-network benefit level.

Once you meet the plan year out-of-network out-of-pocket maximum, the PPO Options pay 100% of recognized charges for most covered expenses for the rest of the plan year. **Note:** Emergency room copays will still apply as they are not subject to the out-of-pocket maximum.
Deductibles

You pay the first portion of contracted or recognized charges for most covered expenses incurred by you and each covered dependent during the plan year before the plan begins paying benefits.

Each PPO Option has separate network and out-of-network medical coverage plan year deductibles. These deductibles are exclusive of each other. This means your covered network expenses count only toward meeting the network medical deductible. Network expenses do not count toward meeting the out-of-network medical deductible.

Similarly, covered out-of-network expenses count toward meeting the out-of-network medical coverage deductible, but do not count toward meeting the network medical deductible.

In addition, the Health+Savings PPO Option has two separate deductibles for network expenses, and two more for out-of-network expenses. Under the Health+Savings option, the lower deductibles apply only if you have You Only coverage. The higher deductibles apply if you have You + Spouse, You + Child(ren) or You + Family coverage, even if only one family member incurs medical expenses during the year. Under the Health+Savings option, the lower You Only deductibles would not apply to any covered individual in your family if you have You + Spouse, You + Child(ren) or You + Family coverage.

If you participate in the HealthPlus and Standard PPO options, any medical expense that counts toward an individual's deductible automatically counts toward the family deductible. This means that once you meet the family network or out-of-network deductible for the plan year, no other covered family member is required to meet his/her individual network or out-of-network medical deductible (as applicable) for that plan year before benefits are paid.

If you participate in the HealthPlus PPO Option, there is no separate plan year deductible for prescription drugs. Prescription drug expenses do not apply to the medical plan deductible.

If you participate in the Standard PPO Option, you pay a separate plan year deductible under the Prescription Drug Program. Medical expenses do not apply to the deductibles under the Prescription Drug Program and vice versa.

If you participate in the Health+Savings PPO Option, there is no separate plan year deductible for prescription drugs. Prescription drug expenses do apply to the medical plan deductible. You must meet the plan year deductible before the plan starts to pay most expenses, including those for formulary brand preventive and non-preventive prescription drugs.

Expenses excluded from the deductibles

The following expenses do not apply to the medical coverage plan year deductibles under the various PPO Options as indicated:

<table>
<thead>
<tr>
<th>Under the HealthPlus and Standard PPO Options</th>
<th>Under the Health+Savings PPO Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visit copays.</td>
<td>Expenses for diabetic insulin pumps and tubing.</td>
</tr>
<tr>
<td>Emergency room/urgent care facility copays.</td>
<td>Penalties for noncompliance with precertification provisions.</td>
</tr>
<tr>
<td>Prescription drug expenses.</td>
<td>Expenses not covered by the PPO Option.</td>
</tr>
<tr>
<td>Expenses for diabetic insulin pumps and tubing.</td>
<td>Charges above recognized charge limits.</td>
</tr>
<tr>
<td>Penalties for noncompliance with precertification provisions.</td>
<td></td>
</tr>
<tr>
<td>Expenses not covered by the PPO Option.</td>
<td></td>
</tr>
<tr>
<td>Charges above recognized charge limits.</td>
<td></td>
</tr>
</tbody>
</table>

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# Copays/coinsurance

## Network providers

A “copay” is a fixed dollar amount you pay in lieu of a deductible and coinsurance at the time you receive medical services. When you see a network provider, copays apply to:

<table>
<thead>
<tr>
<th>Office visits for non-preventive care under the HealthPlus and Health+Savings PPO Options</th>
<th>Note: Under the Health+Savings PPO Option only, you must satisfy the applicable individual or family deductible first before the office visit copay will apply for these services. (The individual deductible applies if you have You Only coverage. The family deductible applies if you have You + Spouse, You + Child(ren) or You + Family coverage.) The office visit copay includes:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I The doctor office visit.</td>
</tr>
<tr>
<td></td>
<td>I Diagnostic laboratory tests or X-rays performed in a doctor’s office and billed as part of the visit.</td>
</tr>
<tr>
<td></td>
<td>I Injections administered in a doctor’s office as part of the visit (including allergy injections).</td>
</tr>
<tr>
<td>The office visit copay does not apply to:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I Office visits if a surgical procedure as defined by Aetna is performed as part of the visit (for example, if a mole is removed or a broken bone is set during the office visit).</td>
</tr>
<tr>
<td></td>
<td>I Prenatal maternity-related office visits (except for the first office visit to confirm the pregnancy). These visits are included in the delivery charge. However, post-natal maternity services are covered at 80% after the deductible.</td>
</tr>
<tr>
<td></td>
<td>I Routine and diagnostic laboratory tests or X-rays performed:</td>
</tr>
<tr>
<td></td>
<td>° In a doctor’s office, but not at the time of the visit.</td>
</tr>
<tr>
<td></td>
<td>° In a facility other than the doctor’s office.</td>
</tr>
<tr>
<td></td>
<td>° By an entity other than the doctor’s office.</td>
</tr>
<tr>
<td></td>
<td>(Ask your doctor whether the lab facilities he/she uses are in the network.)</td>
</tr>
<tr>
<td></td>
<td>I Chiropractic visits.</td>
</tr>
<tr>
<td>Emergency room facility charges</td>
<td>Under the HealthPlus and Standard PPO Options, both network and out-of-network emergency room facility charges are covered at 80% after a copay, with no deductible. Under the Health+Savings PPO Option, both network and out-of-network emergency room facility charges are covered at 80% after a copay, after the deductible.</td>
</tr>
<tr>
<td>Urgent care facility charges under the HealthPlus and Health+Savings PPO Options</td>
<td>Under the HealthPlus PPO Option, network urgent care facility charges are covered at 100% after a copay, with no deductible. Under the Health+Savings PPO Option, network urgent care facility charges are covered at 100% after a copay, and after the deductible is met.</td>
</tr>
</tbody>
</table>

When you use a network provider, eligible preventive care expenses are covered at 100% with no copay and no deductible. See Preventive care for details.

Most other covered services received from network providers (including non-preventive care office visits and urgent care facility charges under the Standard PPO Option) are paid at 80% of the contracted rate after you meet the individual or family plan year deductible, and you pay the remaining portion of the charges (the coinsurance).
Out-of-network providers

When you see an out-of-network provider for a covered expense, you typically pay a larger share of the cost. Most covered services received from out-of-network providers are paid at 60% of recognized charges after you meet the individual or family plan year deductible, and you pay the remaining portion of the charges (the coinsurance). You are responsible for paying any charges above the recognized charge limits.

**Note:** Eligible claims incurred in an emergency room facility will be covered at the applicable in-network benefit level.

You are also responsible for filing claim forms when you see out-of-network providers. (See How to file a claim.)
Out-of-pocket maximums

You pay a certain amount of covered expenses each plan year before the PPO Options begin paying 100% of contracted or recognized charges for most covered services. This is your medical coverage plan year out-of-pocket maximum.

Each BP PPO Option has separate network and out-of-network medical coverage plan year out-of-pocket maximums. These maximums are exclusive of each other. This means that covered network expenses — including the network deductible — count only toward meeting the network medical out-of-pocket maximum. Network expenses do not count toward meeting the out-of-network medical coverage out-of-pocket maximum. Similarly, covered out-of-network expenses — including the out-of-network deductible — count toward meeting the out-of-network medical out-of-pocket maximum, but do not count toward meeting the network medical out-of-pocket maximum.

In addition, each Health+Savings PPO Option has two separate out-of-pocket maximum amounts for network expenses, and two more for out-of-network expenses. Under the Health+Savings option, the lower out-of-pocket maximum amounts apply only if you have You Only coverage. The higher out-of-pocket maximum amounts apply if you have You + Spouse, You + Child(ren) or You + Family coverage, even if only one family member incurs medical expenses during the year. Under the Health+Savings options, the lower You Only out-of-pocket maximum amounts would not apply to any covered individual in your family if you have You + Spouse, You + Child(ren) or You + Family coverage.

Under the HealthPlus and Standard PPO options, any medical expense that counts toward an individual’s out-of-pocket maximum automatically counts toward the family out-of-pocket maximum. For example, once you meet the family plan year network out-of-pocket maximum, no other covered family member is required to meet his/her individual network out-of-pocket maximum for that plan year before plan benefits are paid at 100%.

The expenses that apply to the out-of-pocket maximum vary depending on the option in which you are enrolled.

<table>
<thead>
<tr>
<th>If you are enrolled in this option...</th>
<th>The following expenses apply to the option’s medical out-of-pocket maximum...</th>
<th>The following expenses do not apply to the option’s medical out-of-pocket maximum and are payable by you even after the out-of-pocket maximum has been met...</th>
</tr>
</thead>
</table>
| HealthPlus PPO or Standard PPO Option | i Deductibles.  
i Coinsurance.  
i Office visit copays.  
i Emergency room/urgent care facility copays.  
i Expenses under the Prescription Drug Program. | i Charges above the recognized charge limits.  
i Penalties for noncompliance with precertification provisions.  
i Expenses not covered by the PPO Option. |
| Health+Savings PPO Option             | i Deductibles.  
i Coinsurance.  
i Office visit copays.  
i Emergency room/urgent care facility copays.  
i Expenses under the Prescription Drug Program. | i Charges above the recognized charge limits.  
i Penalties for noncompliance with precertification provisions.  
i Expenses not covered by the PPO Option. |

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The most up-to-date information is available online at http://hr.bpglobal.com/lifebenefits/Core.
Important plan provisions

The HealthPlus and Standard Options include special plan provisions. These important features include preventive care, recognized charge limits, precertification requirements and more. More information about each of these features is outlined in this section.

- Preventive care
- Emergency care
- Recognized charge limits
- Aetna's National Advantage Program (NAP)
- Transplant services
- Precertification requirements
- Coverage while traveling
Preventive care

The HealthPlus, Standard and Health+Savings Options provide coverage for the following preventive care services:

- Routine physicals (once per calendar year).
- Routine well-child care.
- Annual well-woman exams.
- Routine mammograms.
- Routine Prostate Specific Antigen (PSA) tests.
- Colorectal screenings.
- Routine hearing and vision chart exams (once per year).
- Preventive items or services with an “A” or “B” rating from the United States Preventive Services Task Force.
- Immunizations pursuant to the Advisory Committee on Immunization Practices (“ACIP”) recommendations.
- Preventive care and screenings that are provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”).
- Gestational diabetes screening.

Routine physicals are covered annually. All other screenings and tests are covered based on age, gender and medical history. Preventive care benefits are subject to age restrictions/limitations as determined under the claims administrator's guidelines. For additional information about benefits for covered preventive care services, contact the member services number on your medical ID card.

Routine physicals and well-child care include the following services:

- Doctor's exam.
- Immunizations.
- Vision chart and hearing screenings performed in a doctor's office.

Publication date: April 2020
Emergency care

No matter where you are, if you have a medical emergency — that is, a sudden and unexpected change in your physical or mental condition which, if not treated immediately, could result in a loss of life or limb, significant impairment of a bodily function or permanent dysfunction of a body part — you should go to the nearest emergency room to get the care you need.

Emergency medical condition

An emergency medical condition is a recent and severe medical condition, including (but not limited to) severe pain, which would lead a prudent person possessing an average knowledge of medicine and health, to believe that his or her condition, illness or injury is of such a nature that failure to get immediate medical care could result in:

- Placing your health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Examples of medical emergencies include heart attack, stroke, severe bleeding, serious burns and poisoning. It can sometimes be difficult to determine when urgent situations are true emergencies. If you need help determining whether your situation is a true emergency, you can consult a doctor who will be able to tell you what steps to take. You can also contact Aetna's 24-Hour NurseLine at 1-800-556-1555 to speak with a registered nurse.

Emergency services

“Emergency services” means, with respect to an emergency medical condition:

- A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient.

Under all PPO Options, you receive the higher, network level benefits for emergency services — even if you see an out-of-network provider. You do not need prior authorization for the treatment of an emergency medical condition, even if the services are provided by an out-of-network provider. Care provided by an out-of-network provider will be paid at no greater cost to you than if the services were performed by a network provider. You may receive a bill for the difference between the amount billed by the out-of-network provider and the amount paid by Aetna. If an out-of-network provider bills you directly for an amount beyond your cost share for the treatment of an emergency medical condition, you are not responsible for paying that amount. Please send the bill to the address listed on the back of your member ID card and Aetna will resolve any payment dispute with the provider over the amount. Make sure your member ID number is on the bill.

Under all OOA Options, your cost may be lower if you use Aetna's National Advantage Program (NAP). See Aetna's National Advantage Program (NAP) for more information. You do not need prior authorization for the treatment of an emergency medical condition.

Under both the PPO and OOA Options, if you are admitted to the hospital, you or someone on your behalf is required to certify your hospitalization within 48 hours (or two business days) of your emergency admission. Instructions on how to contact your claims administrator are provided on your medical option ID card.

Publication date: April 2020
Recognized charge limits

Benefits under the HealthPlus, Standard and Health+Savings Options are based on recognized charge limits.* These Options do not cover otherwise eligible expenses above recognized charge limits — they are your responsibility. For example, if you incur a $200 doctor expense, but only $180 of the charge is within recognized charge limits, only $180 will be considered an eligible expense under the plan.

Recognized charge limits do not apply to:

- Eligible expenses provided by a network provider under the PPO Options.
- Eligible charges from participating NAP hospitals and doctors under the OOA Options. NAP providers can be found by using BP's custom DocFind website. (See Quick links on the LifeBenefits site.)

The recognized charge for a service or supply is the lower of:

- What the provider bills or submits for that service or supply; and
- The charge the claims administrator determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made, billed or coded.
  - For non-facility charges:
    - PPO Options: The 85th percentile of the Prevailing Charge Rate, for the Geographic Area where the service is furnished.
    - OOA Options: Twice the 95th percentile of the Prevailing Charge Rate, for the Geographic Area where the service is furnished.
  - For facility charges:
    - PPO Options: 150% of the Medicare Fee Schedule for the Geographic Area where the service is furnished. Aetna will determine the usual charge level if a Medicare fee is not applicable.
    - OOA Options: Aetna uses the charge Aetna determines to be the usual charge level made for it in the Geographic Area where it was furnished.

As used above, Geographic Area and Prevailing Charge Rates are defined as follows:

- Geographic Area: This means an expense area grouping defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three-digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three-digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three-digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three-digit zip codes, the grouping never crosses state lines.
- Prevailing Charge Rates: These are rates reported by FAIR Health, a nonprofit company, in their database. FAIR Health reviews and, if necessary, changes these rates periodically. Aetna updates its systems with these changes within 180 days of receiving them from FAIR Health.

* You may be accustomed to seeing the term "reasonable and customary (R&C)," however Aetna uses the term "recognized charge." Recognized charge works in the same manner as reasonable and customary.

Publication date: April 2020
Aetna’s National Advantage Program (NAP)

The National Advantage Program (NAP) offers you access to Aetna-contracted rates for many hospital and doctor expenses that would otherwise be billed at the provider's normal rate. These include:

- For the PPO Options, eligible expenses provided by providers who are not Choice POS II network providers but who are Aetna NAP providers.
- For the OOA Options, eligible expenses provided by a provider who is an Aetna NAP provider.

You may save money with the NAP because the contracted rate is generally lower than the provider's normal charge. In addition, you should not be billed by the provider for the difference between the provider's normal charge and the contracted rate (i.e., no balance billing).

In order to qualify for Aetna's contracted NAP rates, the expense must be covered under the plan and the provider must submit the charge to process at the contracted amount before you pay for services. It is therefore important to remind the provider to submit the claim to Aetna directly before you pay.

The NAP network consists of many of Aetna's directly contracted hospitals, ancillary providers and doctors, as well as hospitals, ancillary providers and doctors accessed through vendor arrangements where Aetna does not have direct contractual arrangements. NAP-participating doctors include primary care doctors, obstetricians, gynecologists, radiologists, anesthesiologists, pathologists and other specialists.

NAP ancillary providers include:

- Acute rehabilitation facilities.
- Ambulatory surgical centers.
- Dialysis centers.
- Freestanding hospices.
- Infusion centers.
- Nursing care agencies.
- Skilled nursing facilities.
- Substance abuse facilities.

Certain claims are not eligible for a NAP discount, including:

- Small hospital or ancillary provider claims (currently below $151) that require manual intervention to obtain a discount.
- Claims involving Medicare or Coordination of benefits (COB) when the plan is not primary.
- Claims that have already been paid directly by the plan participant before the provider has submitted the claim to Aetna at the contracted rate.
- Claims that are not covered by the plan.

To learn more about the providers who participate in the NAP, contact Aetna Member Services or access BP’s custom DocFind website.

Publication date: April 2020
Transplant services

The Institutes of Excellence (IOE) network is the claims administrator's network for transplants and transplant-related services, including evaluation and follow-up care. This is a network of facilities that have demonstrated success at performing these highly specialized procedures.

For the PPO Options:

- The network level of benefits is paid for treatment received at a facility designated by the plan as an IOE for the type of transplant being performed. Each IOE facility has been selected to perform only certain types of transplants.
- Services obtained from a facility that is not designated as an IOE for the transplant being performed will be covered as out-of-network services and supplies, even if the facility is a network facility or IOE for other types of services.

The National Medical Excellence (NME) Program coordinates transplants and other specialized care that may not be available in your local area. If you are referred to a facility that is more than 100 miles from your home or you are required to remain within a certain radius of the treating facility that is farther than your home, the NME Program will help pay certain travel and lodging expenses for you and a companion.

If you or one of your covered family members could be a potential transplant candidate, contact the claims administrator to learn more about this program.

Out-of-country care

The National Medical Excellence (NME) Program coordinates care when an Aetna plan participant develops an urgent or acute illness when traveling outside of the United States. Coordination of some or all of the following may apply:

- Assessment of the urgent or acute care facility’s appropriateness for the required care;
- Transfer of the plan participant to a more appropriate acute care facility for stabilization;
- Transfer of the plan participant back to the United States; and
- Transfer of the plan participant to his/her home.
Precertification requirements

The decision to receive care is between you and your provider. If you do not precertify care when you are required to do so, your benefits will be reduced, or in some instances, not paid at all.

- If you are in a PPO Option and you use a network provider for covered medical care, the provider will take care of precertification for you.
- If you use a NAP provider, confirm that the provider is obtaining precertification on your behalf; otherwise contact Aetna directly for precertification. (The NAP Program is a discount program and does not guarantee precertification.)
- In all other instances, you are responsible for obtaining any required precertification.

Precertification is not required for expenses incurred while you are outside the United States.

It is a good idea to provide a family member, friend and/or your doctor with the precertification instructions. That way, they will be able to make the precertification call for you in case you cannot. Even if you rely on someone else to make the call for you, it is your responsibility to follow up to be sure the call was made. Precertification is required for the following services:

- **Inpatient admissions.** Non-emergency hospital (including hospitalization for mental health/substance abuse treatment), skilled nursing facility, and hospice admissions must be precertified by calling the claims administrator at the toll-free precertification number shown on your medical option ID card (at least 10 days in advance for Aetna).

- **Maternity stays.** Precertification of maternity care is not required. If your doctor recommends an extended stay beyond 48 hours for a vaginal delivery or 96 hours for a Caesarean section, the additional days must be precertified with the claims administrator within 48 hours (or two business days). If the mother is discharged before the baby is allowed to go home, the baby's extended stay must also be precertified.

- **Hospitalization due to a medical emergency.** You must certify by calling the claims administrator within 48 hours (or two business days) of your emergency admission.

- **Enhanced clinical review (NOTE: Applies only to Aetna PPO Options).** Certain services (listed below) are subject to enhanced clinical review through a separate independent company. This company uses medical specialists and diagnostic tools to review your doctor's request, applying national medical standards, with the initial review accomplished typically within 24 hours of the request. Your doctor should submit a request for clinical review for the following services:
  - Cardiac imaging, including non-urgent outpatient diagnostic catheterization and echo stress tests.
  - Cardiac rhythm implantable devices.
  - Sleep studies.
  - High-tech radiology, including MRI/MRA, CT scan, PET scan and nuclear imaging.
  - Outpatient interventional pain management.
  - Hip and knee replacements (inpatient and outpatient).

Responsibility for obtaining preauthorization of the above services is shared by the patient (or the parent plan participant, if a child), the referring physician and the facility rendering the service. In-network physicians have been engaged regarding this requirement and should be aware of the process.

- **Outpatient medical services.** Some outpatient procedures, including outpatient hospice care, home health care and private duty nursing and, in some circumstances, outpatient rehabilitation services require precertification. Additionally, if your doctor recommends an intensive outpatient program for psychiatric, eating disorder care and/or substance abuse care that is generally two or more hours per day, precertification is required. If your doctor recommends these outpatient services, you or your doctor should call the toll-free precertification number shown on your medical option ID card in advance to make sure the procedure is covered by the plan.

- **Partial hospitalization or a day program.** Outpatient care focused on psychiatric, eating disorder care and/or substance abuse care that is generally four or more hours per day and includes individual, group and family therapies must be precertified in advance by calling the claims administrator at the toll-free precertification number shown on your medical option ID card.

- **Electroconvulsive therapy treatment (ECT).** ECT is systematic use of electric shocks to produce convulsions. Care must be
precertified in advance by calling the claims administrator at the toll-free precertification number shown on your medical option ID card.

- **Psychological testing.** Psychological testing must be precertified by calling the claims administrator at the toll-free precertification number shown on your medical option ID card.

- **Biofeedback.** Biofeedback must be precertified by calling the claims administrator at the toll-free precertification number shown on your medical option ID card.

- **Outpatient detoxification.** Outpatient detoxification must be precertified by calling the claims administrator at the toll-free precertification number shown on your medical option ID card.

See Process for formal benefit claims and appeals if you receive an adverse benefit determination with respect to your request for precertification.

**Precertification penalties**

If you do not precertify care (including behavioral health care) when you are required to do so, your benefits will be reduced or, in some instances, not paid at all. Specifically, the following penalties will apply:

- **If you do not call to precertify.** All expenses related to care that has not been precertified are reviewed by the claims administrator. Benefits will not be paid for any expenses (including room and board) that were not medically necessary. A $300 penalty will be deducted from any benefits that are otherwise payable.

- **If you call to precertify, but the claims administrator determines that your admission, proposed treatment or expense is not medically necessary:** No benefits will be paid.

- **If you call to precertify additional hospital days beyond those initially precertified, but the claims administrator determines that those additional days are not medically necessary:** No benefits will be paid for the additional days.

Because PPO network providers are responsible for obtaining precertification of care for you, precertification penalties do not apply under the BP PPO Options for eligible care received from a network provider. However, if you are intending to receive an in-network level of benefits, it is your responsibility to confirm that each provider or facility you use is in the Aetna Choice POS II network. If a provider practices at multiple locations, he/she may not be considered an in-network provider at each location. Confirm with the provider that he/she is in the network at the location you intend to visit before receiving care.

Publication date: April 2020
Coverage while traveling

Eligible medical expenses incurred while traveling within or outside the U.S. are covered. Under all HealthPlus, Standard and Health+Savings Options, you may need to pay the provider in full and submit a claim for reimbursement from your claims administrator.

If you receive medical or behavioral health care or purchase prescription drugs within or outside the U.S. (other than from a PPO network provider, if you are enrolled in a PPO Option), submit a claim to the claims administrator for reimbursement.

If you purchase any prescription medication from a non-network pharmacy, submit a claim to Express Scripts, Inc. (ESI).
Alternatives to physician office visits

Walk-in clinic visits

Covered expenses include charges made by walk-in clinics for:

- Unscheduled, non-emergency illnesses and injuries;
- The administration of certain immunizations administered within the scope of the clinic’s license; and
- Individual screening and counseling services to aid you:
  - to stop the use of tobacco products;
  - in weight reduction due to obesity;
  - in stress management. The stress management counseling sessions will help you to identify the life events which cause you stress (the physical and mental strain on your body.) The counseling sessions will teach you techniques and changes in behavior to reduce the stress.

Unless specified above, not covered under this benefit are charges incurred for services and supplies furnished:

- In a group setting for screening and counseling services.

Important Notes:

- Deductibles, copays and/or coinsurance will apply where applicable. Refer to the applicable summary chart for more information.
- Not all services are available at all walk-in clinics. The types of services offered will vary by the provider and location of the clinic.
- For a complete description of the screening and counseling services provided on the use of tobacco products and to aid in weight reduction due to obesity, refer to the Preventive care and Expenses covered under the BP Medical Plan sections in this SPD for a description of these services. These services may also be obtained from your physician.

Walk-in clinic

Walk-in clinics are free-standing health care facilities. They are an alternative to a physician’s office visit for treatment of:

- Unscheduled, non-emergency illnesses and injuries;
- The administration of certain immunizations; and
- Individual screening and counseling services.

It is not an alternative for emergency room services or the ongoing care provided by a physician.

Neither:

- An emergency room; nor
- The outpatient department of a hospital;

shall be considered a walk-in clinic.

Publication date: April 2020
Teladoc

Teladoc provides you with 24/7 telephonic access to a national network of U.S. board-certified doctors when enrolled in an Aetna medical plan. There is no additional cost to you for this service. You can call a physician from anywhere — home, work or on the road. Teladoc doctors diagnose non-emergency medical problems, recommend treatment, and can even call in any necessary prescription(s) to your pharmacy.

Teladoc is intended to treat minor non-emergency conditions such as:

- Respiratory infections
- Ear infections
- Urinary tract infections
- Allergies
- Colds and flu
- Sore throat

How to use Teladoc

2. Complete your medical history.
3. Request a consultation and a U.S. board-certified physician will call you back within one hour.
4. Pay online. Teladoc visits generally cost less than a regular office visit, with costs not exceeding $40.

Teladoc is available beginning April 1, 2016 to those enrolled in an Aetna medical plan.

Publication date: April 2020
Enhanced Aetna Concierge

How the Enhanced Aetna Concierge program works

Effective April 1, 2019, the Enhanced Aetna Concierge program is available to participants in Aetna-administered medical plans. This program helps you manage your healthcare by putting you at the center of it all. Resources are available to help you 24/7.

This program puts a team of benefits specialists at one location at your disposal, waiting to resolve all of your healthcare coverage questions and concerns. When you call, you'll be assigned a personal concierge as a single point of contact until your situation is resolved. Your concierge can call upon other team members as needed — doctors, nurses, pharmacists, dietitians, behavioral health specialists, social workers, well-being specialists, network provider specialists and more — to consult with you about your coverage.

The BP Enhanced Aetna Concierge team can do many things for you:

- Schedule appointments with your doctor.
- Coordinate care approvals for an upcoming surgery or procedure.
- Help set coverage goals that are right for you.
- Work with you to help resolve claim inquiries or billing issues.
- Check in with you to see how you're doing, both routinely when convenient and urgently if needed.
- Connect you to healthcare resources in your community.

How to reach Enhanced Aetna Concierge

You can call 1-866-436-2606 at any time. Concierge specialists are available 8:00 am to 8:00 pm Monday-Friday, and 8:00 am to 4:30 pm Saturday, Central time. Additional support is available 24/7/365.

Publication date: April 2020
Prescription drug coverage

The medical plans all offer prescription drug coverage. Under the HealthPlus, Standard and Health+Savings Options, the Prescription Drug Program is administered by Express Scripts (ESI).

In general, the program offers prescription drug benefits two ways:

- **For short-term prescriptions**, you must fill your prescription at any Express Scripts network retail pharmacy, unless one is not available in the area.
- **For longer-term maintenance prescriptions**, you must use the home delivery service.

When you participate in either option, you will receive a separate ESI prescription drug ID card. Each time you fill a prescription at an ESI network retail pharmacy, simply show your ID card so the pharmacist knows you are covered under the program.

- If you are a participant in the HealthPlus Option, there is no separate prescription drug deductible. You only pay your applicable prescription drug copay.
- If you are a participant in the Standard Option, you must meet the separate prescription drug deductible before the plan pays a benefit. Once you meet the separate prescription drug deductible, you will pay a copay for generic drugs, or the applicable coinsurance for preferred or non-preferred brand name drugs.
- If you are a participant in the Health+Savings Option, there is no separate prescription drug deductible. You pay your applicable prescription drug copay after you satisfy the medical plan deductible.

When you use home delivery, you must submit information to ESI. (See Home delivery program for more information.)

Prescription drugs usually fall into one of two basic categories — generic and brand name. Regardless of where you choose to fill your prescription, the program covers three levels of medications: generic drugs, brand name preferred drugs and brand name non-preferred drugs.

- **Generic drugs** have the same active ingredients as brand name drugs and are subject to the same Food and Drug Administration (FDA) standards for quality, strength and purity as their brand name counterparts. Not all brand name drugs have generic equivalents. Typically, your pharmacist will fill your prescription with a generic drug, if available, unless you or your doctor specify otherwise.
- **Brand name drugs** are drugs patented by the FDA and subject to an exclusivity agreement, which allows the company to be the sole manufacturer of the drug for a certain number of years. Brand name drugs include preferred drugs and non-preferred drugs.
  - Preferred drugs are drugs that Express Scripts considers preferred choices, based on their effectiveness and cost, and are on ESI's formulary drug list.
  - Non-preferred drugs are those that are not on ESI's formulary drug list.

A formulary is a list of recommended prescription medications that is created, reviewed and continually updated by a team of physicians and pharmacists. The Express Scripts formulary contains a wide range of generic and brand name preferred products that have been approved by the Food and Drug Administration (FDA). The formulary applies to medications that are dispensed in a retail pharmacy or mail service setting. The formulary is developed and maintained by Express Scripts and is available online or a paper copy may be requested. Formulary designations may change as new clinical information becomes available.

If a prescription drug does not have a generic equivalent available, you will be charged the brand name copay (preferred or non-preferred, depending on the drug). Please note that the information on the formulary drug list is not BP-specific, and not all of the preferred drugs covered may be listed nor does BP cover all the drugs that may be listed. If you do not see your drug listed, contact Express Scripts for coverage information.

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Copay<sup>b</sup>/Coinsurance

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The most up-to-date information is available online at http://hr.bpglobal.com/lifebenefits/Core.
Prescriptions purchased at an out-of-network pharmacy are covered only if a network pharmacy is not available.

You always pay the lesser of the actual cost of your prescription or the copay. All brand name non-sedating and low-sedating antihistamines — even if on the formulary drug list — are subject to the brand name non-preferred drug copay.

Prescription drugs are covered (subject to plan exclusions and limitations) under the Prescription Drug Program if they:

- Require a prescription for dispensing;
- Are FDA indicated for an approved diagnosis;
- Are medically necessary; and
- Are not experimental in nature.

If you participate in a Standard Option and have not met the plan year prescription drug deductible, you pay 100% of the negotiated cost of the medication (if applicable) at a network pharmacy — or the billed charges if a network pharmacy is not available — until the deductible is met. After that, you pay only the applicable copay or coinsurance.

Expenses that are not applied to the separate Standard Option Prescription Drug Program deductible include:

- Copays.
- Prescriptions filled at a retail pharmacy after the two-fill limit on maintenance medication is reached.
- Prescriptions filled at a non-network pharmacy when an ESI network pharmacy is available.
- Prescriptions not covered under the Prescription Drug Program.

Inpatient care and your prescription benefit

Prescription drugs received while you are an inpatient at an extended care facility/skilled nursing facility are payable under the Prescription Drug Program (and not under the medical coverage provisions of the plan). Because you have no control over whether a network pharmacy is used, coverage is provided even when the prescription drugs are obtained from a non-network pharmacy. Whether a network or non-network pharmacy is used, you may need to pay for the prescription drug up front and then file a claim for reimbursement.

Prescriptions covered without deductibles or copays

The following prescriptions are 100% covered without a need to pay a medical or prescription drug deductible or pay any copays:

- FDA-approved women's contraception.
- Generic preventive prescriptions (applies to the Health+Savings Options only)

Publication date: April 2020
Retail pharmacy network

To use your prescription drug benefit, present your prescription drug ID card when you have your prescription filled.

You must fill your prescription drug at an ESI network pharmacy unless one is not available in the area. No benefit is provided if you use a non-participating pharmacy when an ESI network pharmacy is available. In addition, if you use a non-participating pharmacy when an ESI network pharmacy is available, eligible expenses incurred at the non-participating pharmacy do not count toward the Standard Option’s prescription drug deductible. These restrictions do not apply if you are outside the ESI network area — there is no ESI network pharmacy within a 40-mile radius of your home or work location — or outside the United States.

You may fill maintenance medications (for example, medication for high blood pressure or for high cholesterol) twice through a retail pharmacy. After that, refills must be filled through ESI’s home delivery program to receive benefits under the Prescription Drug Program.

If there is no participating pharmacy within a 40-mile radius of your home or work location, you can go to any pharmacy, have your prescription filled and pay the full cost for it. You will then need to file a claim with ESI and submit it with your original itemized receipt for reimbursement based on plan limitations.

If you are outside the United States, you can go to any pharmacy, have your prescription filled and pay the full cost for it. You will then need to file a claim with ESI and submit it with your original itemized receipt. If you are enrolled in the Standard Option, you must first meet the Prescription Drug Program plan year deductible before you receive any reimbursement. ESI will reimburse you for your cost, less the appropriate copay or coinsurance. In processing your claim incurred while traveling abroad, ESI uses the conversion rate posted on www.oanda.com as of the date the prescription was filled.

If you are enrolled in the Health+Savings Option, you may use your PayFlex Card® (your HSA debit card) to pay for eligible prescription drug expenses at a participating retail pharmacy. Note: You cannot use the HSA debit card outside the U.S.

Publication date: April 2020
Home delivery program

If you live in the United States you can order up to a 90-day supply of maintenance medication for chronic conditions, such as asthma or high blood pressure, through ESI's home delivery program. The home delivery program is not available if you live outside the United States.

Certain prescription drugs — such as diet medications, growth hormones and topical tretinoin products — are available only through the home delivery program and are available only if they are medically necessary. Anabolic steroids, tretinoin, weight loss management, photo-aged skin products and erectile dysfunction drugs are available only through the home delivery program, subject to plan limits.

To order a prescription through the home delivery program, complete and return an order form (available from ESI or the LifeBenefits website). Return the form, your prescription from your doctor as well as:

- **If you participate in the HealthPlus Option**, any appropriate copay.
- **If you participate in the Standard Option**, any remaining Prescription Drug Program deductible (up to the cost of the prescription) and appropriate copay or coinsurance amount. You may contact ESI to determine your remaining deductible.
- **If you participate in the Health+Savings Option**, any remaining Medical Plan Program deductible (up to the cost of the prescription) and appropriate copay or coinsurance amount. You may contact Aetna to determine your remaining deductible.

Typically, a pharmacist at the home delivery program facility will fill your prescription with a generic drug, if available, unless your doctor specifies otherwise. In addition, the pharmacist may contact your doctor if your prescription is unclear or incomplete, or to ask if a substitution or change may be made to the prescription he/she has written. ESI pharmacists will not make any changes to your prescription unless authorized by your doctor.

You will receive your medication approximately 14 days from the date ESI receives your order with the correct payment. If you need your medication sooner, ask your doctor to write two prescriptions:

- One for up to a 30-day supply to be filled immediately at a retail pharmacy that participates in the ESI network.
- Another that you can send to the home delivery program for an additional supply.

To order a refill from ESI's home delivery program, contact ESI online or via phone. You may also detach the refill slip, complete the patient order form and mail the request to ESI with the correct payment.

If you are enrolled in the Health+Savings Option, you may use your PayFlex Card® (your HSA debit card) to pay for eligible prescription drug expenses you incur through the home delivery program. **Note:** You cannot use the HSA debit card outside the U.S.

Publication date: April 2020
Specialty pharmacy

If you use a specialty medication, the Prescription Drug Program offers an enhanced level of service for medications that are not available through a retail pharmacy. You may receive these medications through Accredo Pharmacy, a special mail order pharmacy affiliated with ESI that is designed to service your unique needs and deliver your medication to your doorstep.

Examples of diseases or conditions for which drugs may be obtained through Accredo Pharmacy include but are not limited to, multiple sclerosis, rheumatoid arthritis, HIV/AIDS, cancer, hepatitis B & C, hemophilia and growth hormone deficiency. Certain drugs such as Insulin, Imitrex, Epinephrine and Glucagon are not considered specialty drugs.

**Note:** Effective April 1, 2020, certain designated specialty medication will be covered only through Accredo Pharmacy. This change does not affect medications supplied by an emergency room, or during an inpatient hospital stay. However, if any of these medications are obtained from an outpatient clinic, a home infusion company, a doctor’s office, or from another pharmacy, they will not be covered.

Accredo will contact you if the medication you’re taking can be supplied or is required to be supplied through the Accredo program. As an Accredo patient, you will have access to a team of specialists who will work closely with you and your physician throughout your course of therapy.

After you have successfully taken the medication for a six-month period and your physician has deemed that the ongoing dosage and medication are appropriate for your condition, you may begin to receive a 90-day supply from Accredo for the applicable home delivery copay or coinsurance. Until that time, you will receive a 30-day supply each month from Accredo at the applicable retail level copay or coinsurance.

**Copays for specialty medications**

Copays for certain specialty medications will vary depending on the amount of available assistance provided by manufacturers of the particular medication. If you have questions regarding the amount of your copay, please contact ESI.

Your out-of-pocket maximum calculations will reflect your copay amount and not include any financial assistance provided to you by manufacturers of your medications.
Drugs not covered

The Prescription Drug Program does not pay benefits for:

- Any drug that can be purchased legally without a prescription.
- Hair growth agents.
- Homeopathic drugs.
- Injectable cosmetics.
- Nutritional supplements.
- Smoking cessation agents (gum and patches) (covered only for employees and eligible dependents who are enrolled in a HealthPlus Option and participate in a smoking cessation program sponsored by StayWell).

In addition, the following expenses are covered under the medical provisions of the HealthPlus, Standard and Health+Savings Options and are not payable through the Prescription Drug Program:

- Prescriptions administered during a hospital stay (treated as part of the hospital expense).
- Injectables provided at a doctor’s office (treated as a part of the office visit expense).

See Expenses not covered under the BP Medical Plan for all other limitations and exclusions.

Publication date: April 2020
A note about Medicare and prescription drug coverage

If you are eligible for Medicare, you are eligible to enroll in a Medicare Part D plan that offers prescription drug coverage. There is a late enrollment penalty if you do not enroll in Medicare Part D coverage when you are first eligible unless you have “creditable coverage” under an employer group health plan. (You must enroll in a Medicare Part D plan within 63 days of losing creditable coverage to avoid the late enrollment penalty.)

The prescription drug coverage offered under the HealthPlus and Standard Options is considered to be “creditable coverage” for purposes of Medicare Part D. Therefore, you do not need to enroll in a Medicare Part D plan while you are covered under one of these options. However, the prescription drug coverage offered under the Health+Savings Option is not considered to be “creditable coverage” for purposes of Medicare Part D.

Each year, you will be sent a notice notifying you whether the plan's prescription drug coverage remains “creditable” for purposes of Medicare Part D.

Publication date: April 2020
## Out-of-Area (OOA) Options (HealthPlus and Standard) summary chart

The OOA Options are available only if you live in an area where the Aetna Choice POS II network is not available. In addition to the options described below, you may want to consider the Health+Savings OOA Option.

If you participate in a PPO Option, see the PPO Options (HealthPlus and Standard) summary chart or the Health+Savings PPO Option summary chart.

### General information

<table>
<thead>
<tr>
<th></th>
<th>HealthPlus OOA Option&lt;sup&gt;a&lt;/sup&gt;,&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Standard OOA Option&lt;sup&gt;a&lt;/sup&gt;,&lt;sup&gt;b&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan year deductible</strong></td>
<td>$300/person; $900/family maximum</td>
<td>$600/person; $1,800/family maximum</td>
</tr>
<tr>
<td><strong>Plan year out-of-pocket maximum</strong></td>
<td>$3,000/person; $6,000/family maximum</td>
<td>$5,000/person; $12,500/family maximum</td>
</tr>
<tr>
<td><strong>Lifetime maximum benefit</strong></td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

### Prescription drug (administered by Express Scripts)

- **Prescription drug plan year deductible (separate from and in addition to your medical plan deductible)**
  - HealthPlus: No separate deductible
  - Standard: $75/person; $225/family

- **FDA-approved women’s contraception and generic and OTC bowel prep medications for colonoscopy**
  - HealthPlus: 100%; no deductible or copay
  - Standard: 100%; no deductible or copay

### Retail Pharmacy Network (up to a 30-day supply)

*Note: Prescriptions purchased at an out-of-network pharmacy are covered only if a network pharmacy is not available.*

<table>
<thead>
<tr>
<th></th>
<th>HealthPlus OOA Option</th>
<th>Standard OOA Option</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Generic</strong></td>
<td>100% after $5 copay</td>
<td>100% after $5 copay</td>
</tr>
<tr>
<td><strong>Brand name (preferred)</strong></td>
<td>100% after $25 copay</td>
<td>80% covered; you pay 20% ($25 minimum; $50 maximum)</td>
</tr>
<tr>
<td><strong>Brand name (non-preferred)</strong></td>
<td>100% after $45 copay</td>
<td>60% covered; you pay 40% ($45 minimum; $100 maximum)</td>
</tr>
<tr>
<td><strong>Brand name (when generic is available)</strong></td>
<td>Brand name copay plus the difference in cost between the brand name and the equivalent generic</td>
<td>Brand name coinsurance plus the difference in cost between the brand name and the equivalent generic</td>
</tr>
</tbody>
</table>

### Home Delivery Program (up to a 90-day supply)

<table>
<thead>
<tr>
<th></th>
<th>HealthPlus OOA Option</th>
<th>Standard OOA Option</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Generic</strong></td>
<td>100% after $12 copay</td>
<td>100% after $12 copay</td>
</tr>
<tr>
<td><strong>Brand name (preferred)</strong></td>
<td>100% after $65 copay</td>
<td>80% covered; you pay 20% ($65 minimum; $130 maximum)</td>
</tr>
<tr>
<td><strong>Brand name (non-preferred)</strong></td>
<td>100% after $125 copay</td>
<td>60% covered; you pay 40% ($125 minimum; $250 maximum)</td>
</tr>
<tr>
<td><strong>Brand name (when generic is available)</strong></td>
<td>Brand name copay plus the difference in cost between the brand name and the equivalent generic</td>
<td>Brand name coinsurance plus the difference in cost between the brand name and the equivalent generic</td>
</tr>
</tbody>
</table>

### For the following covered treatments and services, the OOA Options pay

<table>
<thead>
<tr>
<th></th>
<th>HealthPlus OOA Option</th>
<th>Standard OOA Option</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Doctor visits (other than preventive care)</strong>&lt;sup&gt;d&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service Description</td>
<td>Coverage Details</td>
<td>Percentage</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Primary care office visit</td>
<td>100% after $20 copay, no deductible&lt;sup&gt;e&lt;/sup&gt; Note: surgery is covered at 80% after deductible</td>
<td>80%</td>
</tr>
<tr>
<td>Specialist office visit</td>
<td>100% after $30 copay, no deductible&lt;sup&gt;e&lt;/sup&gt; Note: surgery is covered at 80% after deductible</td>
<td>80%</td>
</tr>
<tr>
<td>Behavioral health office visit</td>
<td>100% after $20 copay, no deductible&lt;sup&gt;e&lt;/sup&gt;</td>
<td>80%</td>
</tr>
<tr>
<td>Maternity services</td>
<td>100%, no deductible/copay (prenatal); 80% after deductible (post-natal)</td>
<td>80%</td>
</tr>
<tr>
<td>Lab and X-ray</td>
<td>80&lt;sup&gt;g&lt;/sup&gt;</td>
<td>80%</td>
</tr>
<tr>
<td>Preventive care&lt;sup&gt;d,f&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine physicals</td>
<td>100%, no copay, no deductible</td>
<td>100%, no copay, no deductible</td>
</tr>
<tr>
<td>Annual well-woman exam</td>
<td>100%, no copay, no deductible</td>
<td>100%, no copay, no deductible</td>
</tr>
<tr>
<td>Mammograms (routine)</td>
<td>100%, no copay, no deductible</td>
<td>100%, no copay, no deductible</td>
</tr>
<tr>
<td>Gestational diabetes screening</td>
<td>100%, no copay, no deductible</td>
<td>100%, no copay, no deductible</td>
</tr>
<tr>
<td>Prostate Specific Antigen (PSA) tests (routine)</td>
<td>100%, no copay, no deductible</td>
<td>100%, no copay, no deductible</td>
</tr>
<tr>
<td>Colorectal screenings (routine)</td>
<td>100%, no copay, no deductible</td>
<td>100%, no copay, no deductible</td>
</tr>
<tr>
<td>Well-child care (routine)</td>
<td>100%, no copay, no deductible</td>
<td>100%, no copay, no deductible</td>
</tr>
<tr>
<td>Emergency services&lt;sup&gt;d&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency room (applies to facility charges only)</td>
<td>80% after $150 copay, no deductible</td>
<td>80% after $150 copay, no deductible</td>
</tr>
<tr>
<td>Ambulance</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Urgent care facility (applies to facility charges only)</td>
<td>100% after $30 copay, no deductible</td>
<td>80%</td>
</tr>
<tr>
<td>Outpatient services (services provided other than in a doctor’s office)&lt;sup&gt;d&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient surgery facility</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Hospital outpatient services</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Doctor/surgeon and related professional fees</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Behavioral health outpatient treatment (other than office visit)&lt;sup&gt;g&lt;/sup&gt;</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Lab and X-ray</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Radiation therapy/chemotherapy</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Inpatient hospital services&lt;sup&gt;d&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Room and board (semi-private room)&lt;sup&gt;g&lt;/sup&gt;</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Inpatient behavioral health stay, including residential treatment and partial hospitalization&lt;sup&gt;g&lt;/sup&gt;</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Doctor hospital visits</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Lab, X-ray and anesthesia</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Alternatives to inpatient hospital care&lt;sup&gt;d&lt;/sup&gt;</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>Skilled nursing facility (up to 60 days/plan year)&lt;sup&gt;g&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health care (limited to 120 visits/plan year)&lt;sup&gt;g&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice care&lt;sup&gt;g&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient private duty nursing (up to 70 shifts/plan year)&lt;sup&gt;g&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other covered services&lt;sup&gt;d&lt;/sup&gt;</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic care (including lab/X-ray provided by a chiropractor); up to 20 visits/plan year</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Contraceptive administration (includes coverage for all contraceptive devices including the associated office visit)</td>
<td>100%, no deductible</td>
<td>100%, no deductible</td>
</tr>
<tr>
<td>Durable medical equipment, orthotics, consumable medical supplies&lt;sup&gt;h&lt;/sup&gt;</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Prosthetic appliances (including external breast prostheses, wigs)</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Breast pumps and supplies (electronic breast pump limited to one per 36 months)</td>
<td>100%, no deductible</td>
<td>100%, no deductible</td>
</tr>
<tr>
<td>Lactation consultation</td>
<td>100%, no deductible/copay for first 6 visits; then 80% after deductible</td>
<td>100%, no deductible/copay for first 6 visits; then 80% after deductible</td>
</tr>
<tr>
<td>Infertility treatment (limited to diagnostic testing and corrective surgery)</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Infertility treatment through Progyny (including IVF, IUI and fertility preservation)</td>
<td>80%, limited to 3 &quot;Smart Cycles&quot; through Progyny network</td>
<td>80%, limited to 3 &quot;Smart Cycles&quot; through Progyny network</td>
</tr>
<tr>
<td>Sterilization (female tubal ligation)</td>
<td>100% covered, no deductible/copay; includes ancillary services</td>
<td>100% covered, no deductible/copay; includes ancillary services</td>
</tr>
<tr>
<td>Sterilization (male vasectomy)</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Outpatient rehabilitation (physical/speech/occupational therapy) and cardiac rehabilitation (A combined maximum of 60 visits per plan year applies to physical, speech and occupational therapy, with no medical review required. Additional visits are not covered.)&lt;sup&gt;i&lt;/sup&gt;</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Coverage for autism spectrum disorders, including physical therapy/occupational therapy/speech therapy (PT/OT/ST visit limit applies)</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Applied Behavioral Analysis (ABA) (requires precertification)</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>TMJ (medical treatment for TMJ covered; TMJ-related dental services and orthodontic appliances not covered)</td>
<td>80%</td>
<td>80%</td>
</tr>
</tbody>
</table>

<sup>a</sup> Benefits are subject to recognized charge limits.
<sup>b</sup> You may need to pay the full amount and submit a claim for reimbursement to Aetna.
<sup>c</sup> Precertification penalties and amounts above recognized charges do not apply to the plan year deductible or out-of-pocket maximum. Office visit copays, urgent care facility copays and prescription drug expenses do not apply to the plan year deductible; however, they do apply to the plan year out-of-pocket maximum.
<sup>d</sup> Unless otherwise noted, benefits paid at 80% or 60% are paid after the plan year deductible has been met.
<sup>e</sup> The office visit copay covers lab and X-ray charges performed in a doctor's office and billed as part of the visit. When these services are not performed at the time of the office visit, performed at another facility or performed by an entity other than the doctor's office, you must first meet your deductible and then the expense, if covered, would be paid at 80%.
<sup>f</sup> For additional information about covered preventive care benefits, see the Preventive care section of this SPD or contact Aetna Member Services at 1-866-436-2606.
Precertification required; benefits may be reduced or denied if precertification not obtained.

Deductible waived for diabetic insulin pumps and tubing.

Speech therapy is subject to medical review if one of the following circumstances exist: developmentally delayed due to an injury or sickness (other than a functional nervous disorder); diagnosis of chronic otitis media; or a congenital defect for which corrective surgery has been performed.

Publication date: April 2020
How the Out-of-Area Options work

The OOA Options are only available if you live in an area where the network used in the PPO Options is not available.

In the HealthPlus OOA Option you receive lower-cost health care services. However, in order to be eligible for the HealthPlus Option, you and your covered spouse/domestic partner are each required to complete the annual Health Questionnaire as well as earn a minimum of 1,000 wellness points by completing various wellness activities associated with the BP Wellness Program.* To learn about the available activities in the BP Wellness Program and their associated points, you can visit the Wellness section on LifeBenefits.

* New hires and newly eligible employees in their initial year of coverage under HealthPlus are not required to accumulate 1,000 wellness points until the following calendar year.

The OOA Options cover a broad range of medical services and supplies, including preventive and emergency care. If you enroll in an OOA Option, you can choose any licensed doctor, nurse, therapist, hospital, lab or other health care facility you wish whenever you need medical care.

- If you use a hospital or doctor that participates in Aetna’s National Advantage Program (NAP) for a covered expense, you may receive the advantage of contracted rates so your costs may be lower.
- If you use a provider who is not a participating NAP member for a covered expense, your costs may be higher since the provider has not agreed to charge participants lower rates.

The OOA Options pay most of the cost of covered expenses up to what is considered a recognized charge after you meet the plan year deductible. You are responsible for filing all claim forms.

The OOA Options also include the Prescription Drug Program, administered by Express Scripts, Inc. (ESI).

Primary doctors

Under the HealthPlus OOA Option, you will pay lower office visit copays for providers who are considered primary doctors than for those who are considered specialists. Primary doctors are:

- Family practitioners.
- General practitioners.
- Internists.
- Pediatricians.
- Obstetricians/Gynecologists (OB/GYNs).

You are not required to designate a primary doctor or have your primary doctor’s referral to see a specialist.
What the OOA Options pay

Under these options, you may receive medical care from any licensed provider you choose. However, when you receive covered care from a provider who participates in Aetna’s National Advantage Program (NAP), your share of the cost may be lower. This is because NAP providers typically charge plan participants lower, contracted rates.

If you receive care from a provider who is not in the Aetna NAP network and does not honor the copay shown on your medical ID card, you will need to pay the full amount and submit a claim for reimbursement to Aetna. (See How to file a claim.)

The OOA Options generally pay 80% of recognized charges for most other covered expenses after you meet the individual or family plan year deductible, and you pay the remaining coinsurance and any costs above recognized charge limits. **Note:** The OOA Options pay 100% of recognized charges for covered preventive care services, with no copay and no deductible. (See Preventive care.)
Deductibles

You pay the first portion of recognized charges for most covered expenses incurred by you and each covered dependent during the plan year before the plan begins paying benefits.

The Health+Savings OOA Option has two separate deductibles. Under the Health+Savings OOA Option, the lower deductible applies only if you have You Only coverage. The higher deductible applies if you have You + Spouse, You + Child(ren) or You + Family coverage, even if only one family member incurs medical expenses during the year. Under the Health+Savings OOA Option, the lower You Only deductibles would not apply to any covered individual in your family if you have You + Spouse, You + Child(ren) or You + Family coverage.

If you participate in the HealthPlus OOA or Standard OOA Option, any medical expense that counts toward an individual’s deductible automatically counts toward the family deductible. This means that once you meet the family deductible for the plan year, no other covered family member is required to meet his/her individual deductible for that plan year before benefits are paid.

If you participate in the HealthPlus OOA Option, there is no separate plan year deductible for prescription drugs. Prescription drug expenses do not apply to the medical plan deductible.

If you participate in the Standard OOA Option there is a separate prescription drug plan year deductible.

If you participate in the Health+Savings OOA Option, there is no separate plan year deductible for prescription drugs. Prescription drug expenses do apply to the medical plan deductible. You must meet the plan year deductible before the plan starts to pay most expenses, including those for formulary brand preventive and non-preventive prescription drugs.

Expenses excluded from the deductibles

The following expenses do not apply to the medical coverage plan year deductibles under the various OOA Options as indicated:

<table>
<thead>
<tr>
<th>Under the HealthPlus and Standard OOA Options</th>
<th>Under the Health+Savings OOA Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>I Office visit copays.</td>
<td>I Expenses for diabetic insulin pumps and tubing.</td>
</tr>
<tr>
<td>I Urgent care facility copays.</td>
<td>I Charges above recognized charge limits.</td>
</tr>
<tr>
<td>I Expenses under the Prescription Drug Program.</td>
<td>I Penalties for noncompliance with precertification provisions.</td>
</tr>
<tr>
<td>I Expenses for diabetic insulin pumps and tubing.</td>
<td>I Expenses not covered by the OOA Option.</td>
</tr>
<tr>
<td>I Charges above recognized charge limits.</td>
<td></td>
</tr>
<tr>
<td>I Penalties for noncompliance with precertification provisions.</td>
<td></td>
</tr>
<tr>
<td>I Expenses not covered by the OOA Option.</td>
<td></td>
</tr>
</tbody>
</table>

Publication date: April 2020
Copays/coinsurance

A “copay” is a fixed dollar amount you pay in lieu of a deductible and coinsurance at the time you receive medical services. They apply to certain expenses under the HealthPlus OOA Option as follows:

<table>
<thead>
<tr>
<th>Office visits for non-preventive care under the HealthPlus OOA Option</th>
<th>The office visit copay includes:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I The doctor office visit.</td>
</tr>
<tr>
<td></td>
<td>I Diagnostic laboratory tests or X-rays performed in a doctor’s office and billed as part of the visit.</td>
</tr>
<tr>
<td></td>
<td>I Injections administered in a doctor’s office as part of the visit (including allergy injections).</td>
</tr>
</tbody>
</table>

The office visit copay does not apply to:

| Office visits if a surgical procedure as defined by the American Medical Association is performed as part of the visit (for example, if a mole is removed or a broken bone is set during the office visit). |
| Maternity-related office visits (except for the first office visit to confirm the pregnancy). These visits are included in the delivery charge. |
| Routine and diagnostic laboratory tests or X-rays performed: |
| * In a doctor’s office, but not at the time of the visit. |
| * In a facility other than the doctor’s office. |
| By an entity other than the doctor’s office. |

(Ask your doctor whether the lab facilities he/she uses are in the network.)

I Chiropractic visits.

| Urgent care facility charges under the HealthPlus OOA Option | Urgent care facility charges are covered at 100% after a copay, with no deductible. |

**Note:** In addition to the copay, you also pay any charges that exceed recognized charge limits. If your doctor does not honor Aetna’s claim procedures, you may need to pay the full amount and submit a claim for reimbursement to Aetna. You will be reimbursed 100% up to recognized charge limits, minus your office visit copay.

Under both OOA Options:

I Eligible preventive care expenses are covered at 100% of recognized charges with no copay and no deductible. See Preventive care for details.

I Most other covered services are paid at 80% of recognized charges after you meet the individual or family plan year deductible, and you pay the remaining 20% (the coinsurance) and any amounts over the recognized charge limit.
Out-of-pocket maximums

You pay a certain amount of covered expenses each plan year before each Out-of-Area Option begins paying 100% of recognized charges for covered services. This is your medical coverage plan year out-of-pocket maximum.

In addition, the Health+Savings OOA Option has two separate out-of-pocket maximum amounts. Under the Health+Savings OOA Option, the lower out-of-pocket maximum amount applies only if you have You Only coverage. The higher out-of-pocket maximum amount applies if you have You + Spouse, You + Child(ren) or You + Family coverage, even if only one family member incurs medical expenses during the year.

Under the Health+Savings OOA Option, the lower You Only out-of-pocket maximum amount would not apply to any covered individual in your family if you have You + Spouse, You + Child(ren) or You + Family coverage.

Under the HealthPlus OOA or Standard OOA Option, any medical expense that counts toward an individual’s plan year out-of-pocket maximum automatically counts toward the family out-of-pocket maximum. This means that once you meet the family plan year out-of-pocket maximum, no other covered family member is required to meet his/her individual out-of-pocket maximum for that plan year.

The expenses that apply to the out-of-pocket maximum vary depending on the option in which you are enrolled.

<table>
<thead>
<tr>
<th>If you are enrolled in this option...</th>
<th>The following expenses apply to the option’s medical out-of-pocket maximum...</th>
<th>The following expenses do not apply to the option’s medical out-of-pocket maximum and are payable by you even after the out-of-pocket maximum has been met...</th>
</tr>
</thead>
<tbody>
<tr>
<td>HealthPlus OOA or Standard OOA Option</td>
<td>- Deductibles. &lt;br&gt; - Coinsurance. &lt;br&gt; - Office visit copays. &lt;br&gt; - Emergency room/urgent care facility copays. &lt;br&gt; - Expenses under the Prescription Drug Program.</td>
<td>- Charges above the recognized charge limits. &lt;br&gt; - Penalties for noncompliance with precertification provisions. &lt;br&gt; - Expenses not covered by the OOA Option.</td>
</tr>
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</table>

| Health+Savings OOA Option | - Deductibles. <br> - Coinsurance. <br> - Office visit copays. <br> - Emergency room/urgent care facility copays. <br> - Expenses under the Prescription Drug Program. | - Charges above the recognized charge limits. <br> - Penalties for noncompliance with precertification provisions. <br> - Expenses not covered by the OOA Option. |

Publication date: April 2020
Important plan provisions

The HealthPlus and Standard Options include special plan provisions. These important features include preventive care, recognized charge limits, precertification requirements and more. More information about each of these features is outlined in this section.

- Preventive care
- Emergency care
- Recognized charge limits
- Aetna's National Advantage Program (NAP)
- Transplant services
- Precertification requirements
- Coverage while traveling
Preventive care

The HealthPlus, Standard and Health+Savings Options provide coverage for the following preventive care services:

- Routine physicals (once per calendar year).
- Routine well-child care.
- Annual well-woman exams.
- Routine mammograms.
- Routine Prostate Specific Antigen (PSA) tests.
- Colorectal screenings.
- Routine hearing and vision chart exams (once per year).
- Preventive items or services with an “A” or “B” rating from the United States Preventive Services Task Force.
- Immunizations pursuant to the Advisory Committee on Immunization Practices (“ACIP”) recommendations.
- Preventive care and screenings that are provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”).
- Gestational diabetes screening.

Routine physicals are covered annually. All other screenings and tests are covered based on age, gender and medical history. Preventive care benefits are subject to age restrictions/limitations as determined under the claims administrator’s guidelines. For additional information about benefits for covered preventive care services, contact the member services number on your medical ID card.

Routine physicals and well-child care include the following services:

- Doctor’s exam.
- Immunizations.
- Vision chart and hearing screenings performed in a doctor’s office.

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Emergency care

No matter where you are, if you have a medical emergency — that is, a sudden and unexpected change in your physical or mental condition which, if not treated immediately, could result in a loss of life or limb, significant impairment of a bodily function or permanent dysfunction of a body part — you should go to the nearest emergency room to get the care you need.

Emergency medical condition

An emergency medical condition is a recent and severe medical condition, including (but not limited to) severe pain, which would lead a prudent person possessing an average knowledge of medicine and health, to believe that his or her condition, illness or injury is of such a nature that failure to get immediate medical care could result in:

- Placing your health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Examples of medical emergencies include heart attack, stroke, severe bleeding, serious burns and poisoning. It can sometimes be difficult to determine when urgent situations are true emergencies. If you need help determining whether your situation is a true emergency, you can consult a doctor who will be able to tell you what steps to take. You can also contact Aetna's 24-Hour NurseLine at 1-800-556-1555 to speak with a registered nurse.

Emergency services

“Emergency services” means, with respect to an emergency medical condition:

- A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient.

Under all PPO Options, you receive the higher, network level benefits for emergency services — even if you see an out-of-network provider. You do not need prior authorization for the treatment of an emergency medical condition, even if the services are provided by an out-of-network provider. Care provided by an out-of-network provider will be paid at no greater cost to you than if the services were performed by a network provider. You may receive a bill for the difference between the amount billed by the out-of-network provider and the amount paid by Aetna. If an out-of-network provider bills you directly for an amount beyond your cost share for the treatment of an emergency medical condition, you are not responsible for paying that amount. Please send the bill to the address listed on the back of your member ID card and Aetna will resolve any payment dispute with the provider over the amount. Make sure your member ID number is on the bill.

Under all OOA Options, your cost may be lower if you use Aetna's National Advantage Program (NAP). See Aetna's National Advantage Program (NAP) for more information. You do not need prior authorization for the treatment of an emergency medical condition.

Under both the PPO and OOA Options, if you are admitted to the hospital, you or someone on your behalf is required to certify your hospitalization within 48 hours (or two business days) of your emergency admission. Instructions on how to contact your claims administrator are provided on your medical option ID card.

Publication date: April 2020
Recognized charge limits

Benefits under the HealthPlus, Standard and Health+Savings Options are based on recognized charge limits.* These Options do not cover otherwise eligible expenses above recognized charge limits — they are your responsibility. For example, if you incur a $200 doctor expense, but only $180 of the charge is within recognized charge limits, only $180 will be considered an eligible expense under the plan.

Recognized charge limits do not apply to:

1. Eligible expenses provided by a network provider under the PPO Options.
2. Eligible charges from participating NAP hospitals and doctors under the OOA Options. NAP providers can be found by using BP’s custom DocFind website. (See Quick links on the LifeBenefits site.)

The recognized charge for a service or supply is the lower of:

1. What the provider bills or submits for that service or supply; and
2. The charge the claims administrator determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made, billed or coded.
   - For non-facility charges:
     1. PPO Options: The 85th percentile of the Prevailing Charge Rate, for the Geographic Area where the service is furnished.
     2. OOA Options: Twice the 95th percentile of the Prevailing Charge Rate, for the Geographic Area where the service is furnished.
   - For facility charges:
     1. PPO Options: 150% of the Medicare Fee Schedule for the Geographic Area where the service is furnished. Aetna will determine the usual charge level if a Medicare fee is not applicable.
     2. OOA Options: Aetna uses the charge Aetna determines to be the usual charge level made for it in the Geographic Area where it was furnished.

As used above, Geographic Area and Prevailing Charge Rates are defined as follows:

1. **Geographic Area**: This means an expense area grouping defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three-digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three-digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three-digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three-digit zip codes, the grouping never crosses state lines.
2. **Prevailing Charge Rates**: These are rates reported by FAIR Health, a nonprofit company, in their database. FAIR Health reviews and, if necessary, changes these rates periodically. Aetna updates its systems with these changes within 180 days of receiving them from FAIR Health.

* You may be accustomed to seeing the term "reasonable and customary (R&C)," however Aetna uses the term "recognized charge."
Recognized charge works in the same manner as reasonable and customary.
Aetna’s National Advantage Program (NAP)

The National Advantage Program (NAP) offers you access to Aetna-contracted rates for many hospital and doctor expenses that would otherwise be billed at the provider's normal rate. These include:

- For the PPO Options, eligible expenses provided by providers who are not Choice POS II network providers but who are Aetna NAP providers.
- For the OOA Options, eligible expenses provided by a provider who is an Aetna NAP provider.

You may save money with the NAP because the contracted rate is generally lower than the provider's normal charge. In addition, you should not be billed by the provider for the difference between the provider's normal charge and the contracted rate (i.e., no balance billing).

In order to qualify for Aetna's contracted NAP rates, the expense must be covered under the plan and the provider must submit the charge to process at the contracted amount before you pay for services. It is therefore important to remind the provider to submit the claim to Aetna directly before you pay.

The NAP network consists of many of Aetna's directly contracted hospitals, ancillary providers and doctors, as well as hospitals, ancillary providers and doctors accessed through vendor arrangements where Aetna does not have direct contractual arrangements. NAP-participating doctors include primary care doctors, obstetricians, gynecologists, radiologists, anesthesiologists, pathologists and other specialists.

NAP ancillary providers include:

- Acute rehabilitation facilities.
- Ambulatory surgical centers.
- Dialysis centers.
- Freestanding hospices.
- Infusion centers.
- Nursing care agencies.
- Skilled nursing facilities.
- Substance abuse facilities.

Certain claims are not eligible for a NAP discount, including:

- Small hospital or ancillary provider claims (currently below $151) that require manual intervention to obtain a discount.
- Claims involving Medicare or Coordination of benefits (COB) when the plan is not primary.
- Claims that have already been paid directly by the plan participant before the provider has submitted the claim to Aetna at the contracted rate.
- Claims that are not covered by the plan.

To learn more about the providers who participate in the NAP, contact Aetna Member Services or access BP's custom DocFind website.

Publication date: April 2020
Transplant services

The Institutes of Excellence (IOE) network is the claims administrator’s network for transplants and transplant-related services, including evaluation and follow-up care. This is a network of facilities that have demonstrated success at performing these highly specialized procedures.

For the PPO Options:

- The network level of benefits is paid for treatment received at a facility designated by the plan as an IOE for the type of transplant being performed. Each IOE facility has been selected to perform only certain types of transplants.
- Services obtained from a facility that is not designated as an IOE for the transplant being performed will be covered as out-of-network services and supplies, even if the facility is a network facility or IOE for other types of services.

The National Medical Excellence (NME) Program coordinates transplants and other specialized care that may not be available in your local area. If you are referred to a facility that is more than 100 miles from your home or you are required to remain within a certain radius of the treating facility that is farther than your home, the NME Program will help pay certain travel and lodging expenses for you and a companion.

If you or one of your covered family members could be a potential transplant candidate, contact the claims administrator to learn more about this program.

Out-of-country care

The National Medical Excellence (NME) Program coordinates care when an Aetna plan participant develops an urgent or acute illness when traveling outside of the United States. Coordination of some or all of the following may apply:

- Assessment of the urgent or acute care facility’s appropriateness for the required care;
- Transfer of the plan participant to a more appropriate acute care facility for stabilization;
- Transfer of the plan participant back to the United States; and
- Transfer of the plan participant to his/her home.

Publication date: April 2020
Precertification requirements

The decision to receive care is between you and your provider. If you do not precertify care when you are required to do so, your benefits will be reduced, or in some instances, not paid at all.

- If you are in a PPO Option and you use a network provider for covered medical care, the provider will take care of precertification for you.
- If you use a NAP provider, confirm that the provider is obtaining precertification on your behalf; otherwise contact Aetna directly for precertification. (The NAP Program is a discount program and does not guarantee precertification.)
- In all other instances, you are responsible for obtaining any required precertification.

Precertification is not required for expenses incurred while you are outside the United States.

It is a good idea to provide a family member, friend and/or your doctor with the precertification instructions. That way, they will be able to make the precertification call for you in case you cannot. Even if you rely on someone else to make the call for you, it is your responsibility to follow up to be sure the call was made. Precertification is required for the following services:

- **Inpatient admissions.** Non-emergency hospital (including hospitalization for mental health/substance abuse treatment), skilled nursing facility, and hospice admissions must be precertified by calling the claims administrator at the toll-free precertification number shown on your medical option ID card (at least 10 days in advance for Aetna).

- **Maternity stays.** Precertification of maternity care is not required. If your doctor recommends an extended stay beyond 48 hours for a vaginal delivery or 96 hours for a Caesarean section, the additional days must be precertified with the claims administrator within 48 hours (or two business days). If the mother is discharged before the baby is allowed to go home, the baby's extended stay must also be precertified.

- **Hospitalization due to a medical emergency.** You must certify by calling the claims administrator within 48 hours (or two business days) of your emergency admission.

- **Enhanced clinical review (NOTE: Applies only to Aetna PPO Options).** Certain services (listed below) are subject to enhanced clinical review through a separate independent company. This company uses medical specialists and diagnostic tools to review your doctor's request, applying national medical standards, with the initial review accomplished typically within 24 hours of the request. Your doctor should submit a request for clinical review for the following services:
  - Cardiac imaging, including non-urgent outpatient diagnostic catheterization and echo stress tests.
  - Cardiac rhythm implantable devices.
  - Sleep studies.
  - High-tech radiology, including MRI/MRA, CT scan, PET scan and nuclear imaging.
  - Outpatient interventional pain management.
  - Hip and knee replacements (inpatient and outpatient).

Responsibility for obtaining preauthorization of the above services is shared by the patient (or the parent plan participant, if a child), the referring physician and the facility rendering the service. In-network physicians have been engaged regarding this requirement and should be aware of the process.

- **Outpatient medical services.** Some outpatient procedures, including outpatient hospice care, home health care and private duty nursing and, in some circumstances, outpatient rehabilitation services require precertification. Additionally, if your doctor recommends an intensive outpatient program for psychiatric, eating disorder care and/or substance abuse care that is generally two or more hours per day, precertification is required. If your doctor recommends these outpatient services, you or your doctor should call the toll-free precertification number shown on your medical option ID card in advance to make sure the procedure is covered by the plan.

- **Partial hospitalization or a day program.** Outpatient care focused on psychiatric, eating disorder care and/or substance abuse care that is generally four or more hours per day and includes individual, group and family therapies must be precertified in advance by calling the claims administrator at the toll-free precertification number shown on your medical option ID card.

- **Electroconvulsive therapy treatment (ECT).** ECT is systematic use of electric shocks to produce convulsions. Care must be
precertified in advance by calling the claims administrator at the toll-free precertification number shown on your medical option ID card.

- **Psychological testing.** Psychological testing must be precertified by calling the claims administrator at the toll-free precertification number shown on your medical option ID card.

- **Biofeedback.** Biofeedback must be precertified by calling the claims administrator at the toll-free precertification number shown on your medical option ID card.

- **Outpatient detoxification.** Outpatient detoxification must be precertified by calling the claims administrator at the toll-free precertification number shown on your medical option ID card.

See Process for formal benefit claims and appeals if you receive an adverse benefit determination with respect to your request for precertification.

**Precertification penalties**

If you do not precertify care (including behavioral health care) when you are required to do so, your benefits will be reduced or, in some instances, not paid at all. Specifically, the following penalties will apply:

- **If you do not call to precertify.** All expenses related to care that has not been precertified are reviewed by the claims administrator. Benefits will not be paid for any expenses (including room and board) that were not medically necessary. A $300 penalty will be deducted from any benefits that are otherwise payable.

- **If you call to precertify, but the claims administrator determines that your admission, proposed treatment or expense is not medically necessary:** No benefits will be paid.

- **If you call to precertify additional hospital days beyond those initially precertified, but the claims administrator determines that those additional days are not medically necessary:** No benefits will be paid for the additional days.

Because PPO network providers are responsible for obtaining precertification of care for you, precertification penalties do not apply under the BP PPO Options for eligible care received from a network provider. However, if you are intending to receive an in-network level of benefits, it is your responsibility to confirm that each provider or facility you use is in the Aetna Choice POS II network. If a provider practices at multiple locations, he/she may not be considered an in-network provider at each location. Confirm with the provider that he/she is in the network at the location you intend to visit before receiving care.
Coverage while traveling

Eligible medical expenses incurred while traveling within or outside the U.S. are covered. Under all HealthPlus, Standard and Health+Savings Options, you may need to pay the provider in full and submit a claim for reimbursement from your claims administrator.

If you receive medical or behavioral health care or purchase prescription drugs within or outside the U.S. (other than from a PPO network provider, if you are enrolled in a PPO Option), submit a claim to the claims administrator for reimbursement.

If you purchase any prescription medication from a non-network pharmacy, submit a claim to Express Scripts, Inc. (ESI).
Alternatives to physician office visits

Walk-in clinic visits

Covered expenses include charges made by walk-in clinics for:

- Unscheduled, non-emergency illnesses and injuries;
- The administration of certain immunizations administered within the scope of the clinic's license; and
- Individual screening and counseling services to aid you:
  - to stop the use of tobacco products;
  - in weight reduction due to obesity;
  - in stress management. The stress management counseling sessions will help you to identify the life events which cause you stress (the physical and mental strain on your body.) The counseling sessions will teach you techniques and changes in behavior to reduce the stress.

Unless specified above, not covered under this benefit are charges incurred for services and supplies furnished:

- In a group setting for screening and counseling services.

Important Notes:

- Deductibles, copays and/or coinsurance will apply where applicable. Refer to the applicable summary chart for more information.
- Not all services are available at all walk-in clinics. The types of services offered will vary by the provider and location of the clinic.
- For a complete description of the screening and counseling services provided on the use of tobacco products and to aid in weight reduction due to obesity, refer to the Preventive care and Expenses covered under the BP Medical Plan sections in this SPD for a description of these services. These services may also be obtained from your physician.

Walk-in clinic

Walk-in clinics are free-standing health care facilities. They are an alternative to a physician's office visit for treatment of:

- Unscheduled, non-emergency illnesses and injuries;
- The administration of certain immunizations; and
- Individual screening and counseling services.

It is not an alternative for emergency room services or the ongoing care provided by a physician.

Neither:

- An emergency room; nor
- The outpatient department of a hospital;

shall be considered a walk-in clinic.
Teladoc provides you with 24/7 telephonic access to a national network of U.S. board-certified doctors when enrolled in an Aetna medical plan. There is no additional cost to you for this service. You can call a physician from anywhere — home, work or on the road. Teladoc doctors diagnose non-emergency medical problems, recommend treatment, and can even call in any necessary prescription(s) to your pharmacy.

Teladoc is intended to treat minor non-emergency conditions such as:

- Respiratory infections
- Ear infections
- Urinary tract infections
- Allergies
- Colds and flu
- Sore throat

How to use Teladoc

2. Complete your medical history.
3. Request a consultation and a U.S. board-certified physician will call you back within one hour.
4. Pay online. Teladoc visits generally cost less than a regular office visit, with costs not exceeding $40.

Teladoc is available beginning April 1, 2016 to those enrolled in an Aetna medical plan.

Publication date: April 2020
Enhanced Aetna Concierge

How the Enhanced Aetna Concierge program works

Effective April 1, 2019, the Enhanced Aetna Concierge program is available to participants in Aetna-administered medical plans. This program helps you manage your healthcare by putting you at the center of it all. Resources are available to help you 24/7.

This program puts a team of benefits specialists at one location at your disposal, waiting to resolve all of your healthcare coverage questions and concerns. When you call, you'll be assigned a personal concierge as a single point of contact until your situation is resolved. Your concierge can call upon other team members as needed — doctors, nurses, pharmacists, dietitians, behavioral health specialists, social workers, well-being specialists, network provider specialists and more — to consult with you about your coverage.

The BP Enhanced Aetna Concierge team can do many things for you:

- Schedule appointments with your doctor.
- Coordinate care approvals for an upcoming surgery or procedure.
- Help set coverage goals that are right for you.
- Work with you to help resolve claim inquiries or billing issues.
- Check in with you to see how you're doing, both routinely when convenient and urgently if needed.
- Connect you to healthcare resources in your community.

How to reach Enhanced Aetna Concierge

You can call 1-866-436-2606 at any time. Concierge specialists are available 8:00 am to 8:00 pm Monday-Friday, and 8:00 am to 4:30 pm Saturday, Central time. Additional support is available 24/7/365.

Publication date: April 2020
Prescription drug coverage

The medical plans all offer prescription drug coverage. Under the HealthPlus, Standard and Health+Savings Options, the Prescription Drug Program is administered by Express Scripts (ESI).

In general, the program offers prescription drug benefits two ways:

- **For short-term prescriptions**, you must fill your prescription at any Express Scripts network retail pharmacy, unless one is not available in the area.
- **For longer-term maintenance prescriptions**, you must use the home delivery service.

When you participate in either option, you will receive a separate ESI prescription drug ID card. Each time you fill a prescription at an ESI network retail pharmacy, simply show your ID card so the pharmacist knows you are covered under the program.

- If you are a participant in the HealthPlus Option, there is no separate prescription drug deductible. You only pay your applicable prescription drug copay.
- If you are a participant in the Standard Option, you must meet the separate prescription drug deductible before the plan pays a benefit. Once you meet the separate prescription drug deductible, you will pay a copay for generic drugs, or the applicable coinsurance for preferred or non-preferred brand name drugs.
- If you are a participant in the Health+Savings Option, there is no separate prescription drug deductible. You pay your applicable prescription drug copay after you satisfy the medical plan deductible.

When you use home delivery, you must submit information to ESI. (See Home delivery program for more information.)

Prescription drugs usually fall into one of two basic categories — generic and brand name. Regardless of where you choose to fill your prescription, the program covers three levels of medications: generic drugs, brand name preferred drugs and brand name non-preferred drugs.

- **Generic drugs** have the same active ingredients as brand name drugs and are subject to the same Food and Drug Administration (FDA) standards for quality, strength and purity as their brand name counterparts. Not all brand name drugs have generic equivalents. Typically, your pharmacist will fill your prescription with a generic drug, if available, unless you or your doctor specify otherwise.
- **Brand name drugs** are drugs patented by the FDA and subject to an exclusivity agreement, which allows the company to be the sole manufacturer of the drug for a certain number of years. Brand name drugs include preferred drugs and non-preferred drugs.
  - Preferred drugs are drugs that Express Scripts considers preferred choices, based on their effectiveness and cost, and are on ESI’s formulary drug list.
  - Non-preferred drugs are those that are not on ESI’s formulary drug list.

A formulary is a list of recommended prescription medications that is created, reviewed and continually updated by a team of physicians and pharmacists. The Express Scripts formulary contains a wide range of generic and brand name preferred products that have been approved by the Food and Drug Administration (FDA). The formulary applies to medications that are dispensed in a retail pharmacy or mail service setting. The formulary is developed and maintained by Express Scripts and is available online or a paper copy may be requested. Formulary designations may change as new clinical information becomes available.

If a prescription drug does not have a generic equivalent available, you will be charged the brand name copay (preferred or non-preferred, depending on the drug). Please note that the information on the formulary drug list is not BP-specific, and not all of the preferred drugs covered may be listed nor does BP cover all the drugs that may be listed. If you do not see your drug listed, contact Express Scripts for coverage information.

<table>
<thead>
<tr>
<th>Prescription Drug</th>
<th>HealthPlus Option</th>
<th>Standard Option</th>
<th>Health+Savings Option</th>
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<tr>
<td></td>
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<td>Retail(^a)</td>
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<tr>
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<td>No separate Rx deductible; Rx subject to medical plan deductible</td>
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\(^a\) Copay/Coincursance
Prescriptions purchased at an out-of-network pharmacy are covered only if a network pharmacy is not available.

You always pay the lesser of the actual cost of your prescription or the copay. All brand name non-sedating and low-sedating antihistamines — even if on the formulary drug list — are subject to the brand name non-preferred drug copay.

Prescription drugs are covered (subject to plan exclusions and limitations) under the Prescription Drug Program if they:

- Require a prescription for dispensing;
- Are FDA indicated for an approved diagnosis;
- Are medically necessary; and
- Are not experimental in nature.

If you participate in a Standard Option and have not met the plan year prescription drug deductible, you pay 100% of the negotiated cost of the medication (if applicable) at a network pharmacy — or the billed charges if a network pharmacy is not available — until the deductible is met. After that, you pay only the applicable copay or coinsurance.

Expenses that are not applied to the separate Standard Option Prescription Drug Program deductible include:

- Copays.
- Prescriptions filled at a retail pharmacy after the two-fill limit on maintenance medication is reached.
- Prescriptions filled at a non-network pharmacy when an ESI network pharmacy is available.
- Prescriptions not covered under the Prescription Drug Program.

Inpatient care and your prescription benefit

Prescription drugs received while you are an inpatient at an extended care facility/skilled nursing facility are payable under the Prescription Drug Program (and not under the medical coverage provisions of the plan). Because you have no control over whether a network pharmacy is used, coverage is provided even when the prescription drugs are obtained from a non-network pharmacy. Whether a network or non-network pharmacy is used, you may need to pay for the prescription drug up front and then file a claim for reimbursement.

Prescriptions covered without deductibles or copays

The following prescriptions are 100% covered without a need to pay a medical or prescription drug deductible or pay any copays:

- FDA-approved women’s contraception.
- Generic preventive prescriptions (applies to the Health+Savings Options only)
To use your prescription drug benefit, present your prescription drug ID card when you have your prescription filled.

You must fill your prescription drug at an ESI network pharmacy unless one is not available in the area. No benefit is provided if you use a non-participating pharmacy when an ESI network pharmacy is available. In addition, if you use a non-participating pharmacy when an ESI network pharmacy is available, eligible expenses incurred at the non-participating pharmacy do not count toward the Standard Option’s prescription drug deductible. These restrictions do not apply if you are outside the ESI network area — there is no ESI network pharmacy within a 40-mile radius of your home or work location — or outside the United States.

You may fill maintenance medications (for example, medication for high blood pressure or for high cholesterol) twice through a retail pharmacy. After that, refills must be filled through ESI’s home delivery program to receive benefits under the Prescription Drug Program.

If there is no participating pharmacy within a 40-mile radius of your home or work location, you can go to any pharmacy, have your prescription filled and pay the full cost for it. You will then need to file a claim with ESI and submit it with your original itemized receipt for reimbursement based on plan limitations.

If you are outside the United States, you can go to any pharmacy, have your prescription filled and pay the full cost for it. You will then need to file a claim with ESI and submit it with your original itemized receipt. If you are enrolled in the Standard Option, you must first meet the Prescription Drug Program plan year deductible before you receive any reimbursement. ESI will reimburse you for your cost, less the appropriate copay or coinsurance. In processing your claim incurred while traveling abroad, ESI uses the conversion rate posted on www.oanda.com as of the date the prescription was filled.

If you are enrolled in the Health+Savings Option, you may use your PayFlex Card® (your HSA debit card) to pay for eligible prescription drug expenses at a participating retail pharmacy. **Note:** You cannot use the HSA debit card outside the U.S.
Home delivery program

If you live in the United States you can order up to a 90-day supply of maintenance medication for chronic conditions, such as asthma or high blood pressure, through ESI's home delivery program. The home delivery program is not available if you live outside the United States.

Certain prescription drugs — such as diet medications, growth hormones and topical tretinoin products — are available only through the home delivery program and are available only if they are medically necessary. Anabolic steroids, tretinoin, weight loss management, photo-aged skin products and erectile dysfunction drugs are available only through the home delivery program, subject to plan limits.

To order a prescription through the home delivery program, complete and return an order form (available from ESI or the LifeBenefits website). Return the form, your prescription from your doctor as well as:

1. **If you participate in the HealthPlus Option**, any appropriate copay.
1. **If you participate in the Standard Option**, any remaining Prescription Drug Program deductible (up to the cost of the prescription) and appropriate copay or coinsurance amount. You may contact ESI to determine your remaining deductible.
1. **If you participate in the Health+Savings Option**, any remaining Medical Plan Program deductible (up to the cost of the prescription) and appropriate copay or coinsurance amount. You may contact Aetna to determine your remaining deductible.

Typically, a pharmacist at the home delivery program facility will fill your prescription with a generic drug, if available, unless your doctor specifies otherwise. In addition, the pharmacist may contact your doctor if your prescription is unclear or incomplete, or to ask if a substitution or change may be made to the prescription he/she has written. ESI pharmacists will not make any changes to your prescription unless authorized by your doctor.

You will receive your medication approximately 14 days from the date ESI receives your order with the correct payment. If you need your medication sooner, ask your doctor to write two prescriptions:

1. One for up to a 30-day supply to be filled immediately at a retail pharmacy that participates in the ESI network.
1. Another that you can send to the home delivery program for an additional supply.

To order a refill from ESI's home delivery program, contact ESI online or via phone. You may also detach the refill slip, complete the patient order form and mail the request to ESI with the correct payment.

If you are enrolled in the Health+Savings Option, you may use your PayFlex Card® (your HSA debit card) to pay for eligible prescription drug expenses you incur through the home delivery program. **Note:** You cannot use the HSA debit card outside the U.S.
If you use a specialty medication, the Prescription Drug Program offers an enhanced level of service for medications that are not available through a retail pharmacy. You may receive these medications through Accredo Pharmacy, a special mail order pharmacy affiliated with ESI that is designed to service your unique needs and deliver your medication to your doorstep.

Examples of diseases or conditions for which drugs may be obtained through Accredo Pharmacy include but are not limited to, multiple sclerosis, rheumatoid arthritis, HIV/AIDS, cancer, hepatitis B & C, hemophilia and growth hormone deficiency. Certain drugs such as Insulin, Imitrex, Epinephrine and Glucagon are not considered specialty drugs.

**Note:** Effective April 1, 2020, certain designated specialty medication will be covered **only** through Accredo Pharmacy. This change does not affect medications supplied by an emergency room, or during an inpatient hospital stay. However, if any of these medications are obtained from an outpatient clinic, a home infusion company, a doctor’s office, or from another pharmacy, they will not be covered.

Accredo will contact you if the medication you’re taking can be supplied or is required to be supplied through the Accredo program. As an Accredo patient, you will have access to a team of specialists who will work closely with you and your physician throughout your course of therapy.

After you have successfully taken the medication for a six-month period and your physician has deemed that the ongoing dosage and medication are appropriate for your condition, you may begin to receive a 90-day supply from Accredo for the applicable home delivery copay or coinsurance. Until that time, you will receive a 30-day supply each month from Accredo at the applicable retail level copay or coinsurance.

**Copays for specialty medications**

Copays for certain specialty medications will vary depending on the amount of available assistance provided by manufacturers of the particular medication. If you have questions regarding the amount of your copay, please contact ESI.

Your out-of-pocket maximum calculations will reflect your copay amount and not include any financial assistance provided to you by manufacturers of your medications.

**Publication date: April 2020**
Drugs not covered

The Prescription Drug Program does not pay benefits for:

- Any drug that can be purchased legally without a prescription.
- Hair growth agents.
- Homeopathic drugs.
- Injectable cosmetics.
- Nutritional supplements.
- Smoking cessation agents (gum and patches) (covered only for employees and eligible dependents who are enrolled in a HealthPlus Option and participate in a smoking cessation program sponsored by StayWell).

In addition, the following expenses are covered under the medical provisions of the HealthPlus, Standard and Health+Savings Options and are not payable through the Prescription Drug Program:

- Prescriptions administered during a hospital stay (treated as part of the hospital expense).
- Injectables provided at a doctor’s office (treated as a part of the office visit expense).

See Expenses not covered under the BP Medical Plan for all other limitations and exclusions.

Publication date: April 2020
A note about Medicare and prescription drug coverage

If you are eligible for Medicare, you are eligible to enroll in a Medicare Part D plan that offers prescription drug coverage. There is a late enrollment penalty if you do not enroll in Medicare Part D coverage when you are first eligible unless you have “creditable coverage” under an employer group health plan. (You must enroll in a Medicare Part D plan within 63 days of losing creditable coverage to avoid the late enrollment penalty.)

The prescription drug coverage offered under the HealthPlus and Standard Options is considered to be “creditable coverage” for purposes of Medicare Part D. Therefore, you do not need to enroll in a Medicare Part D plan while you are covered under one of these options. However, the prescription drug coverage offered under the Health+Savings Option is not considered to be “creditable coverage” for purposes of Medicare Part D.

Each year, you will be sent a notice notifying you whether the plan’s prescription drug coverage remains “creditable” for purposes of Medicare Part D.

Publication date: April 2020
The Health+Savings OOA Option is available only if you live in an area where the Aetna Choice POS II network is not available. In addition to the option described below, you may want to consider the HealthPlus and Standard OOA Options.

If you participate in a PPO Option, see the PPO Options (HealthPlus and Standard) summary chart or the Health+Savings PPO Option summary chart.

<table>
<thead>
<tr>
<th>General information</th>
<th>Health+Savings OOA Option(^a,b) 2020/2021 Plan Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan year deductible(^c)</td>
<td>$1,500 if you have You Only coverage; $3,000 if you have You + Spouse, You + Child(ren) or You + Family coverage</td>
</tr>
<tr>
<td>See Deductibles for more information</td>
<td></td>
</tr>
<tr>
<td>Plan year out-of-pocket maximum(^c)</td>
<td>$3,000 if you have You Only coverage; $6,000 if you have You + Spouse, You + Child(ren) or You + Family coverage</td>
</tr>
<tr>
<td>See Out-of-pocket maximums for more information</td>
<td></td>
</tr>
<tr>
<td>Lifetime maximum benefit</td>
<td>None</td>
</tr>
</tbody>
</table>

**Prescription drug (administered by Express Scripts)**

| Prescription drug plan year deductible (separate from and in addition to your medical plan deductible) | No separate deductible |
| FDA-approved women’s contraception and generic and OTC bowel prep medications for colonoscopy | 100%; no deductible or copay |

**Retail Pharmacy Network (up to a 30-day supply)**

*Note: Prescriptions purchased at an out-of-network pharmacy are covered only if a network pharmacy is not available.*

| Generic | After medical deductible is met, 100% after $5 copay, except for generic preventive covered at 100% with no copay or deductible |
| Brand name (preferred) | After medical deductible is met, 100% after $25 copay |
| Brand name (non-preferred) | After medical deductible is met, 100% after $45 copay |
| Brand name (when generic is available) | After medical deductible is met, brand name copay plus the difference in cost between the brand name and the equivalent generic |

**Home Delivery Program (up to a 90-day supply)**

| Generic | After medical deductible is met, 100% after $12 copay, except for generic preventive covered at 100% with no copay or deductible |
| Brand name (preferred) | After medical deductible is met, 100% after $65 copay |
| Brand name (non-preferred) | After medical deductible is met, 100% after $125 copay |
| Brand name (when generic is available) | After medical deductible is met, brand |
For the following covered treatments and services, the Health+Savings OOA Option pays

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Coverage Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Doctor visits (other than preventive care)</strong></td>
<td></td>
</tr>
<tr>
<td>Primary care office visit</td>
<td>100% after $20 copay, after deductible&lt;sup&gt;e&lt;/sup&gt;</td>
</tr>
</tbody>
</table>
| Note: surgery is covered at 80% after deductible
| Specialist office visit                        | 100% after $30 copay, after deductible<sup>e</sup>   |
| Note: surgery is covered at 80% after deductible
| Behavioral health office visit                 | 100% after $20 copay, after deductible<sup>e</sup>   |
| Maternity services                             | 100%, no deductible/copay (prenatal); 80% after deductible (post-natal)
<p>| Lab and X-ray                                  | 80%&lt;sup&gt;e&lt;/sup&gt;                                      |
| <strong>Preventive care</strong>                            |                                                      |
| Routine physicals                              | 100%, no copay, no deductible                        |
| Annual well-woman exam                         | 100%, no copay, no deductible                        |
| Mammograms (routine)                           | 100%, no copay, no deductible                        |
| Gestational diabetes screening                 | 100%, no copay, no deductible                        |
| Prostate Specific Antigen (PSA) tests (routine)| 100%, no copay, no deductible                        |
| Colorectal screenings (routine)                | 100%, no copay, no deductible                        |
| Well-child care (routine)                      | 100%, no copay, no deductible                        |
| <strong>Emergency services</strong>                         |                                                      |
| Emergency room (applies to facility charges only) | 80% after $150 copay, after deductible              |
| Ambulance                                      | 80%                                                  |
| Urgent care facility (applies to facility charges only) | 100% after $30 copay, after deductible             |
| <strong>Outpatient services (services provided other than in a doctor’s office)</strong> |                      |
| Outpatient surgery facility                    | 80%                                                  |
| Hospital outpatient services                   | 80%                                                  |
| Doctor/surgeon and related professional fees   | 80%                                                  |
| Behavioral health outpatient treatment (other than office visit)&lt;sup&gt;h&lt;/sup&gt; | 80%                                                  |
| Lab and X-ray                                  | 80%                                                  |
| Radiation therapy/chemotherapy                 | 80%                                                  |
| <strong>Inpatient hospital services</strong>                |                                                      |
| Room and board (semi-private room)&lt;sup&gt;g&lt;/sup&gt; | 80%                                                  |
| Inpatient behavioral health stay, including residential treatment and partial hospitalization&lt;sup&gt;g&lt;/sup&gt; | 80%                                                  |
| Doctor hospital visits                         | 80%                                                  |</p>
<table>
<thead>
<tr>
<th>Benefits are subject to recognized charge limits.</th>
</tr>
</thead>
<tbody>
<tr>
<td>You may need to pay the full amount and submit a claim for reimbursement to Aetna.</td>
</tr>
<tr>
<td>Precertification penalties and amounts above recognized charges do not apply to the plan year deductible or out-of-pocket maximum. Office visit copays and urgent care facility copays do not apply to the plan year deductible; however, they do apply to the out-of-pocket maximum. Prescription drug expenses apply to the plan year deductible and out-of-pocket maximum.</td>
</tr>
<tr>
<td>Unless otherwise noted, benefits paid at 80% or 60% are paid after the plan year deductible has been met.</td>
</tr>
<tr>
<td>The office visit copay covers lab and X-ray charges performed in a doctor's office and billed as part of the visit. When these services are not performed at the time of the office visit, performed at another facility or performed by an entity other than the doctor's office, you must first meet your deductible and then the expense, if covered, would be paid at 80%.</td>
</tr>
<tr>
<td>For additional information about covered preventive care benefits, see the Preventive care section of this SPD or contact Aetna Member Services at 1-866-436-2606.</td>
</tr>
<tr>
<td>Precertification required; benefits may be reduced or denied if precertification not obtained.</td>
</tr>
<tr>
<td>Deductible waived for diabetic insulin pumps and tubing.</td>
</tr>
<tr>
<td>Speech therapy is subject to medical review if one of the following circumstances exist: developmentally delayed due to an injury or sickness (other than a functional nervous disorder); diagnosis of chronic otitis media; or a congenital defect for which corrective surgery has been performed.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lab, X-ray and anesthesia</th>
<th>80%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alternatives to inpatient hospital care</strong>&lt;sup&gt;d&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>Skilled nursing facility (up to 60 days/plan year)&lt;sup&gt;g&lt;/sup&gt;</td>
<td>80%</td>
</tr>
<tr>
<td>Home health care (limited to 120 visits/plan year)&lt;sup&gt;g&lt;/sup&gt;</td>
<td>80%</td>
</tr>
<tr>
<td>Hospice care&lt;sup&gt;g&lt;/sup&gt;</td>
<td>80%</td>
</tr>
<tr>
<td>Outpatient private duty nursing (up to 70 shifts/plan year)&lt;sup&gt;g&lt;/sup&gt;</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Other covered services</strong>&lt;sup&gt;d&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>Chiropractic care (including lab/X-ray provided by a chiropractor); up to 20 visits/plan year</td>
<td>80%</td>
</tr>
<tr>
<td>Contraceptive administration (includes coverage for all contraceptive devices including the associated office visit)</td>
<td>100%, no deductible</td>
</tr>
<tr>
<td>Durable medical equipment, orthotics, consumable medical supplies&lt;sup&gt;h&lt;/sup&gt;</td>
<td>80%</td>
</tr>
<tr>
<td>Prosthetic appliances (including external breast prostheses, wigs)</td>
<td>80%</td>
</tr>
<tr>
<td>Breast pumps and supplies (electronic breast pump limited to one per 36 months)</td>
<td>100%, no deductible</td>
</tr>
<tr>
<td>Lactation consultation</td>
<td>100% first 6 visits; no deductible/copay; then 80% after deductible</td>
</tr>
<tr>
<td>Infertility treatment (limited to diagnostic testing and corrective surgery)</td>
<td>80%</td>
</tr>
<tr>
<td>Infertility treatment through Progyny (including IVF, IUI and fertility preservation)</td>
<td>80%, limited to 3 &quot;Smart Cycles&quot; through Progyny network</td>
</tr>
<tr>
<td>Sterilization (female tubal ligation)</td>
<td>100% covered, no deductible/copay; includes ancillary services</td>
</tr>
<tr>
<td>Sterilization (male vasectomy)</td>
<td>80%</td>
</tr>
<tr>
<td>Outpatient rehabilitation (physical/speech/occupational therapy) and cardiac rehabilitation (A combined maximum of 60 visits per plan year applies to physical, speech and occupational therapy, with no medical review required. Additional visits are not covered.)*&lt;sup&gt;i&lt;/sup&gt;</td>
<td>80%</td>
</tr>
<tr>
<td>Coverage for autism spectrum disorders, including physical therapy/occupational therapy/speech therapy (PT/OT/ST visit limit applies)</td>
<td>80%</td>
</tr>
<tr>
<td>Applied Behavioral Analysis (ABA) (requires precertification)</td>
<td>80%</td>
</tr>
<tr>
<td>TMJ (medical treatment for TMJ covered; TMJ-related dental services and orthodontic appliances not covered)</td>
<td>80%</td>
</tr>
</tbody>
</table>
performed.
How the Out-of-Area Options work

The OOA Options are only available if you live in an area where the network used in the PPO Options is not available.

In the HealthPlus OOA Option you receive lower-cost health care services. However, in order to be eligible for the HealthPlus Option, you and your covered spouse/domestic partner are each required to complete the annual Health Questionnaire as well as earn a minimum of 1,000 wellness points by completing various wellness activities associated with the BP Wellness Program.* To learn about the available activities in the BP Wellness Program and their associated points, you can visit the Wellness section on LifeBenefits.

* New hires and newly eligible employees in their initial year of coverage under HealthPlus are not required to accumulate 1,000 wellness points until the following calendar year.

The OOA Options cover a broad range of medical services and supplies, including preventive and emergency care. If you enroll in an OOA Option, you can choose any licensed doctor, nurse, therapist, hospital, lab or other health care facility you wish whenever you need medical care.

- If you use a hospital or doctor that participates in Aetna’s National Advantage Program (NAP) for a covered expense, you may receive the advantage of contracted rates so your costs may be lower.
- If you use a provider who is not a participating NAP member for a covered expense, your costs may be higher since the provider has not agreed to charge participants lower rates.

The OOA Options pay most of the cost of covered expenses up to what is considered a recognized charge after you meet the plan year deductible. You are responsible for filing all claim forms.

The OOA Options also include the Prescription Drug Program, administered by Express Scripts, Inc. (ESI).

Primary doctors

Under the HealthPlus OOA Option, you will pay lower office visit copays for providers who are considered primary doctors than for those who are considered specialists. Primary doctors are:

- Family practitioners.
- General practitioners.
- Internists.
- Pediatricians.
- Obstetricians/Gynecologists (OB/GYNs).

You are not required to designate a primary doctor or have your primary doctor’s referral to see a specialist.
Health Savings Account (HSA)

The Health Savings Account (HSA) is a bank account that works with the Health+Savings medical option to help you pay for your health care expenses, including any expenses before you meet your Health+Savings deductible. You, and not BP, own that account.

Administered by PayFlex (now part of Aetna), it works like the Health Care Flexible Spending Account (HCFSA) in that you can use tax-free dollars to cover the cost of eligible health care expenses. But unlike the HCFSA, unused funds at year end are kept by you, BP also may make contributions to the account, and you can invest your HSA money in investment funds to potentially grow your savings (assuming your balance is high enough). The earnings you make on your investment are tax-free. (Note: Federal regulations do not allow you or your spouse to contribute to both an HSA and BP’s HCFSA.)

You can use the money in your HSA to pay for eligible health care expenses, or you can choose to save your funds for the future. You never forfeit your contributions to the HSA. Unused money will carry over from one year to the next, helping you save for future expenses. You can keep any remaining money you have saved in your HSA year after year, even if you leave BP. So you can contribute tax-free, the money can grow tax-free and you can use the balance for eligible expenses tax-free — a triple tax advantage!

Who can contribute to an HSA

You are eligible for an HSA if you are:

- Covered by a high deductible health plan, such as the Health+Savings Option.
- Not covered under another health plan (including a plan your spouse/domestic partner may have, unless your spouse’s plan is a high deductible health plan).
- Not enrolled in a Health Care Flexible Spending Account (including an account your spouse may have with BP or a separate employer).*
- Not enrolled in Medicare.
- Not eligible to be claimed as a dependent on another person’s tax return.

* If you have participated in a Health Care Flexible Spending Account during any portion of the BP plan year, you may not switch to the Health+Savings medical option and/or contribute to the Health Savings Account during the remainder of that plan year.

How to enroll

When you enroll in the Health+Savings Option, Aetna will send your information to PayFlex, and PayFlex will set up your account. After you pass a customer identification process, you will receive a mailing with your PayFlex Card® (your HSA debit card) as confirmation that your HSA has been established. In some cases, PayFlex may request that you verify personal information (e.g., Social Security number, home address, date of birth) before opening your HSA.

To access your account information there are three options.

- Log on to the Aetna website at www.aetna.com using your Aetna login information. From here you will have Single Sign On access to your PayFlex accounts.
- You can log in directly at www.payflex.com.
- Using your Mobile App to sign in directly to PayFlex.

Your HSA Information will be accessible through any of these three options. See the HSA Quick Reference Guide for tips on how to manage your account online.

You can start, stop and change your contribution amount at any time, as long as you don’t exceed the annual maximum. While employed at BP, you must be enrolled in the Health+Savings Option to continue contributing to your HSA.

Note that if you dis-enroll from the Health+Savings Option during a calendar year, this could have a retroactive effect on the tax-free nature of some of your HSA contributions — either made by BP or you. You should consult a tax advisor for any tax issues related to the HSA.
BP’s contributions to your HSA

As part of the wellbeing program mentioned earlier, if you complete and return a physician certification form showing that your physician certifies that three out of the five of your metabolic syndrome screening results are within the normal ranges, BP, through the plan, will contribute an additional $1,000 to your HSA. If you cannot meet three out of the five metabolic results, there is an alternative method for you to obtain the $1,000 contribution to your HSA. Your physician can document on your form that those areas have been discussed and are being managed, which would still qualify you for the additional plan contribution. **Your physician must check that box** in order for you to qualify for the $1,000.

If your spouse/domestic partner also completes a physician certification form and his/her physician certifies that three out of the five metabolic syndrome results are within normal ranges, he or she will also earn $1,000, for a family total of $2,000.

To qualify for the additional HSA contributions, send your family’s physician certification forms to StayWell, BP’s wellbeing program administrator.

If there is a medical reason why the above processes to obtain the $1,000 plan contribution are insufficient for you, additional reasonable alternatives will be provided to you. Please contact StayWell to discuss those alternatives, if necessary. Note that simple unavailability later in the year, either via travel or business reasons, will not be a reason to request an alternative process.

Your contributions to your HSA

You can contribute to your HSA through automatic payroll deductions at BP, or you can mail a deposit coupon and payment directly to PayFlex, our HSA administrator. Use the HSA Contribution Coupon to deposit new funds via check.

For the 2020 calendar year, the IRS allows up to $3,550 to be contributed for employee-only coverage and up to $7,100 for family coverage. Please note that any contributions made to your HSA by the plan for completing and returning the physician certification form count toward the maximum amount which can be contributed to your HSA during the year.

During annual enrollment, you decide how much to contribute to your HSA on a before-tax basis, up to the IRS limits, which can change annually. Your contributions will be deducted from your paychecks throughout the year.

If you’re over age 55, you’re also eligible to make an additional $1,000 catch-up contribution per year to your HSA. If your spouse is over age 55, he/she may also make an additional $1,000 contribution to an HSA, but he/she may not make that contribution to your HSA.

You should keep track of your contributions to ensure you don’t exceed these limits. If you do, the excess will be taxed as ordinary income and is subject to a penalty. To avoid penalties, make sure to contribute less than the legal limits, or withdraw any excess contributions and interest on those contributions before the tax-filing deadline. See the HSA Quick Reference Guide for information on how to keep track of your contributions online.

Investment of your HSA

In addition to new contributions, your HSA account can grow through any investment income on your account.

Once your balance reaches $1,000, you have the option to open an investment account for your HSA. Your investment options include Asset Allocation, Fixed Income, and Equity Funds. Each fund has a different investment goal and offers a different level of investment risk and potential return. Accounts for domestic partners and retirees will be charged small monthly fees. For more information, go to www.payflex.com. See the HSA Quick Reference Guide for tips on how to choose your investments online.

Any interest or investment earnings on your HSA account are tax-free.
Spending your HSA

Once you have enrolled, you will receive a mailing with your PayFlex Card® that makes it easy to access your HSA money. Just swipe the card at the point of service for eligible health care expenses, and the funds will be taken directly from your account. Be sure to select “credit” rather than “debit” when you use your card, because the card does not have a separate PIN.

You can use your card to pay for health care products and services, including doctor and dentist visits, hospital stays, prescriptions and hearing and vision care. You may also use your card at some discount and grocery stores, as long as they have a system that can process a health care card. Note: The merchants and providers must accept MasterCard® in order for your card to work.

If you don’t make a payment at the point you receive the service, you should wait for the claim to be processed through the claim system. The doctor’s office or other provider may send you a bill requesting payment for the difference between the billed charges and the amount covered by your health plan. You can write your HSA debit card number on the doctor’s bill and submit it as payment, or you can pay for the expense out of pocket and reimburse yourself later. You should keep your receipts for all expenses.

You can use your debit card for health care bills that have a “Patient Balance Due” if your account is active, you incurred the expense in the current plan year and you have enough funds in your account. To do this, write your debit card number on the bill from the provider in the space requesting credit card information. Make sure you keep your original statement.

To file your claim online, go to the PayFlex site, My Dashboard, via the PayFlex website at www.payflex.com. You can also complete a paper claim form and fax your claim to 1-888-238-3539 or 1-888-AET-FLEX or mail it to the following address:

PayFlex Systems USA, Inc.
P.O. Box 4000
Richmond, KY 40476-4000

You will have access to your account online through My Dashboard on PayFlex’s website at www.payflex.com. When you log in, you can track your expenses, claims and account balance, in addition to submitting claims online. See the HSA Quick Reference Guide for details on how to manage your account online.

Remember to keep all receipts and documentation for future reference or to answer any questions that may arise.

Keep in mind that you can only use your debit card up to the amount already in your HSA, even though you expect to contribute more in the future. If you do not have enough money in your HSA to pay for an eligible medical expense, you’ll need to pay for the expense by some other means. Once the money is in your HSA, you can reimburse yourself for the amount you personally paid for the expense.

Eligible expenses

You can use your HSA for eligible health care expenses for you, your spouse, or your dependents (even if they’re not covered under the Health+Savings Option), as defined by IRS Code Section 213(d).

According to current regulations, the expense must be primarily to alleviate or prevent a physical or mental defect or illness. Examples include prescriptions, doctors’ office visits, and vision and dental care. You can also use your HSA for some health care expenses not covered by your health plan, such as glasses or contact lenses, but such expenses will not count toward your deductible. For a complete list of eligible expenses, go to www.irs.gov or www.payflex.com.

Examples of expenses that do not qualify include most cosmetic surgery, health club dues, maternity clothing, and toiletries. In addition, insurance premiums are not an eligible medical expense for your HSA, though there are exceptions for long-term care coverage premiums and some types of retiree health premiums.

If you use your HSA for expenses other than eligible health care expenses, you automatically subject yourself to IRS penalties. However, the requirement to spend your HSA on eligible health care expenses no longer applies once you turn age 65 or if you become permanently disabled or die.

By law, PayFlex cannot require you to submit documentation backing up the reason for your HSA withdrawal. So it is very important that you keep your receipts as your reimbursements could be subject to a review by the IRS.
If you change medical plans or leave BP

Your HSA is “portable” — it belongs to you. This means that even if you change health plans, take a new job or retire, you can still use the money in the account to pay for eligible expenses. Remember, though, that you must be enrolled in a high deductible medical plan, not be claimed as a tax dependent by someone else and not be enrolled in Medicare to make contributions to your HSA.

If you have an HSA in one year and choose a BP medical option that doesn’t allow for HSA contributions in a future year, you can still use any balance remaining in your HSA for health care expenses. You won’t be able to make new contributions or receive any BP contributions to your HSA while you aren’t enrolled in an eligible high deductible health plan like the Health+Savings Option. As well, this may render some of the contributions to your HSA taxable. You should consult a tax advisor before taking this step.

If you leave BP, any remaining money in your HSA account is still yours. You can transfer it to another HSA account or keep it with PayFlex, paying any required administrative fees.
What the OOA Options pay

Under these options, you may receive medical care from any licensed provider you choose. However, when you receive covered care from a provider who participates in Aetna’s National Advantage Program (NAP), your share of the cost may be lower. This is because NAP providers typically charge plan participants lower, contracted rates.

If you receive care from a provider who is not in the Aetna NAP network and does not honor the copay shown on your medical ID card, you will need to pay the full amount and submit a claim for reimbursement to Aetna. (See How to file a claim.)

The OOA Options generally pay 80% of recognized charges for most other covered expenses after you meet the individual or family plan year deductible, and you pay the remaining coinsurance and any costs above recognized charge limits. **Note:** The OOA Options pay 100% of recognized charges for covered preventive care services, with no copay and no deductible. (See Preventive care.)
Deductibles

You pay the first portion of recognized charges for most covered expenses incurred by you and each covered dependent during the plan year before the plan begins paying benefits.

The Health+Savings OOA Option has two separate deductibles. Under the Health+Savings OOA Option, the lower deductible applies only if you have You Only coverage. The higher deductible applies if you have You + Spouse, You + Child(ren) or You + Family coverage, even if only one family member incurs medical expenses during the year. Under the Health+Savings OOA Option, the lower You Only deductibles would not apply to any covered individual in your family if you have You + Spouse, You + Child(ren) or You + Family coverage.

If you participate in the HealthPlus OOA or Standard OOA Option, any medical expense that counts toward an individual’s deductible automatically counts toward the family deductible. This means that once you meet the family deductible for the plan year, no other covered family member is required to meet his/her individual deductible for that plan year before benefits are paid.

If you participate in the HealthPlus OOA Option, there is no separate plan year deductible for prescription drugs. Prescription drug expenses do not apply to the medical plan deductible.

If you participate in the Standard OOA Option there is a separate prescription drug plan year deductible.

If you participate in the Health+Savings OOA Option, there is no separate plan year deductible for prescription drugs. Prescription drug expenses do apply to the medical plan deductible. You must meet the plan year deductible before the plan starts to pay most expenses, including those for formulary brand preventive and non-preventive prescription drugs.

Expenses excluded from the deductibles

The following expenses do not apply to the medical coverage plan year deductibles under the various OOA Options as indicated:

<table>
<thead>
<tr>
<th>Under the HealthPlus and Standard OOA Options</th>
<th>Under the Health+Savings OOA Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visit copays.</td>
<td>Expenses for diabetic insulin pumps and tubing.</td>
</tr>
<tr>
<td>Urgent care facility copays.</td>
<td>Charges above recognized charge limits.</td>
</tr>
<tr>
<td>Expenses under the Prescription Drug Program.</td>
<td>Penalties for noncompliance with precertification provisions.</td>
</tr>
<tr>
<td>Expenses for diabetic insulin pumps and tubing.</td>
<td>Expenses not covered by the OOA Option.</td>
</tr>
<tr>
<td>Charges above recognized charge limits.</td>
<td></td>
</tr>
<tr>
<td>Penalties for noncompliance with precertification provisions.</td>
<td></td>
</tr>
<tr>
<td>Expenses not covered by the OOA Option.</td>
<td></td>
</tr>
</tbody>
</table>

Publication date: April 2020
Copays/coinsurance

A “copay” is a fixed dollar amount you pay in lieu of a deductible and coinsurance at the time you receive medical services. They apply to certain expenses under the HealthPlus OOA Option as follows:

<table>
<thead>
<tr>
<th>Office visits for non-preventive care under the HealthPlus OOA Option</th>
<th>The office visit copay includes:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 The doctor office visit.</td>
</tr>
<tr>
<td></td>
<td>1 Diagnostic laboratory tests or X-rays performed in a doctor’s office and billed as part of the visit.</td>
</tr>
<tr>
<td></td>
<td>1 Injections administered in a doctor's office as part of the visit (including allergy injections).</td>
</tr>
<tr>
<td>The office visit copay does not apply to:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 Office visits if a surgical procedure as defined by the American Medical Association is performed as part of the visit (for example, if a mole is removed or a broken bone is set during the office visit).</td>
</tr>
<tr>
<td></td>
<td>1 Maternity-related office visits (except for the first office visit to confirm the pregnancy). These visits are included in the delivery charge.</td>
</tr>
<tr>
<td></td>
<td>1 Routine and diagnostic laboratory tests or X-rays performed:</td>
</tr>
<tr>
<td></td>
<td>° In a doctor's office, but not at the time of the visit.</td>
</tr>
<tr>
<td></td>
<td>° In a facility other than the doctor's office.</td>
</tr>
<tr>
<td></td>
<td>° By an entity other than the doctor's office.</td>
</tr>
<tr>
<td>(Ask your doctor whether the lab facilities he/she uses are in the network.)</td>
<td></td>
</tr>
<tr>
<td>1 Chiropractic visits.</td>
<td></td>
</tr>
</tbody>
</table>

| Urgent care facility charges under the HealthPlus OOA Option | Urgent care facility charges are covered at 100% after a copay, with no deductible. |

**Note:** In addition to the copay, you also pay any charges that exceed recognized charge limits. If your doctor does not honor Aetna’s claim procedures, you may need to pay the full amount and submit a claim for reimbursement to Aetna. You will be reimbursed 100% up to recognized charge limits, minus your office visit copay.

**Under both OOA Options:**

1. Eligible preventive care expenses are covered at 100% of recognized charges with no copay and no deductible. See Preventive care for details.
2. Most other covered services are paid at 80% of recognized charges after you meet the individual or family plan year deductible, and you pay the remaining 20% (the coinsurance) and any amounts over the recognized charge limit.
Out-of-pocket maximums

You pay a certain amount of covered expenses each plan year before each Out-of-Area Option begins paying 100% of recognized charges for covered services. This is your medical coverage plan year out-of-pocket maximum.

In addition, the Health+Savings OOA Option has two separate out-of-pocket maximum amounts. Under the Health+Savings OOA Option, the lower out-of-pocket maximum amount applies only if you have You Only coverage. The higher out-of-pocket maximum amount applies if you have You + Spouse, You + Child(ren) or You + Family coverage, even if only one family member incurs medical expenses during the year. Under the Health+Savings OOA Option, the lower You Only out-of-pocket maximum amount would not apply to any covered individual in your family if you have You + Spouse, You + Child(ren) or You + Family coverage.

Under the HealthPlus OOA or Standard OOA Option, any medical expense that counts toward an individual's plan year out-of-pocket maximum automatically counts toward the family out-of-pocket maximum. This means that once you meet the family plan year out-of-pocket maximum, no other covered family member is required to meet his/her individual out-of-pocket maximum for that plan year.

The expenses that apply to the out-of-pocket maximum vary depending on the option in which you are enrolled.

<table>
<thead>
<tr>
<th>If you are enrolled in this option...</th>
<th>The following expenses apply to the option's medical out-of-pocket maximum...</th>
<th>The following expenses do not apply to the option's medical out-of-pocket maximum and are payable by you even after the out-of-pocket maximum has been met...</th>
</tr>
</thead>
</table>
| HealthPlus OOA or Standard OOA Option | i  Deductibles.  
i  Coinsurance.  
i  Office visit copays.  
i  Emergency room/urgent care facility copays.  
i  Expenses under the Prescription Drug Program. | i  Charges above the recognized charge limits.  
i  Penalties for noncompliance with precertification provisions.  
i  Expenses not covered by the OOA Option. |
| Health+Savings OOA Option            | i  Deductibles.  
i  Coinsurance.  
i  Office visit copays.  
i  Emergency room/urgent care facility copays.  
i  Expenses under the Prescription Drug Program. | i  Charges above the recognized charge limits.  
i  Penalties for noncompliance with precertification provisions.  
i  Expenses not covered by the OOA Option. |

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The HealthPlus and Standard Options include special plan provisions. These important features include preventive care, recognized charge limits, precertification requirements and more. More information about each of these features is outlined in this section.

- Preventive care
- Emergency care
- Recognized charge limits
- Aetna's National Advantage Program (NAP)
- Transplant services
- Precertification requirements
- Coverage while traveling
Preventive care

The HealthPlus, Standard and Health+Savings Options provide coverage for the following preventive care services:

- Routine physicals (once per calendar year).
- Routine well-child care.
- Annual well-woman exams.
- Routine mammograms.
- Routine Prostate Specific Antigen (PSA) tests.
- Colorectal screenings.
- Routine hearing and vision chart exams (once per year).
- Preventive items or services with an “A” or “B” rating from the United States Preventive Services Task Force.
- Immunizations pursuant to the Advisory Committee on Immunization Practices (“ACIP”) recommendations.
- Preventive care and screenings that are provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”).
- Gestational diabetes screening.

Routine physicals are covered annually. All other screenings and tests are covered based on age, gender and medical history. Preventive care benefits are subject to age restrictions/limitations as determined under the claims administrator's guidelines. For additional information about benefits for covered preventive care services, contact the member services number on your medical ID card.

Routine physicals and well-child care include the following services:

- Doctor's exam.
- Immunizations.
- Vision chart and hearing screenings performed in a doctor's office.

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Emergency care

No matter where you are, if you have a medical emergency — that is, a sudden and unexpected change in your physical or mental condition which, if not treated immediately, could result in a loss of life or limb, significant impairment of a bodily function or permanent dysfunction of a body part — you should go to the nearest emergency room to get the care you need.

Emergency medical condition

An emergency medical condition is a recent and severe medical condition, including (but not limited to) severe pain, which would lead a prudent person possessing an average knowledge of medicine and health, to believe that his or her condition, illness or injury is of such a nature that failure to get immediate medical care could result in:

- Placing your health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Examples of medical emergencies include heart attack, stroke, severe bleeding, serious burns and poisoning. It can sometimes be difficult to determine when urgent situations are true emergencies. If you need help determining whether your situation is a true emergency, you can consult a doctor who will be able to tell you what steps to take. You can also contact Aetna's 24-Hour NurseLine at 1-800-556-1555 to speak with a registered nurse.

Emergency services

“Emergency services” means, with respect to an emergency medical condition:

- A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient.

Under all PPO Options, you receive the higher, network level benefits for emergency services — even if you see an out-of-network provider. You do not need prior authorization for the treatment of an emergency medical condition, even if the services are provided by an out-of-network provider. Care provided by an out-of-network provider will be paid at no greater cost to you than if the services were performed by a network provider. You may receive a bill for the difference between the amount billed by the out-of-network provider and the amount paid by Aetna. If an out-of-network provider bills you directly for an amount beyond your cost share for the treatment of an emergency medical condition, you are not responsible for paying that amount. Please send the bill to the address listed on the back of your member ID card and Aetna will resolve any payment dispute with the provider over the amount. Make sure your member ID number is on the bill.

Under all OOA Options, your cost may be lower if you use Aetna's National Advantage Program (NAP). See Aetna's National Advantage Program (NAP) for more information. You do not need prior authorization for the treatment of an emergency medical condition.

Under both the PPO and OOA Options, if you are admitted to the hospital, you or someone on your behalf is required to certify your hospitalization within 48 hours (or two business days) of your emergency admission. Instructions on how to contact your claims administrator are provided on your medical option ID card.

Publication date: April 2020
Recognized charge limits

Benefits under the HealthPlus, Standard and Health+Savings Options are based on recognized charge limits.* These Options do not cover otherwise eligible expenses above recognized charge limits — they are your responsibility. For example, if you incur a $200 doctor expense, but only $180 of the charge is within recognized charge limits, only $180 will be considered an eligible expense under the plan.

Recognized charge limits do not apply to:

- Eligible expenses provided by a network provider under the PPO Options.
- Eligible charges from participating NAP hospitals and doctors under the OOA Options. NAP providers can be found by using BP’s custom DocFind website. (See Quick links on the LifeBenefits site.)

The recognized charge for a service or supply is the lower of:

- What the provider bills or submits for that service or supply; and
- The charge the claims administrator determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made, billed or coded.
  - For non-facility charges:
    - PPO Options: The 85th percentile of the Prevailing Charge Rate, for the Geographic Area where the service is furnished.
    - OOA Options: Twice the 95th percentile of the Prevailing Charge Rate, for the Geographic Area where the service is furnished.
  - For facility charges:
    - PPO Options: 150% of the Medicare Fee Schedule for the Geographic Area where the service is furnished. Aetna will determine the usual charge level if a Medicare fee is not applicable.
    - OOA Options: Aetna uses the charge Aetna determines to be the usual charge level made for it in the Geographic Area where it was furnished.

As used above, Geographic Area and Prevailing Charge Rates are defined as follows:

- **Geographic Area**: This means an expense area grouping defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three-digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three-digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three-digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three-digit zip codes, the grouping never crosses state lines.

- **Prevailing Charge Rates**: These are rates reported by FAIR Health, a nonprofit company, in their database. FAIR Health reviews and, if necessary, changes these rates periodically. Aetna updates its systems with these changes within 180 days of receiving them from FAIR Health.

* You may be accustomed to seeing the term "reasonable and customary (R&C)," however Aetna uses the term "recognized charge." Recognized charge works in the same manner as reasonable and customary.

Publication date: April 2020
Aetna’s National Advantage Program (NAP)

The National Advantage Program (NAP) offers you access to Aetna-contracted rates for many hospital and doctor expenses that would otherwise be billed at the provider’s normal rate. These include:

- For the PPO Options, eligible expenses provided by providers who are not Choice POS II network providers but who are Aetna NAP providers.
- For the OOA Options, eligible expenses provided by a provider who is an Aetna NAP provider.

You may save money with the NAP because the contracted rate is generally lower than the provider’s normal charge. In addition, you should not be billed by the provider for the difference between the provider’s normal charge and the contracted rate (i.e., no balance billing).

In order to qualify for Aetna’s contracted NAP rates, the expense must be covered under the plan and the provider must submit the charge to process at the contracted amount before you pay for services. It is therefore important to remind the provider to submit the claim to Aetna directly before you pay.

The NAP network consists of many of Aetna’s directly contracted hospitals, ancillary providers and doctors, as well as hospitals, ancillary providers and doctors accessed through vendor arrangements where Aetna does not have direct contractual arrangements. NAP-participating doctors include primary care doctors, obstetricians, gynecologists, radiologists, anesthesiologists, pathologists and other specialists.

NAP ancillary providers include:

- Acute rehabilitation facilities.
- Ambulatory surgical centers.
- Dialysis centers.
- Freestanding hospices.
- Infusion centers.
- Nursing care agencies.
- Skilled nursing facilities.
- Substance abuse facilities.

Certain claims are not eligible for a NAP discount, including:

- Small hospital or ancillary provider claims (currently below $151) that require manual intervention to obtain a discount.
- Claims involving Medicare or Coordination of benefits (COB) when the plan is not primary.
- Claims that have already been paid directly by the plan participant before the provider has submitted the claim to Aetna at the contracted rate.
- Claims that are not covered by the plan.

To learn more about the providers who participate in the NAP, contact Aetna Member Services or access BP’s custom DocFind website.
Transplant services

The Institutes of Excellence (IOE) network is the claims administrator's network for transplants and transplant-related services, including evaluation and follow-up care. This is a network of facilities that have demonstrated success at performing these highly specialized procedures.

For the PPO Options:

- The network level of benefits is paid for treatment received at a facility designated by the plan as an IOE for the type of transplant being performed. Each IOE facility has been selected to perform only certain types of transplants.
- Services obtained from a facility that is not designated as an IOE for the transplant being performed will be covered as out-of-network services and supplies, even if the facility is a network facility or IOE for other types of services.

The National Medical Excellence (NME) Program coordinates transplants and other specialized care that may not be available in your local area. If you are referred to a facility that is more than 100 miles from your home or you are required to remain within a certain radius of the treating facility that is farther than your home, the NME Program will help pay certain travel and lodging expenses for you and a companion.

If you or one of your covered family members could be a potential transplant candidate, contact the claims administrator to learn more about this program.

Out-of-country care

The National Medical Excellence (NME) Program coordinates care when an Aetna plan participant develops an urgent or acute illness when traveling outside of the United States. Coordination of some or all of the following may apply:

- Assessment of the urgent or acute care facility’s appropriateness for the required care;
- Transfer of the plan participant to a more appropriate acute care facility for stabilization;
- Transfer of the plan participant back to the United States; and
- Transfer of the plan participant to his/her home.
Precertification requirements

The decision to receive care is between you and your provider. If you do not precertify care when you are required to do so, your benefits will be reduced, or in some instances, not paid at all.

- If you are in a PPO Option and you use a network provider for covered medical care, the provider will take care of precertification for you.
- If you use a NAP provider, confirm that the provider is obtaining precertification on your behalf; otherwise contact Aetna directly for precertification. (The NAP Program is a discount program and does not guarantee precertification.)
- In all other instances, you are responsible for obtaining any required precertification.

Precertification is not required for expenses incurred while you are outside the United States.

It is a good idea to provide a family member, friend and/or your doctor with the precertification instructions. That way, they will be able to make the precertification call for you in case you cannot. Even if you rely on someone else to make the call for you, it is your responsibility to follow up to be sure the call was made. Precertification is required for the following services:

- **Inpatient admissions.** Non-emergency hospital (including hospitalization for mental health/substance abuse treatment), skilled nursing facility, and hospice admissions must be precertified by calling the claims administrator at the toll-free precertification number shown on your medical option ID card (at least 10 days in advance for Aetna).

- **Maternity stays.** Precertification of maternity care is not required. If your doctor recommends an extended stay beyond 48 hours for a vaginal delivery or 96 hours for a Caesarean section, the additional days must be precertified with the claims administrator within 48 hours (or two business days). If the mother is discharged before the baby is allowed to go home, the baby’s extended stay must also be precertified.

- **Hospitalization due to a medical emergency.** You must certify by calling the claims administrator within 48 hours (or two business days) of your emergency admission.

- **Enhanced clinical review (NOTE: Applies only to Aetna PPO Options).** Certain services (listed below) are subject to enhanced clinical review through a separate independent company. This company uses medical specialists and diagnostic tools to review your doctor’s request, applying national medical standards, with the initial review accomplished typically within 24 hours of the request. Your doctor should submit a request for clinical review for the following services:
  - Cardiac imaging, including non-urgent outpatient diagnostic catheterization and echo stress tests.
  - Cardiac rhythm implantable devices.
  - Sleep studies.
  - High-tech radiology, including MRI/MRA, CT scan, PET scan and nuclear imaging.
  - Outpatient interventional pain management.
  - Hip and knee replacements (inpatient and outpatient).

Responsibility for obtaining preauthorization of the above services is shared by the patient (or the parent plan participant, if a child), the referring physician and the facility rendering the service. In-network physicians have been engaged regarding this requirement and should be aware of the process.

- **Outpatient medical services.** Some outpatient procedures, including outpatient hospice care, home health care and private duty nursing and, in some circumstances, outpatient rehabilitation services require precertification. Additionally, if your doctor recommends an intensive outpatient program for psychiatric, eating disorder care and/or substance abuse care that is generally two or more hours per day, precertification is required. If your doctor recommends these outpatient services, you or your doctor should call the toll-free precertification number shown on your medical option ID card in advance to make sure the procedure is covered by the plan.

- **Partial hospitalization or a day program.** Outpatient care focused on psychiatric, eating disorder care and/or substance abuse care that is generally four or more hours per day and includes individual, group and family therapies must be precertified in advance by calling the claims administrator at the toll-free precertification number shown on your medical option ID card.

- **Electroconvulsive therapy treatment (ECT).** ECT is systematic use of electric shocks to produce convulsions. Care must be
Precertified in advance by calling the claims administrator at the toll-free precertification number shown on your medical option ID card.

1 Psychological testing. Psychological testing must be precertified by calling the claims administrator at the toll-free precertification number shown on your medical option ID card.

1 Biofeedback. Biofeedback must be precertified by calling the claims administrator at the toll-free precertification number shown on your medical option ID card.

1 Outpatient detoxification. Outpatient detoxification must be precertified by calling the claims administrator at the toll-free precertification number shown on your medical option ID card.

See Process for formal benefit claims and appeals if you receive an adverse benefit determination with respect to your request for precertification.

Precertification penalties

If you do not precertify care (including behavioral health care) when you are required to do so, your benefits will be reduced or, in some instances, not paid at all. Specifically, the following penalties will apply:

1 If you do not call to precertify. All expenses related to care that has not been precertified are reviewed by the claims administrator. Benefits will not be paid for any expenses (including room and board) that were not medically necessary. A $300 penalty will be deducted from any benefits that are otherwise payable.

1 If you call to precertify, but the claims administrator determines that your admission, proposed treatment or expense is not medically necessary: No benefits will be paid.

1 If you call to precertify additional hospital days beyond those initially precertified, but the claims administrator determines that those additional days are not medically necessary: No benefits will be paid for the additional days.

Because PPO network providers are responsible for obtaining precertification of care for you, precertification penalties do not apply under the BP PPO Options for eligible care received from a network provider. However, if you are intending to receive an in-network level of benefits, it is your responsibility to confirm that each provider or facility you use is in the Aetna Choice POS II network. If a provider practices at multiple locations, he/she may not be considered an in-network provider at each location. Confirm with the provider that he/she is in the network at the location you intend to visit before receiving care.

Publication date: April 2020
Coverage while traveling

Eligible medical expenses incurred while traveling within or outside the U.S. are covered. Under all HealthPlus, Standard and Health+Savings Options, you may need to pay the provider in full and submit a claim for reimbursement from your claims administrator.

If you receive medical or behavioral health care or purchase prescription drugs within or outside the U.S. (other than from a PPO network provider, if you are enrolled in a PPO Option), submit a claim to the claims administrator for reimbursement.

If you purchase any prescription medication from a non-network pharmacy, submit a claim to Express Scripts, Inc. (ESI).

Publication date: April 2020
Alternatives to physician office visits

Walk-in clinic visits

Covered expenses include charges made by walk-in clinics for:

- Unscheduled, non-emergency illnesses and injuries;
- The administration of certain immunizations administered within the scope of the clinic’s license; and
- Individual screening and counseling services to aid you:
  - to stop the use of tobacco products;
  - in weight reduction due to obesity;
  - in stress management. The stress management counseling sessions will help you to identify the life events which cause you stress (the physical and mental strain on your body.) The counseling sessions will teach you techniques and changes in behavior to reduce the stress.

Unless specified above, not covered under this benefit are charges incurred for services and supplies furnished:

- In a group setting for screening and counseling services.

Important Notes:

- Deductibles, copays and/or coinsurance will apply where applicable. Refer to the applicable summary chart for more information.
- Not all services are available at all walk-in clinics. The types of services offered will vary by the provider and location of the clinic.
- For a complete description of the screening and counseling services provided on the use of tobacco products and to aid in weight reduction due to obesity, refer to the Preventive care and Expenses covered under the BP Medical Plan sections in this SPD for a description of these services. These services may also be obtained from your physician.

Walk-in clinic

Walk-in clinics are free-standing health care facilities. They are an alternative to a physician’s office visit for treatment of:

- Unscheduled, non-emergency illnesses and injuries;
- The administration of certain immunizations; and
- Individual screening and counseling services.

It is not an alternative for emergency room services or the ongoing care provided by a physician.

Neither:

- An emergency room; nor
- The outpatient department of a hospital;

shall be considered a walk-in clinic.

Publication date: April 2020
Teladoc provides you with 24/7 telephonic access to a national network of U.S. board-certified doctors when enrolled in an Aetna medical plan. There is no additional cost to you for this service. You can call a physician from anywhere — home, work or on the road. Teladoc doctors diagnose non-emergency medical problems, recommend treatment, and can even call in any necessary prescription(s) to your pharmacy.

Teladoc is intended to treat minor non-emergency conditions such as:

- Respiratory infections
- Ear infections
- Urinary tract infections
- Allergies
- Colds and flu
- Sore throat

**How to use Teladoc**

2. Complete your medical history.
3. Request a consultation and a U.S. board-certified physician will call you back within one hour.
4. Pay online. Teladoc visits generally cost less than a regular office visit, with costs not exceeding $40.

Teladoc is available beginning April 1, 2016 to those enrolled in an Aetna medical plan.

Publication date: April 2020
**Enhanced Aetna Concierge**

**How the Enhanced Aetna Concierge program works**

Effective April 1, 2019, the Enhanced Aetna Concierge program is available to participants in Aetna-administered medical plans. This program helps you manage your healthcare by putting you at the center of it all. Resources are available to help you 24/7.

This program puts a team of benefits specialists at one location at your disposal, waiting to resolve all of your healthcare coverage questions and concerns. When you call, you'll be assigned a personal concierge as a single point of contact until your situation is resolved. Your concierge can call upon other team members as needed — doctors, nurses, pharmacists, dietitians, behavioral health specialists, social workers, well-being specialists, network provider specialists and more — to consult with you about your coverage.

The BP Enhanced Aetna Concierge team can do many things for you:

- Schedule appointments with your doctor.
- Coordinate care approvals for an upcoming surgery or procedure.
- Help set coverage goals that are right for you.
- Work with you to help resolve claim inquiries or billing issues.
- Check in with you to see how you’re doing, both routinely when convenient and urgently if needed.
- Connect you to healthcare resources in your community.

**How to reach Enhanced Aetna Concierge**

You can call 1-866-436-2606 at any time. Concierge specialists are available 8:00 am to 8:00 pm Monday-Friday, and 8:00 am to 4:30 pm Saturday, Central time. Additional support is available 24/7/365.

Publication date: April 2020
Prescription drug coverage

The medical plans all offer prescription drug coverage. Under the HealthPlus, Standard and Health+Savings Options, the Prescription Drug Program is administered by Express Scripts (ESI).

In general, the program offers prescription drug benefits two ways:

- **For short-term prescriptions**, you must fill your prescription at any Express Scripts network retail pharmacy, unless one is not available in the area.
- **For longer-term maintenance prescriptions**, you must use the home delivery service.

When you participate in either option, you will receive a separate ESI prescription drug ID card. Each time you fill a prescription at an ESI network retail pharmacy, simply show your ID card so the pharmacist knows you are covered under the program.

- If you are a participant in the HealthPlus Option, there is no separate prescription drug deductible. You only pay your applicable prescription drug copay.
- If you are a participant in the Standard Option, you must meet the separate prescription drug deductible before the plan pays a benefit. Once you meet the separate prescription drug deductible, you will pay a copay for generic drugs, or the applicable coinsurance for preferred or non-preferred brand name drugs.
- If you are a participant in the Health+Savings Option, there is no separate prescription drug deductible. You pay your applicable prescription drug copay after you satisfy the medical plan deductible.

When you use home delivery, you must submit information to ESI. (See Home delivery program for more information.)

Prescription drugs usually fall into one of two basic categories — generic and brand name. Regardless of where you choose to fill your prescription, the program covers three levels of medications: generic drugs, brand name preferred drugs and brand name non-preferred drugs.

- **Generic drugs** have the same active ingredients as brand name drugs and are subject to the same Food and Drug Administration (FDA) standards for quality, strength and purity as their brand name counterparts. Not all brand name drugs have generic equivalents. Typically, your pharmacist will fill your prescription with a generic drug, if available, unless you or your doctor specify otherwise.
- **Brand name drugs** are drugs patented by the FDA and subject to an exclusivity agreement, which allows the company to be the sole manufacturer of the drug for a certain number of years. Brand name drugs include preferred drugs and non-preferred drugs.
  - Preferred drugs are drugs that Express Scripts considers preferred choices, based on their effectiveness and cost, and are on ESI's formulary drug list.
  - Non-preferred drugs are those that are not on ESI's formulary drug list.

A *formulary* is a list of recommended prescription medications that is created, reviewed and continually updated by a team of physicians and pharmacists. The Express Scripts formulary contains a wide range of generic and brand name preferred products that have been approved by the Food and Drug Administration (FDA). The formulary applies to medications that are dispensed in a retail pharmacy or mail service setting. The formulary is developed and maintained by Express Scripts and is available online or a paper copy may be requested. Formulary designations may change as new clinical information becomes available.

If a prescription drug does not have a generic equivalent available, you will be charged the brand name copay (preferred or non-preferred, depending on the drug). Please note that the information on the formulary drug list is not BP-specific, and not all of the preferred drugs covered may be listed nor does BP cover all the drugs that may be listed. If you do not see your drug listed, contact Express Scripts for coverage information.

<table>
<thead>
<tr>
<th>Prescription Drug</th>
<th>HealthPlus Option</th>
<th>Standard Option</th>
<th>Health+Savings Option</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Retail&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Home Delivery</td>
<td>Retail&lt;sup&gt;a&lt;/sup&gt;</td>
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<tr>
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<td>No separate Rx deductible</td>
<td>$75/person; $225/family</td>
<td>No separate Rx deductible; Rx subject to medical plan deductible</td>
</tr>
<tr>
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<td>$5 copay</td>
<td>$12 copay</td>
<td>$5 copay</td>
</tr>
</tbody>
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13/Nov/20 06:55 The most up-to-date information is available online at http://hr.bpglobal.com/lifebenefits/Core. Page 137 of 207
Prescriptions purchased at an out-of-network pharmacy are covered only if a network pharmacy is not available.

You always pay the lesser of the actual cost of your prescription or the copay. All brand name non-sedating and low-sedating antihistamines — even if on the formulary drug list — are subject to the brand name non-preferred drug copay.

Prescription drugs are covered (subject to plan exclusions and limitations) under the Prescription Drug Program if they:

- Require a prescription for dispensing;
- Are FDA indicated for an approved diagnosis;
- Are medically necessary; and
- Are not experimental in nature.

If you participate in a Standard Option and have not met the plan year prescription drug deductible, you pay 100% of the negotiated cost of the medication (if applicable) at a network pharmacy — or the billed charges if a network pharmacy is not available — until the deductible is met. After that, you pay only the applicable copay or coinsurance.

Expenses that are not applied to the separate Standard Option Prescription Drug Program deductible include:

- Copays.
- Prescriptions filled at a retail pharmacy after the two-fill limit on maintenance medication is reached.
- Prescriptions filled at a non-network pharmacy when an ESI network pharmacy is available.
- Prescriptions not covered under the Prescription Drug Program.

Inpatient care and your prescription benefit

Prescription drugs received while you are an inpatient at an extended care facility/skilled nursing facility are payable under the Prescription Drug Program (and not under the medical coverage provisions of the plan). Because you have no control over whether a network pharmacy is used, coverage is provided even when the prescription drugs are obtained from a non-network pharmacy. Whether a network or non-network pharmacy is used, you may need to pay for the prescription drug up front and then file a claim for reimbursement.

Prescriptions covered without deductibles or copays

The following prescriptions are 100% covered without a need to pay a medical or prescription drug deductible or pay any copays:

- FDA-approved women’s contraception.
- Generic preventive prescriptions (applies to the Health+Savings Options only)

Publication date: April 2020
Retail pharmacy network

To use your prescription drug benefit, present your prescription drug ID card when you have your prescription filled.

You must fill your prescription drug at an ESI network pharmacy unless one is not available in the area. No benefit is provided if you use a non-participating pharmacy when an ESI network pharmacy is available. In addition, if you use a non-participating pharmacy when an ESI network pharmacy is available, eligible expenses incurred at the non-participating pharmacy do not count toward the Standard Option’s prescription drug deductible. These restrictions do not apply if you are outside the ESI network area — there is no ESI network pharmacy within a 40-mile radius of your home or work location — or outside the United States.

You may fill maintenance medications (for example, medication for high blood pressure or for high cholesterol) twice through a retail pharmacy. After that, refills must be filled through ESI’s home delivery program to receive benefits under the Prescription Drug Program.

If there is no participating pharmacy within a 40-mile radius of your home or work location, you can go to any pharmacy, have your prescription filled and pay the full cost for it. You will then need to file a claim with ESI and submit it with your original itemized receipt for reimbursement based on plan limitations.

If you are outside the United States, you can go to any pharmacy, have your prescription filled and pay the full cost for it. You will then need to file a claim with ESI and submit it with your original itemized receipt. If you are enrolled in the Standard Option, you must first meet the Prescription Drug Program plan year deductible before you receive any reimbursement. ESI will reimburse you for your cost, less the appropriate copay or coinsurance. In processing your claim incurred while traveling abroad, ESI uses the conversion rate posted on www.oanda.com as of the date the prescription was filled.

If you are enrolled in the Health+Savings Option, you may use your PayFlex Card® (your HSA debit card) to pay for eligible prescription drug expenses at a participating retail pharmacy. **Note:** You cannot use the HSA debit card outside the U.S.
If you live in the United States you can order up to a 90-day supply of maintenance medication for chronic conditions, such as asthma or high blood pressure, through ESI’s home delivery program. The home delivery program is not available if you live outside the United States.

Certain prescription drugs — such as diet medications, growth hormones and topical tretinoin products — are available only through the home delivery program and are available only if they are medically necessary. Anabolic steroids, tretinoin, weight loss management, photo-aged skin products and erectile dysfunction drugs are available only through the home delivery program, subject to plan limits.

To order a prescription through the home delivery program, complete and return an order form (available from ESI or the LifeBenefits website). Return the form, your prescription from your doctor as well as:

1. **If you participate in the HealthPlus Option**, any appropriate copay.
2. **If you participate in the Standard Option**, any remaining Prescription Drug Program deductible (up to the cost of the prescription) and appropriate copay or coinsurance amount. You may contact ESI to determine your remaining deductible.
3. **If you participate in the Health+Savings Option**, any remaining Medical Plan Program deductible (up to the cost of the prescription) and appropriate copay or coinsurance amount. You may contact Aetna to determine your remaining deductible.

Typically, a pharmacist at the home delivery program facility will fill your prescription with a generic drug, if available, unless your doctor specifies otherwise. In addition, the pharmacist may contact your doctor if your prescription is unclear or incomplete, or to ask if a substitution or change may be made to the prescription he/she has written. ESI pharmacists will not make any changes to your prescription unless authorized by your doctor.

You will receive your medication approximately 14 days from the date ESI receives your order with the correct payment. If you need your medication sooner, ask your doctor to write two prescriptions:

1. One for up to a 30-day supply to be filled immediately at a retail pharmacy that participates in the ESI network.
2. Another that you can send to the home delivery program for an additional supply.

To order a refill from ESI’s home delivery program, contact ESI online or via phone. You may also detach the refill slip, complete the patient order form and mail the request to ESI with the correct payment.

If you are enrolled in the Health+Savings Option, you may use your PayFlex Card® (your HSA debit card) to pay for eligible prescription drug expenses you incur through the home delivery program. **Note:** You cannot use the HSA debit card outside the U.S.

**Publication date: April 2020**
Specialty pharmacy

If you use a specialty medication, the Prescription Drug Program offers an enhanced level of service for medications that are not available through a retail pharmacy. You may receive these medications through Accredo Pharmacy, a special mail order pharmacy affiliated with ESI that is designed to service your unique needs and deliver your medication to your doorstep.

Examples of diseases or conditions for which drugs may be obtained through Accredo Pharmacy include but are not limited to, multiple sclerosis, rheumatoid arthritis, HIV/AIDS, cancer, hepatitis B & C, hemophilia and growth hormone deficiency. Certain drugs such as Insulin, Imitrex, Epinephrine and Glucagon are not considered specialty drugs.

Note: Effective April 1, 2020, certain designated specialty medication will be covered only through Accredo Pharmacy. This change does not affect medications supplied by an emergency room, or during an inpatient hospital stay. However, if any of these medications are obtained from an outpatient clinic, a home infusion company, a doctor’s office, or from another pharmacy, they will not be covered.

Accredo will contact you if the medication you’re taking can be supplied or is required to be supplied through the Accredo program. As an Accredo patient, you will have access to a team of specialists who will work closely with you and your physician throughout your course of therapy.

After you have successfully taken the medication for a six-month period and your physician has deemed that the ongoing dosage and medication are appropriate for your condition, you may begin to receive a 90-day supply from Accredo for the applicable home delivery copay or coinsurance. Until that time, you will receive a 30-day supply each month from Accredo at the applicable retail level copay or coinsurance.

Copays for specialty medications

Copays for certain specialty medications will vary depending on the amount of available assistance provided by manufacturers of the particular medication. If you have questions regarding the amount of your copay, please contact ESI.

Your out-of-pocket maximum calculations will reflect your copay amount and not include any financial assistance provided to you by manufacturers of your medications.
Drugs not covered

The Prescription Drug Program does not pay benefits for:

- Any drug that can be purchased legally without a prescription.
- Hair growth agents.
- Homeopathic drugs.
- Injectable cosmetics.
- Nutritional supplements.
- Smoking cessation agents (gum and patches) (covered only for employees and eligible dependents who are enrolled in a HealthPlus Option and participate in a smoking cessation program sponsored by StayWell).

In addition, the following expenses are covered under the medical provisions of the HealthPlus, Standard and Health+Savings Options and are not payable through the Prescription Drug Program:

- Prescriptions administered during a hospital stay (treated as part of the hospital expense).
- Injectables provided at a doctor’s office (treated as a part of the office visit expense).

See Expenses not covered under the BP Medical Plan for all other limitations and exclusions.

Publication date: April 2020
A note about Medicare and prescription drug coverage

If you are eligible for Medicare, you are eligible to enroll in a Medicare Part D plan that offers prescription drug coverage. There is a late enrollment penalty if you do not enroll in Medicare Part D coverage when you are first eligible unless you have “creditable coverage” under an employer group health plan. (You must enroll in a Medicare Part D plan within 63 days of losing creditable coverage to avoid the late enrollment penalty.)

The prescription drug coverage offered under the HealthPlus and Standard Options is considered to be “creditable coverage” for purposes of Medicare Part D. Therefore, you do not need to enroll in a Medicare Part D plan while you are covered under one of these options. However, the prescription drug coverage offered under the Health+Savings Option is not considered to be “creditable coverage” for purposes of Medicare Part D.

Each year, you will be sent a notice notifying you whether the plan's prescription drug coverage remains “creditable” for purposes of Medicare Part D.
How HMOs work

Under an HMO, you must coordinate your care through a primary doctor

An HMO, or Health Maintenance Organization, takes a different approach to health care relative to the BP Medical Plan options. If you participate in an HMO, all of your health care must be provided by the HMO’s network of providers to receive benefits. You must select a primary care physician (PCP) from the HMO's network for yourself and for each family member you cover. Your PCP will direct your care, including providing referrals to see a specialist. If you want to change to a different PCP, you need to contact your HMO.

You have the right to designate any PCP who participates in the HMO's network and who is available to accept you or your family members. For children, you may designate a pediatrician as the PCP. Women do not need to obtain authorization from their HMO or PCP to obtain access to obstetrical or gynecological care from HMO network providers who specialize in obstetrics or gynecology.

Some HMOs do not provide coverage for domestic partners. If you want to cover a domestic partner, be sure to call the HMO's member services department for information before you enroll in the plan. Contact information for the available HMOs is available through the LifeBenefits site.

If you see a health care provider who is not affiliated with the HMO or receive medical care without the proper referrals, no benefits will be paid.

If you are enrolled in an HMO and have benefit questions, contact your HMO’s member services department for answers at the phone number listed on your HMO ID card.

You may also request a booklet describing your HMO's general rules and services. Be aware that covered services and treatments may vary from HMO to HMO and may be different from those provided by the BP Medical Plan.

HMOs are subject to the same rules regarding health care claims that apply to the BP Medical Plan. Therefore, the HMO’s rules and procedures must be no less beneficial to HMO participants than the rules that apply to claimants under the BP Medical Plan. Because HMOs are generally insured, they may be subject to claims and appeals rules and procedures under applicable state laws that provide participants even greater potential procedural protections. Contact your HMO for its rules and procedures regarding health care claims.

What else you should know about HMOs

HMOs are independent business entities. The HMO — and not BP — is fully responsible for providing benefits and coverage once the HMO premium has been paid. As a result, neither BP nor the plan administrator can interfere in medical or administrative decisions made by an HMO or direct the HMO in any way regarding benefits or coverage. Therefore, if you and an HMO medical provider do not agree on a course of treatment, you must personally pursue the matter through the HMO's appeals process. Similarly, if an HMO fails to pay its network provider for service you receive, you may be individually liable to pay for such services. Additional financial assistance from BP will not be provided.

Publication date: April 2020
BP has partnered with a third-party wellness organization, StayWell, to offer a variety of wellbeing programs to support the health needs and interests of plan participants. These wellbeing programs are only available to covered BP employees and their covered spouse/domestic partner.

Participation in these programs also determines your eligibility to enroll in the HealthPlus or Health+Savings Options. You (and your covered spouse/domestic partner if electing You + spouse/domestic partner or You + family coverage) must each earn a minimum of 1,000 points annually by participating in these programs.

To learn more about the available activities in the BP wellbeing program and their associated points, visit the StayWell website, which you can log onto via the BP Benefits Center. Also, as with all other plan benefits, you are not eligible to participate in the wellbeing program unless you are a participant in this plan.

**Wellbeing for all of you**

Whether it’s exercising regularly, utilizing preventive care or educating yourself on wellbeing, we want you to discover new ways to advance your wellbeing throughout the year.

Here is a snapshot of your 2020 wellbeing program and points.

**Health and wellbeing**

**Health questionnaire (125 points)**

Want to learn how your lifestyle habits affect your health and wellbeing? Complete the Health Questionnaire. Once this is completed, you'll receive a confidential online health report with tips to improve your health. Plus, you'll earn 125 points!

*Please know that your report is not a substitute for medical care and cannot be used to diagnose health problems.*

**BP Million Step Challenge (250-1,000 points)**

With every million steps you take during the year, you’ll earn 250 wellbeing points, up to a maximum of four million steps and 1,000 points!

Participating in the challenge is easier than ever. While Fitbit is still the recommended tracking device, you have the option to connect other devices to the challenge.

You will need to connect your tracking device to the new portal. To connect, log on to the StayWell portal via LifeBenefits, click the transmitter icon in the upper right navigation of the desktop site and select “Sync Devices,” then “Choose Source,” and follow the steps to connect your device.

On the “My StayWell” app, simply click “Sync Device” from the “More” option on the bottom navigation. Connect Apple Healthkit or Apple watch through the “My StayWell” app. Wear your tracker and sync to your StayWell account.

*Only device-tracked steps will count toward the Million Step goals. Self-reported or manually tracked steps will not be applied toward the goals.*

**1,500 active minutes (125-500 points)**

Challenge yourself to be physically active for at least 1,500 minutes each quarter (500 points max). Points are awarded on a quarterly basis via device tracked and synced activity.

*Only device-tracked activity will count towards active minutes. Self-reported or manually tracked minutes will not be applied toward the goals.*
Annual physical (375 points)

If you are enrolled in the HealthPlus, Health+Savings, or Standard medical option, Aetna and BCBS-IL will automatically notify StayWell when a claim is processed for an annual physical/well-woman exam and you will earn 375 points. It can take up to 8 weeks for Aetna or BCBS-IL to notify StayWell and points to be awarded.

To earn points immediately, you may also choose to self-report your exam by visiting the StayWell portal and uploading your completed Preventive Visit/Annual Physical Report Form. Find the self-report form via “My Points” or the Resources Tab on the StayWell portal.

Preventive exam: mammogram/colonoscopy (125 points)

If you are enrolled in the HealthPlus, Health+Savings, or Standard medical option, Aetna and BCBS-IL will automatically notify StayWell when a claim is processed for a mammogram or colonoscopy exam. It can take up to 8 weeks from your office visit for StayWell to be notified and your 125 points to be awarded.

To earn points immediately, you may also choose to self-report your exam by uploading your completed Preventive exam: mammogram/colonoscopy self-report form.

Preventive health: flu shot (75 points)

Get your flu shot this season and earn 75 points. Self-report your flu shot by visiting the StayWell portal and uploading your completed Preventive health: flu shot self-report form.

Preventive visit: dental (125 points)

Visit your dentist for a preventive exam in 2020 and earn 125 points! If you are enrolled in Cigna dental coverage, StayWell will receive a record of your visit and your 125 points will be awarded. It can take up to 8 weeks for Cigna to notify StayWell and points to be awarded.

To earn points immediately, you may also choose to self-report your exam by visiting the StayWell portal and uploading your completed Preventive visit: dental self-report form.

Preventive visit: vision (125 points)

Visit your vision clinic for a preventive exam in 2020 and earn 125 points! Self-report your exam by visiting the StayWell portal and uploading your completed Preventive visit: vision self-report form.

Care management (250 points)

Care management includes condition management and complex case management, and is coordinated through plan providers.

Condition management is for participants managing certain chronic conditions such as asthma, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF) and coronary artery disease (CAD). You’ll receive confidential support to help you learn to better care for your condition. Complete at least three calls with an Aetna or BCBS-IL nurse to earn 250 points.

Complex case management is for participants with an acute condition such as a severe stroke, transplant, severe injury or cancer that requires extensive treatment. The program allows you to receive support with navigating healthcare, creating a care plan and optimizing your health benefits. Complete a plan and at least three calls with an Aetna or BCBS-IL case management nurse (depending on your medical plan enrollment) to earn 250 points.

To see if you qualify, call your plan provider: Aetna at 1-866-436-2606 or BCBS-IL at 1-800-635-1928.

These programs are available to eligible participants who are identified for care management by Aetna or BCBS-IL.

Livongo diabetes management (15 checks) (50-250 points)

If you have diabetes, you may be eligible to participate in Livongo for Diabetes, a health benefit that makes living with diabetes easier at no cost to you. Earn 50 points for every 15 checks per month, 250 points max. Livongo will provide StayWell with monthly check counts. Look for your points to be updated each month.

To see if you qualify, visit https://welcome.livongo.com or call 1-800-945-4355.
Lifestyle management coaching (250 points)
Available through telephonic or virtual coaching, you work one-on-one with a trained health coach to achieve your wellbeing goals. Complete at least three calls with a StayWell coach to earn 250 points.

Call 1-888-343-9862 to register for telephonic coaching. For virtual coaching, click on the “Coach” icon just beneath your profile picture on the dashboard.

To earn your points, you must start this program no later than September 1, 2020, and complete it by December 31, 2020.

Weight management (250 points)
Coming soon! Stay tuned for information on this program and how to participate.

Wellbeing workshops (onsite or digital learning) (125-375 points)
Attend a live workshop or complete an online course that interests you. New topics are released quarterly. Access information via “My Points” on the StayWell portal. Earn 125 points each, up to 375 points.

Sessions (digital learning) (25-300 points)
Every month a new educational session will be released! Each session includes three actions: reading a short, informative article; completing a fun activity; and picking and tracking a wellbeing goal for a month. Earn 25 points for each session you complete, up to 300 points.

Daily Dash (25-125 points)
Participate in wellbeing challenges to help build healthy habits to move more, eat well, stress less and sleep better. Enroll in the Daily Dash email campaign to earn 25 points per month, up to 125 points.

Social wellbeing

Participate in a community event (125 points)
Complete a run, walk, bike, or swim event that is 10k or longer and earn 125 points. The event must be an official, sanctioned event. To earn points, upload a picture of yourself at the event or your participant bib, online results with time/name/website, or an email of your race completion from the race organizer. Events may include triathlons, relay races, marathons, MS150, etc.

Participate in a 5k (75 points)
Run, walk, or jog a 5k (about 3.2 miles) and earn 75 points. The event must be an official, sanctioned 5k. To earn your points, upload a picture of yourself at the event, your participant bib, online results with time/name/website, or an email of your race completion from the race organizer.

Group exercise classes (10 classes) (75-150 points)
Attend 10 group exercise classes and earn 75 points, up to a maximum 150 points. Once all 10 sessions are completed, upload a copy of your attendance from your fitness center’s or studio’s account. Or complete the Tracking Form available on the StayWell portal by recording each group exercise class you attended.

Local activity (75-150 points)
Participate in a BP-sponsored local activity and earn 75 points, up to 150 points maximum. Visit the StayWell portal for events happening at your location.

Personal training sessions (5 sessions) (75-150 points)
Attend 5 personal training sessions and earn 75 points, up to a maximum 150 points. Complete the Tracking Form available via the StayWell platform by recording each personal training session you attended and having your instructor sign the form.
Complete a certified CPR/first aid training course (75 points)

Complete a certified CPR/First Aid Training Course and earn 75 points. Upload a copy of your certification or certificate of participation via the StayWell portal.

Donate blood/platelets (75 points)

Donate blood or platelets, save lives and earn 75 points. Upload your proof of completion via the StayWell portal. Examples of proof would be a picture of yourself with the “I donated” sticker, a confirmation email or a “thank you for donating” email.

Attend a BP BRG networking event (75 points)

Attend a BP-sanctioned BRG event and earn 75 points. See your BRG lead to find out about upcoming events that are eligible for points. Following the event, upload the self-report form provided by the BRG event lead to the StayWell platform.

Volunteer (75 points)

Take part in a volunteer opportunity of your choice in your community and earn 75 points. The volunteer event must last for at least 1 hour. Upload a picture of your proof of completion via the StayWell platform.

Emotional wellbeing

Sleep tracking (75-300 points)

Track 7 hours of sleep for at least 30 nights each quarter to earn up to 300 points.

*Only device-tracked minutes will count for points. Self-reported or manually tracked minutes will not be applied toward the goals.*

Sleep Basics digital learning (75 points)

This online digital learning will provide tips for improving your sleep and information on common sleep disorders, causes of sleepless nights, and effects of sleep deprivation. Attend the online class to earn 75 points.

Sound Science for Sound Sleep digital learning (75 points)

Learn research-based ways to maximize your sleep and become a healthier you. This digital learning will cover why you need sleep and how much you need; types of sleep; improving sleep habits and sleep efficiency; and understanding shift work and sleep. Attend the online class to earn 75 points.

Meditation sessions (25-125 points)

Practice meditation and track at least 10 sessions to earn 25 points, up to 125 points max. To sync your meditation minutes, download the Provata VR meditation or Headspace app.

Headspace must be connected to your Apple Healthkit or Google Healthkit in order for your activity to be tracked automatically on this site. Use the My StayWell App Guide in the Resources Tab of the StayWell portal for instructions on syncing mindful minutes.

On the Provata VR app, login with your StayWell user credentials.

EAP counseling (125 points)

Participate in an EAP counseling session and earn 125 points. The program is completely voluntary and confidential. To set up a session, contact an EAP professional counselor at 1-800-409-3687.

EAP or Bright Horizons webinar (75 points)

Complete an EAP or Bright Horizons webinar and earn 75 points.
BP Resilience & Psychological Wellbeing briefing (125 points)

Attend a BP Resilience or Mental Wellbeing training through the BP “My Talent and Learning” portal to earn 125 points. Briefing is only accessible to active BP employees, Sessions are limited.

Financial wellbeing

Financial fitness assessment (125 points)

Complete the online Financial Fitness Assessment to receive a personalized report with key action steps to improve your financial wellbeing. Schedule a follow-up call with a PwC financial coach to discuss the results of the assessment and develop an action plan. Complete your assessment and coaching call by December 18, 2020, to earn 125 points.

Retirement readiness assessment (125 points)

Complete the online Retirement Readiness Assessment to receive a personalized report with key action steps to improve your financial wellbeing. Schedule a follow-up call with a PwC financial coach to discuss the results of the assessment and develop an action plan. Complete your assessment and coaching call by December 18, 2020, to earn points.

Financial wellbeing classes (125-375 points)

Get the information you need to make smart financial decisions. Choose from a wide variety of personal financial topics. View an online class (45 to 60 minutes long) and complete the knowledge-check questions. Or you can choose to participate in a scheduled onsite class. Earn 125 points for each class, up to 375 points.

Financial coaching (3 sessions) (250 points)

Work toward specific financial goals with the help of a PwC financial coach. Sign up for the goal you want to achieve (pay down debt, save for education expenses, buy my first home, plan for retirement, protect my assets, or prepare for the unexpected). Then complete three telephonic coaching sessions to earn 250 points. To earn points for the current calendar year, schedule your first telephonic coaching session before September 15, 2020, and complete your three sessions by December 18, 2020.

Financial digital workshops (25-125 points)

Increase your financial knowledge with a range of useful financial planning topics. Earn 25 points per digital workshop completed, up to 125 points. Start participating by going to LifeBenefits, then Quick Links, PwC – financial wellbeing. Watch for a new series on generating income in retirement that will be released in Q1 and Q2 of 2020.

Invest your HSA dollars (125 points)

Earn 125 points for investing with your Health Savings Account. Invest for the first time or increase your investments to be eligible for this incentive. For more information, go to www.aetna.com. Invest via the PayFlex website. For more information or questions, contact the Enhanced Aetna Concierge at 1-866-436-2606.

Review/update your beneficiaries (25 points)

Confirm that you have reviewed/updated your beneficiary designations on retirement accounts and life insurance within the current calendar year via PwC and earn 25 points.

Develop a financial plan (25 points)

Confirm that you have created/reviewed your financial plan within the current calendar year and earn 25 points. If you have not, PwC can help you create and review your financial plan by contacting the PwC CounselLine at 1-866-237-6165 Monday through Friday 8 am-7 pm CT.

Bonus points

Complete an activity from each category (75 points)

Focus on BP’s 4 pillars of wellbeing: Health, Emotional, Financial and Social. When you complete at least one activity from each category, you’ll receive 75 bonus points.
Physician Certification Form

Metabolic syndrome is a group of conditions associated with the development of cardiovascular disease and type 2 diabetes. It is important to complete a metabolic screening to learn your numbers, identify your risks, and plan positive lifestyle changes that will help you maintain or improve your results.

You can also earn up to $1,000 as a BP contribution into your HSA account! Here’s how:

1. Beginning April 1, 2020, complete your Physician Certification Form (PCF). You must have all 5 measures submitted on your form. If at least 3 of the 5 measures are within the target range and you submit your completed and signed PCF form to StayWell by December 15, 2020, you’ll qualify to receive the $1,000 BP HSA contribution.

2. If you do not have at least 3 of the 5 measures in the target range, you may still receive the HSA incentive by completing the alternative option. Complete 3 calls with a StayWell health coach to be eligible for the $1,000 BP HSA contribution. Note: It is recommended that your PCF form be completed by November 1, 2020, in order to allow enough time to complete the 3 coaching calls before the deadline. The coaching calls can take anywhere from 6-12 weeks to complete and must be completed by December 15, 2020, to be eligible for the incentive in 2020.

3. Spouses/domestic partners are also eligible for the $1,000 BP HSA contribution by following the procedures above. 3 of 5 measures must be in the target range, or the alternative option must be completed.

**Note:** Retirees and their spouses/domestic partners and retail employees are not eligible for this incentive.

Notice regarding wellness program

BP’s wellbeing program is a voluntary wellness program available to all participants in the BP Medical Plan. The program is administered according to federal rules governing wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellbeing program, you will have the opportunity to complete the Health Questionnaire. The Health Questionnaire is a voluntary health risk assessment that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). If you participate in the Health+Savings option, you will also have the opportunity to complete the physician certification form where you will complete a metabolic screening and measure your blood pressure, HDL cholesterol, triglycerides, fasting blood glucose and waist circumference.

Both of these opportunities are voluntary to you, as is participation in the wellbeing program overall. However, participants who choose to participate in the wellbeing program earn points towards your eligibility for the HealthPlus and Health+Savings options. As well, if you are in the Health+Savings option, although you are not required to complete the physician certification form, only employees who do so will receive the BP contribution to their Health Savings Account.

Additional points-earning opportunities are available throughout the BP wellbeing program, some of which are health-related. Please refer to the Points snapshot or the StayWell portal for a complete description of each opportunity. If you are unable due to a medical condition to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, a reasonable accommodation or an alternative standard is available. You may request a reasonable accommodation or an alternative standard by contacting the BP Benefits Center at 1-800-890-4100.

The information from the Health Questionnaire and from your physician certification form will be used to provide you with information to help you understand your current health and potential risks, and may also be used in partnership with a StayWell health advisor to design wellbeing activities that suit you specifically. You also are encouraged to share your results or concerns with your own doctor.
Protections from disclosure of medical information

As further described in the Plan's summary plan description, the BP Medical Plan is required by law to maintain the privacy and security of your personally identifiable health information. Although the wellbeing program coordinator and BP's Benefits team may use aggregate information it collects to design a program based on identified health risks, the BP Medical Plan will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellbeing program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellbeing program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellbeing program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellbeing program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellbeing program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information from the BP wellbeing program are Alight, StayWell, Livongo, approved members of the BP Benefits department, Aetna and/or BCBS-IL, and all done in order to provide you with services under the wellbeing program.

In addition, all personally identifiable medical information obtained by BP Benefits through the wellbeing program will be maintained wholly separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellbeing program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellbeing program, we will notify you in accordance with applicable law.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellbeing program, nor may you be subjected to retaliation if you choose not to participate.

Publication date: April 2020
How the Employee Assistance Program (EAP) works

For immediate EAP assistance, call 1-800-409-3687. This service is available 24 hours a day, seven days a week.

When you find that you need help with a situation that disrupts your family life or negatively affects job performance, reach out to the EAP (also known as BP Care, your Employee Assistance and Work Life Program) for help. The EAP’s Work-Life Consultants and referrals for care can help you and the members of your household lead healthier and more productive lives. The program is completely voluntary and confidential.

The EAP is provided at no cost to you and any members of your household, regardless of relationship or whether the person qualifies as an eligible dependent under the BP Medical Program. You do not have to participate in any other BP benefits to access information and services provided by the EAP. You and all of your household members are automatically enrolled in the EAP once you begin your BP employment.

BP Care offers two ways to get help and information — by phone or online. BP Care can provide you with assistance or referrals for assistance in a wide range of areas that may be causing problems in your work or home life, including:

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Contacting BP Care via phone

You can reach the EAP by phone at 1-800-409-3687. BP Care Work-Life Consultants are available 24 hours a day, seven days a week. Each time you call the EAP, you speak with a counselor who can help you address your issues and concerns. If you contact the EAP by phone, you are eligible for up to six phone counseling sessions at no cost.

Contacting BP Care online

If you choose to research issues or get help using the Internet, you can access BP Care online at EAPHelplink.com (the Company Code is “BP”). The site provides information on a variety of topics such as mental health and substance abuse, child and elder care referrals and more. You can access the site 24 hours a day, seven days a week. Much of the information on the site is also available in Spanish.

If you choose to reach out for help via the BP Care website, you will find a variety of information on numerous topics. You can even connect with a counselor via the BP Care “instant message” service. Online counselors are available 24 hours a day, seven days a week, with the exception of regularly scheduled and emergency maintenance.

The BP Care website also provides quick links to the following tools in the right navigation, click on:

- **Locate Resources** to find help in your area, for example, to locate available day care, schools and volunteer opportunities.
- **Live Connect** to instant message with a Work-Life Consultant.
- **Savings Center** to find discounts on name-brand, everyday and luxury items.
- **Learning Center** to access lessons to improve your mental and physical health, and relationships at work and at home.
- **Relocation Center** to get inside information on a community. Lists the schools, hospitals and places of worship near you. Provides statistics on crime rates, cost and types of housing, age and more.
- **Events** to see a listing of upcoming online seminars on topics that may be of interest such as “Preparing to Leave the Nest: Tips for Young Adults and Parents.”
Employee Assistance Program claims

You are not required to file a claim for services provided through the EAP (BP Care). If you need additional sessions beyond the six EAP sessions, your BP Care counselor may refer you to a local behavioral health care or medical provider.

Publication date: April 2020
Eligible/ineligible expenses

Find out more about what medical care is covered and what is not

The BP Medical Plan covers the majority of care you may likely need, such as doctor office visits, emergency care and hospitalization, at certain costs to you. Benefits are also provided for certain preventive care, as well as for behavioral health care and prescription drugs.

- Expenses covered under the BP Medical Plan
- Expenses not covered under the BP Medical Plan

Publication date: April 2020
Expenses covered under the BP Medical Plan

Medically necessary is defined as a treatment, service or supply determined by the applicable claims administrator to be:

- Necessary for the diagnosis, care or treatment of a covered person’s mental or physical illness, including pregnancy, illness or injury, such as to restore the health and extend the life of the covered person;
- Part of a course of treatment generally accepted by all branches of the American professional medical community;
- Legal and ordered by a licensed physician or other provider licensed to treat the covered person’s condition;
- Utilized in the proper quantity, frequency and duration for the treatment of the condition for which they are ordered; and
- Not redundant when combined with other treatment being rendered to the covered person.

For inpatient services, “medically necessary” further means that an individual’s medical symptoms or condition requires that the diagnosis or treatment cannot safely be provided to the individual through outpatient services.

Medically Necessary or Medical Necessity

Health care or dental services and supplies or prescription drugs that a physician, other health care provider or dental provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms and that provision of the service, supply or prescription drug is:

a) In accordance with generally accepted standards of medical or dental practice;
b) Clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease;
c) Not primarily for the convenience of the patient, physician or other health care or dental provider; and
d) Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, “generally accepted standards of medical or dental practice” means standards that are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community, or otherwise consistent with physician or dental specialty society recommendations and the views of the physicians or dentists practicing in relevant clinical areas and any other relevant factors.

For more details about medical expenses or behavioral health care covered under the BP Medical Plan, call Aetna. For more details about prescription drug expenses covered under the BP Medical Plan’s Prescription Drug Program, call ESI.
Expenses covered under the BP Medical Plan

The BP Medical Plan covers a broad range of medical services and supplies that are medically necessary, subject to the deductibles, copays, coinsurance, exclusions and limits applicable for the relevant option. It does not provide benefits for all medical care.

- Acupuncture in lieu of anesthesia.

- Autism spectrum disorder:
  - Covered expenses include charges made by a physician or behavioral health provider for the services and supplies for the diagnosis and treatment (including routine behavioral health services such as office visits or therapy and Applied Behavioral Analysis) of Autism Spectrum Disorder when ordered by a physician, licensed psychologist or licensed clinical social worker, as part of a treatment plan; and the covered child is diagnosed with Autism Spectrum Disorder.
  - Applied Behavioral Analysis is an educational service that is the process of applying interventions:
    - That systematically change behavior; and
    - That are responsible for the observable improvement in behavior.
  - Autism Spectrum Disorder is defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

- Behavioral health (mental health and substance abuse), including:
  - Inpatient hospital care.
  - Residential treatment facility care.
  - Outpatient physician and facility care.
  - Partial hospitalization. This includes day care and night care treatment.

  Behavioral health care includes treatment of:
  - Anorexia/Bulimia Nervosa (including nutritional counseling).
  - Bipolar disorder.
  - Major depressive disorder.
  - Obsessive compulsive disorder.
  - Panic disorder.
  - Psychotic disorders/Delusional disorder.
  - Schizo-affective disorder.
  - Schizophrenia.
  - Substance abuse.

- Biofeedback.

- Chiropractic care (up to 20 visits/plan year combined maximum for network and out-of-network care).

- Contraceptive drugs (administered in a physician’s office) and contraceptive devices prescribed by a physician provided they have been approved by the Federal Drug Administration, as well as associated office visits, procedures, and other medical services and supplies.

- Durable medical equipment, orthotics and consumable medical supplies, including diabetic insulin pumps and tubing.

- Emergency services, including:
  - Ambulance services (ground, air or water).
  - Hospital emergency room/urgent care center.

- Habilitation therapy services:
  - Habilitation therapy services are services that help you keep, learn, or improve skills and functioning for daily living (e.g., therapy for a child who isn’t walking or talking at the expected age).
  - Eligible health services include habilitation therapy services your physician prescribes. The services have to be performed by:
    - A licensed or certified physical, occupational or speech therapist.
    - A hospital, skilled nursing facility or hospice facility.
    - A home health care agency.
    - A physician.
    - Other provider acting within the scope of their license.
  - Habilitation therapy services have to follow a specific treatment plan ordered by your physician.

- Home health care expenses (up to 120 visits/plan year combined maximum for network and out-of-network care) provided: Home health care expenses are charges for:
  - Charges for the expenses are made by a home health care agency;
  - The care is given under a home health care plan; and
  - The care is given to a recipient in his or her home.
  - Part-time or intermittent care by a registered nurse, or by a licensed practical nurse if a registered nurse is not available.
  - Part-time or intermittent home health aide services supervised by a registered nurse, up to four hours per visit, consisting primarily for patient care.
  - Physical, occupational and speech therapy.
  - Medical supplies, drugs and medicines prescribed by a doctor, and lab services provided by or for a home health care agency. Charges for these services are covered to the extent they would have been covered under the plan if the recipient had been confined in a hospital or extended care/skilled nursing facility.

- Hospice care, including:
Charges made by a hospital, hospice or skilled nursing facility for:
   - Room and board (semi-private room) and other services and supplies furnished during a stay for pain control and other acute and chronic symptom management; and
   - Services and supplies furnished on an outpatient basis.

Charges made on an outpatient basis by a Hospice Care Agency for:
   - Part-time or intermittent nursing care by an R.N. or L.P.N for up to eight hours a day;
   - Part-time or intermittent home health aide services for up to eight hours a day;
   - Medical social services under the direction of a physician. These include but are not limited to:
     - Assessment of your social, emotional and medical needs, and your home and family situation;
     - Identification of available community resources; and
     - Assistance provided to you to obtain resources to meet your assessed needs;
   - Physical and occupational therapy;
   - Consultation or case management services by a physician;
   - Medical supplies and prescription drugs;
   - Dietary counseling; and
   - Psychological counseling.

Charges made by the providers below if they are not an employee of a Hospice Care Agency; and such Agency retains responsibility for your care:
   - A physician for a consultation or case management;
   - A physical or occupational therapist;
   - A home health care agency for:
     - Physical and occupational therapy;
     - Part-time or intermittent home health aide services for up to eight hours a day;
     - Medical supplies and prescription drugs;
     - Psychological counseling; and
     - Dietary counseling.

Infertility treatment (limited to diagnostic testing, corrective surgery and drug therapy for the underlying medical cause of infertility, except as noted in the following item).

Infertility treatment through Progyny's network of fertility specialists, including timed intercourse (TIC), intrauterine insemination (IUI), frozen oocyte transfer (FOT), in-vitro fertilization (IVF) freeze-all, frozen embryo transfer (FET) and fresh IVF. Limited to 3 "Smart Cycles."

Inpatient hospital services, including:
   - Room and board (semi-private room), other facility services and supplies.
   - Doctor hospital visits, surgery and related professional fees.
   - Maternity and newborn care.
   - Lab, X-ray and anesthesia.

Metabolic formulas for a covered person diagnosed with phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homosystinuria.

Outpatient rehabilitation (physical/speech/occupational therapy) and cardiac rehabilitation (A combined maximum of 60 visits per plan year applies to physical, speech and occupational therapy, with no medical review required. Additional visits are not covered.) Eligible health services include:
   - Physical therapy (except for services provided in an educational or training setting), if it is expected to develop any impaired function.
   - Occupational therapy (except for vocational rehabilitation or employment counseling or services provided in an educational or training setting), if it is expected to:
     - Develop any impaired function, or
     - Relearn skills to significantly develop your ability to perform activities of daily living on your own.
   - Speech therapy (except for services provided in an educational or training setting or to teach sign language) is covered, provided the therapy is expected to develop speech function as a result of delayed development. (Speech function is the ability to express thoughts, speak words and form sentences.)

Outpatient services (i.e., services provided other than in a doctor's office), including:
   - Outpatient surgery facility.
   - Doctor, surgeon and related professional fees.
   - Lab and X-ray and complex imaging, including:
     - C.A.T. scans;
     - Magnetic Resonance Imaging (MRI); and
     - Positron Emission Tomography (PET) scans.
   - Radiation therapy/chemotherapy/infusion therapy.

Preventive care in accordance with the claims administrator's standards and pursuant to that which is identified by the United States Preventive Services Task Force as a requirement for coverage, including:
   - Routine physicals (once per calendar year).
   - Well-child care (routine).
   - Annual well-woman exams.
   - Routine mammograms.
Routine PSA tests.
- Colorectal screenings (routine).
- Gestational diabetes screening.

- Primary care/specialist office visits, including:
  - Lab and X-ray.
  - Maternity services.

- Private duty nursing by an R.N. or L.P.N., if the person's condition requires skilled nursing care and visiting nursing care is not adequate, for up to 70 8-hour shifts per plan year.

- Prosthetic appliances (including external breast prosthesis following a mastectomy).

- Skilled nursing facility (up to 60 days/plan year combined maximum for network and out-of-network care).

- Sterilization (tubal ligation or vasectomy).

- Temporomandibular Joint Dysfunction (TMJ) syndrome (limited to medical treatment).

- Transgender reassignment surgery, when deemed medically necessary and subject to satisfying specific criteria established by the claims administrator depending on the type of reassignment. Contact the medical claims administrator at the number on your ID card for further details about medical necessity and coverage criteria.

- Treatment for morbid obesity as follows:
  - Charges made by a physician, licensed or certified dietician, nutritionist or hospital for non-surgical treatment of obesity for the following outpatient weight management services: initial medical history and physical exam, diagnostic tests given or ordered during the first exam, and prescription drugs.
  - Charges for one morbid obesity surgical procedure, unless a multi-stage procedure is planned.
  - Morbid obesity means a body mass index (calculated by dividing the weight in kilograms by the height in meters squared) that is greater than 40 kilograms per meter squared, or equal to greater than 35 kilograms per meter squared with a comorbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea or diabetes.

- Urgent care services.
- Wigs, if hair loss is due to certain medical conditions.

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**The Women's Health and Cancer Rights Act of 1998 (WHCRA)** requires that group health plans providing coverage for mastectomies also provide certain mastectomy-related benefits or services. Since the BP Medical Plan provides medical and surgical benefits for mastectomies, it must also provide coverage for:

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction on the other breast to produce a symmetrical appearance.
- Coverage for prostheses (such as a breast implant).
- Treatment for physical complications at all stages of the mastectomy, including lymphedema.

The same deductibles and coinsurance limitations apply to these procedures as apply to any other illness.

**The Newborns’ and Mothers' Health Protection Act of 1996 (NMHPA)** requires coverage for 48 hours of hospitalization for mothers and their newborn children following a normal vaginal delivery and 96 hours following an uncomplicated Caesarean section. Shorter or longer lengths of stay may be approved by the claims administrator at the request of the attending doctor.

**The Patient Protection and Affordable Care Act (PPACA)** requires coverage for women's preventive health care services, including breast pumps and lactation consultants. The BP Medical Plan will cover these services both in-network and out-of-network. They are subject to the same deductibles and coinsurance limitations as other services.

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Publication date: April 2020
Expenses not covered under the BP Medical Plan

Although not expressly identified in the following list(s), an expense — even if medically necessary — will not be covered by the BP Medical Plan if:

1. The item is not expressly treated as covered under the plan.
2. The item is expressly excluded under the applicable claims administrator's standard administrative guidelines, as may be changed by the claims administrator from time to time.

While the BP Medical Plan provides benefits for many medical services, some services are not covered.

1. Amniocentesis, ultrasound or any other procedures requested solely to determine the gender of a fetus, unless medically necessary to determine the existence of a gender-linked genetic disorder.
2. Any biomechanical external prosthetic device or replacement of external prosthetics due to loss, theft or destruction.
3. Blood and the administration of blood and blood products when it is for the sole purpose of enhancing one's physical status or when related to sports activities.
4. Care provided by Christian Science Sanitariums and Practitioners.
5. Charges for services not ordered by a covered provider.
6. Charges made by a physician for, or in connection with, a surgery that exceeds the following maximum when two or more surgical procedures are performed at one time. Multiple surgical procedures are covered as follows:
   - Primary procedure: allow 100% of the eligible expense.
   - Secondary procedure: allow 50% of the eligible expense.
   - Tertiary and additional procedures: allow 25% of the eligible expense.
7. Charges made by a provider for complex imaging and ultrasound tests that exceed the following maximum when multiple complex imaging and ultrasound tests are performed by the same provider on the same day. Multiple tests performed the same day are covered as follows:
   - First charge received: allow 100% of the eligible expense.
   - Subsequent charges received: allow 50% of the eligible expense.
8. Drugs that do not require a prescription, even if prescribed by a doctor.
9. Expenses associated with a nurse or other person assisting in surgery who is not a medical doctor, and expenses associated with an assistant surgeon if the claims administrator determines that a second doctor is not medically necessary.
10. Expenses for any in vitro fertilization, artificial insemination or other impregnation procedures (including, but not limited to, drugs, home ovulation prediction kits, preservation, storage of frozen eggs or embryos, or egg or sperm donor expenses) or for reversal of sterilization, except as noted elsewhere in this SPD.
11. Expenses that are in excess of recognized charge/maximum reimbursable charge limits, as determined by the claims administrator.
12. Fees for directed blood donations — i.e., when someone designates donation of blood to a specific person.
13. Injury due to a military action, unless the injury results from being an innocent bystander in the situation.
14. Injury or illness covered by Workers’ Compensation or other federal, state or local laws.
15. Inpatient personal services such as television rental and guest meals.
16. Mental health services for the following categories (or equivalent terms as listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association):
   - Stay in a facility for treatment for dementia and amnesia without a behavioral disturbance that necessitates mental health treatment;
   - Sexual deviations and disorders except for gender identity disorders;
   - Tobacco use disorders, except as noted otherwise in this SPD;
   - Pathological gambling, kleptomania, pyromania;
   - School and/or education service, including special education, remedial education, wilderness treatment programs, or any such related or similar programs;
   - Services provided in conjunction with school, vocation, work or recreational activities;
   - Transportation; and
   - Wilderness treatment programs.
17. Most cosmetic surgery or treatment, unless required to correct a condition caused by an accidental injury or a medically necessary surgery.
18. Most dental services (including anesthesia), unless required to correct a condition caused by an injury that occurred within the last year (one-year limitation waived for a dependent child) or due to a concurrent hazardous medical condition that requires that oral surgery be done in a hospital/outpatient surgical facility, or when related to preventive care identified by the United States Preventive Services Task Force as a requirement for coverage.
19. Orthoptic or visual training or visual therapy.
20. Orthotics that are store bought (not custom made).
21. Outpatient rehabilitation for learning disabilities, developmental delays and autism, except as noted otherwise in this SPD.
Outpatient rehabilitation that is considered long term and that does not result in the significant improvement of a covered person's condition.

Preventive care that is not described as a covered benefit.

Reports, evaluations, examinations or hospitalizations not required for health reasons.

Routine eye examinations, eyeglasses and contact lenses (except for the first pair following cataract/lens removal), or hearing aids, including the examination and fitting.

Routine foot care. However, services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.

Services of a dietitian, foods required for special diets or nutritional supplements that do not require a prescription (except as an inpatient hospital expense or prior to surgical treatment of morbid obesity, or metabolic formulas for a covered person diagnosed with phenylketonuria (PKU), branch-chain ketonuria, galactosemia, homocystinuria or autism).

Services or supplies for which there is no charge.

Services or supplies that are not medically necessary as determined by the claims administrator.

Services provided by persons without nationally recognized licensure or which do not fall within the scope of the license.

Services received (including room and board) for custodial care that is given primarily to help a person with personal hygiene or to perform activities of daily living and that, by generally accepted medical standards, can be adequately provided by someone other than a licensed medical professional or nurse, regardless of who recommends, provides or directs the care. Custodial care includes:

- Routine patient care such as changing dressings, periodic turning and positioning in bed, administering medications;
- Care of a stable tracheostomy (including intermittent suctioning);
- Care of a stable colostomy/lileoestomy;
- Care of a stable gastronomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings;
- Care of a stable indwelling bladder catheter (including emptying/changing containers and clamping tubing);
- Watching or protecting you;
- Respite care, adult (or child) day care, or convalescent care;
- Institutional care, including room and board for rest cures, adult day care and convalescent care; and
- Help with daily living activities such as walking, grooming, bathing, dressing, getting into or out of bed, toileting, eating or preparing foods.

Services rendered by a family member.

Services that are billed separately but are identified by the claims administrator as an integral part of care or evaluation of a patient for which there is an overall reimbursable charge.

Smoking deterrents.

Speech therapy that is custodial or educational or is not restorative in nature.

Speech therapy to improve speech skills that have not been fully developed or to maintain speech communication.

Surgical correction of refractive errors, such as radial keratotomy or LASIK surgery.

Telephone, internet, digital, video, interactive audio/video or any other electronic consultation which takes place in lieu of in-person, direct patient contact, with the exception of covered charges rendered by a physician(s) specifically contracted by the plan or the claims administrator with regard to telephone, internet, digital, video, interactive audio/video or other electronic based services.

Testing or training for educational purposes, including services associated with developmental delay or learning disabilities.

Therapies and tests, including but not limited to:
- Full body CT scans;
- Hair analysis;
- Hypnosis and hypnotherapy;
- Massage therapy, except when used as a physical therapy modality; and
- Sensory or auditory integration therapy.

TMJ-related dental services and orthodontic appliances.

Transportation services other than ambulance service to the nearest hospital where the needed medical care and treatment can be provided.

Treatment of mental disorders, custodial care and other treatment in an institution that is not a legally constituted hospital, except as covered under the plan.

Treatments, procedures or devices considered experimental or investigational in nature by the claims administrator that:
- Clinical trials (published in peer-reviewed literature) do not show to be safe and effective for treating the illness, disease or injury of the covered person;
- The FDA has not approved for marketing (if such approval is required);
- A national medical or dental society or a regulatory agency has determined to be experimental, investigational or for research purposes;
- Is the subject of ongoing phase I, II or III clinical trials; or
- Protocol or written informed consent of the treatment facility (or of another facility studying the same drug, device, procedure or treatment) considers to be experimental, investigational or for research purposes.

Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications; exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions; except as described in Expenses covered under the BP Medical Plan.

Work-hardening therapy or programs.
Coordination of benefits

BP’s medical options coordinate with other medical coverage in which you may participate

If you have medical coverage in addition to the BP Medical Plan, coverage under the BP Medical Plan is subject to coordination of benefit (COB) rules.

COB rules prevent a duplication or double payment of a provider’s charges for services. Under COB rules, the combined medical coverages pay up to, but not more than, 100% of covered expenses. You may never receive more than the actual charges.

COB rules generally apply to group insurance plans, no-fault auto insurance and Medicare. Under COB, one plan is primary and the other plan is secondary. In some instances, you may also have a third plan, which is known as tertiary. When a claim is made, the primary plan pays its benefits without any consideration to the secondary or tertiary plans. The secondary and tertiary plans adjust their benefits so that the total benefits paid by all plans will not be more than the total covered expenses.

The following rules determine which plan is primary:

1. A plan that does not coordinate benefits is the primary plan and determines its benefits first.
2. If you have continuation coverage under the BP Medical Plan and other group health coverage, the BP Medical Plan will not be the primary plan.
3. If your spouse/domestic partner is enrolled in his/her employer-sponsored health plan as an active employee, a COBRA participant or a retiree, that plan is the primary plan for him/her.
4. If your children are covered by the BP Medical Plan and your spouse’s/domestic partner’s employer-sponsored health plan, a rule known as the “birthday rule” will be applied to determine the order of benefit payments. Under this rule, the plan of the parent whose month and day of birth is earlier in the calendar year (not necessarily the older parent) is the primary plan. If both parents have the same birthday, the plan that has had coverage in effect longer is the primary plan.
5. If you are separated or divorced and your children are covered by more than one group health plan:
   - The plan of the natural parent with custody is the primary plan.
   - The plan of the spouse/domestic partner of the natural parent with custody is the secondary plan.
   - The plan of the other natural parent is the tertiary plan.

If the natural parent without custody has legal financial responsibility for the child’s medical care, the plan of that parent becomes the primary plan.

1. If you have coverage under a motor vehicle policy including liability, Medpay, PIP, no fault, underinsured motorist or uninsured motorist, such coverage is primary and the BP Medical Plan is secondary.
2. If an employee or dependent of an active employee has Medicare coverage, the BP Medical Plan is the primary plan for the person(s) with Medicare coverage and Medicare is the secondary plan, except in the case of a person who is Medicare-eligible due to end-stage renal disease, where special rules apply\(^a\).
3. If a person has Medicare coverage and coverage under the BP Medical Plan other than as an active employee or dependent of an active employee (e.g., a COBRA participant), Medicare is the primary plan and the BP Medical Plan is the secondary plan, as long as no tertiary plan is involved. When the BP Medical Plan is the secondary plan, the benefits paid by Medicare are subtracted from the benefits that would normally be paid by the BP Medical Plan. The reduction of Medicare benefits is called a Medicare offset and will be applied on the basis that the Medicare-eligible person is enrolled in Medicare Part A and Part B, even if the person is not actually enrolled in Part B or is not Medicare-eligible. If a person permanently lives in the United States but is traveling temporarily outside the country, the BP Medical Plan will consider full plan benefits without applying the Medicare offset\(^a\).

With coordination of benefits, if the BP Medical Plan is the secondary (or tertiary) plan and another plan covering you or a covered dependent is the primary plan, it is possible that the BP Medical Plan will not pay any benefits if the primary plan’s benefits are in all cases equal to or better than the BP Medical Plan’s benefits.

\(^a\) Employees who receive Long-Term Disability (LTD) benefits from the BP Long-Term Disability Plan are typically considered active employees during the first 24 months of LTD. After 24 months, a person is no longer eligible for coverage as an active employee in the BP Medical Plan, regardless of the person’s status on BP’s payroll system. If you are receiving LTD benefits from the BP Long-Term Disability Plan, and are in the initial 24-month period, this plan will be the primary plan and Medicare will be secondary as long as you are considered an active employee by BP. After the earlier to occur of the end of this 24-month period or the termination of your active employment, Medicare will be the primary plan and the BP Medical plan will be secondary.
If you are enrolled in an HMO

If you are enrolled in an HMO, contact the HMO to learn how that plan coordinates benefits.

Publication date: April 2020
Subrogation, reimbursement and right of recovery provisions

Immediately upon paying or providing any benefit under this plan, the plan shall be subrogated to all rights of recovery a participant has against any party potentially responsible for making any payment to a participant due to a participant’s injuries or illness, to the full extent of benefits provided or to be provided by the plan.

In addition, if a participant receives any payment from any potentially responsible party as a result of an injury or illness, the plan has the right to recover from, and be reimbursed by, the participant for all amounts this plan has paid and will pay as a result of that injury or illness, up to and including the full amount the participant receives from all potentially responsible parties. The participant agrees that if he/she receives any payment from any potentially responsible party as a result of an injury or illness, he/she will serve as a constructive trustee over the funds. Failure to hold such funds in trust will be deemed a breach of the participant’s fiduciary responsibility to the plan.

Further, the plan will automatically have a lien, to the extent of benefits advanced, upon any recovery whether by settlement, judgment or otherwise, that a participant receives from a third party, the third party’s insurer or any other source as a result of the participant’s injuries. The lien is in the amount of benefits paid by the plan for the treatment of the illness, injury or condition for which another party is responsible.

As used throughout this provision, the term responsible party means any party possibly responsible for making any payment to a participant due to a participant’s injuries or illness or any insurance coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, Workers’ Compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage. For purposes of this provision, a participant includes anyone on whose behalf the plan pays or provides any benefit including, but not limited to, the minor child or dependent of any plan member or person covered by the plan or entitled to receive any benefits from the plan.

The participant acknowledges that this plan’s recovery rights are a first priority claim against all potentially responsible parties and are to be paid to the plan before any other claim for the participant’s damages. This plan shall be entitled to full reimbursement first from any potential responsible party payments, even if such payment to the plan will result in a recovery to the participant which is insufficient to make the participant whole or to compensate the participant in part or in whole for the damages sustained. It is further agreed that the plan is not required to participate in or pay court costs or attorney fees to the attorney hired by the participant to pursue the participant’s damage claim.

The terms of this entire right of recovery provision shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party and regardless of whether settlement or judgment received by the participant identifies the medical benefits the plan provided. The plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering or non-economic damages only.

The participant shall fully cooperate with the plan’s efforts to recover its benefits paid. It is the duty of the participant to notify the plan within 30 days of the date when any notice is given to any party, including an attorney, of the intention to pursue or investigate a claim to recover damages or obtain compensation due to injuries or illness sustained by the participant.

The participant shall provide all information requested by the plan, the claims administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the plan may reasonably request. Failure to provide this information shall be deemed a breach of contract, and may result in the termination of health benefits or the instigation of legal action against the participant.

The participant shall do nothing to prejudice the plan’s recovery rights as herein set forth. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan.

In the event that any claim is made that any part of this right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the participant and this plan agree that the plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

The participant agrees that any legal action or proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. Upon receiving benefits under this plan, the participant hereby submits to each such jurisdiction, waiving whatever rights may correspond to him/her by reason of his/her present or future domicile.
How to file a claim

Claims for health care should be filed with the claims administrator

Deadline for filing claims

To receive benefits under the BP Medical Plan, you must submit all claims to the applicable claims administrator within 12 months of the date of service. Any claims that the claims administrator receives more than 12 months after the date of service will not be paid.

Need help with claims issues?

The Advocacy Service is available to help you with issues regarding health care claims and services. Advocacy team members work with you and the claims administrator to understand, research and resolve claims issues.

You must make at least one attempt to contact and resolve your issue directly with the appropriate claims administrator before contacting the Advocacy Service.

To reach the Advocacy Service, call the BP Benefits Center. Keep in mind that your issue may not necessarily be resolved in your favor, as the terms of the plan will apply in all situations.

Responsibility for filing claims

The following can help you determine when providers will file claims on your behalf and when you must file claims directly with the appropriate claims administrator.

<table>
<thead>
<tr>
<th>PPO Options, including Health+Savings PPO</th>
<th>Out-of-Area Options, including Health+Savings OOA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and behavioral health care</td>
<td></td>
</tr>
<tr>
<td>In-network Provider files medical claims.</td>
<td>You may have to pay for services at the time you receive them and file a claim with Aetna for reimbursement.</td>
</tr>
<tr>
<td>Out-of-network You pay for services and file a claim with Aetna.</td>
<td>You pay for services and file a claim with Aetna.</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td></td>
</tr>
<tr>
<td>In-network Provider files claims.</td>
<td>Provider files claims.</td>
</tr>
<tr>
<td>Out-of-network You pay for services and file a claim with ESI.</td>
<td>You pay for services and file a claim with ESI.</td>
</tr>
</tbody>
</table>

To file a claim for reimbursement, you will need to submit the following to the claims administrator:

- A completed claim form.
- All itemized bills indicating the date of service, description of service provided, diagnosis, name of the provider and charges incurred.

You can request claim forms from the claims administrator or download them from the claims administrator’s Internet site. A list of claims administrators is available under Administrative Information.

If you have other medical coverage

Periodically, a claims administrator will ask you to provide information about other medical coverage you and/or your eligible dependents may have. This request may occur in connection with a claim you have submitted. In that case, you will be advised that the other medical coverage information, including an Explanation of Benefits (EOB) from the other coverage’s administrator, is required before your claim can be processed.
Your claim will not be processed until you comply with the claims administrator’s request.

**Health Savings Account (HSA) Debit Card**

Your share of the cost for eligible medical expenses you incur may be paid to the provider through your PayFlex Card® (your HSA debit card), if you contribute to the HSA and have an available balance in your account. **Note:** You cannot use the HSA debit card outside the U.S.

Publication date: April 2020
Submitting claims for expenses incurred with out-of-network providers

To submit claims for expenses incurred with out-of-network providers, or if you have questions about how to file a claim, here is what you need to do:

<table>
<thead>
<tr>
<th>For ...</th>
<th>Submit claims for expenses incurred with out-of-network providers to ...</th>
<th>If you have questions about how to file a claim, call ...</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical claims</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| The HealthPlus Options (including behavioral health care) | Aetna  
P.O. Box 14586  
Lexington, KY 40512-4586 | Aetna  
1-866-436-2606 |
| The Standard Options (including behavioral health care) | | |
| The Health+Savings Options (including behavioral health care) | | |
| **Prescription drug claims** | | |
| The HealthPlus, Standard and Health+Savings Options | Express Scripts  
P.O. Box 2872  
Clinton, IA 52733 | Express Scripts  
Within the U.S.  
1-800-451-6245 (claims)  
1-800-216-6506 (customer service) |

If you file a claim, an Explanation of Benefits (EOB) will be generated. The Aetna and Express Scripts websites allow you to print this information, which you can keep for your records or use to file a claim for reimbursement from your Health Care Flexible Spending Account (HCFSA) or Health Savings Account (HSA).

What else you should know about claims administrators under the BP Medical Plan

The claims administrators for the benefits and services provided under the BP Medical Plan are business entities independent of BP and independent of each other. While plan benefits are not funded by the claims administrators, the claims administrators are solely responsible for making determinations regarding benefits and services provided based on the provisions of the BP Medical Plan. BP has delegated authority to render decisions on benefits and services to these claims administrators. Therefore, if you do not agree with a claims administrator’s determination regarding benefits that have been paid or provided, you must pursue the matter through the claims and appeals process with the applicable administrator to which claims and appeals have been delegated.

Solely for purposes of final claims appeals under the BP Prescription Drug Program, MCMC and not ESI is the applicable claims administrator.

Publication date: April 2020
Process for formal benefit claims and appeals

Under the BP Medical Plan, you may file claims for benefits and appeal Adverse Benefit Determinations. Any reference to “you” in this section includes a covered person and his/her authorized representative. An “Authorized Representative” is a person you authorize, in writing, to act on your behalf using the plan's designation of authority form for appeals. The Medical Plan will also recognize a court order giving a person authority to submit claims on your behalf. In the case of an urgent care claim, a health care professional with knowledge of your condition may always act as your “Authorized Representative.”

If your claim is denied in whole or in part, you will receive a written notice of the denial from the respective claims administrator. The notice will explain the reason for the denial and the appeal procedures available under the Medical Plan.

If you are enrolled in an Aetna-administered PPO Option, Health+Savings Option or Out-of-Area Option, you can choose to submit an appeal or complaint electronically through Aetna's website at www.aetna.com. On that site, choose the "Contact Us" link, select "A complaint or appeal" from the drop-down menu of message topics, and provide the necessary information prior to submitting.

Note: This feature is not available to participants who are:

- Enrolled in any other medical option; or
- Eligible for Medicare

Urgent care claims

An “Urgent Care Claim” is legally defined as “any claim for medical care or treatment for which the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.”

If the Medical Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if the claims administrator or your physician determines that it is an Urgent Care Claim, you will be notified of the decision, whether adverse or not, as soon as possible but not later than 24 hours after the claim is received.

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

Other claims (pre-service and post-service)

If the Medical Plan requires you to obtain advance approval of a non-urgent service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim.

For other claims (post-service claims), you will be notified of the decision not later than 30 days after receipt of the claim.

For either a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside the claims administrator's control. In that case, you will be notified of the extension before the end of the initial 15- or 30-day period. For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of the claims administrator's claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

For pre-service claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to a claims administrator representative responsible for handling benefit matters, but which otherwise fail to follow the Medical Plan's procedures for filing pre-service claims, you will be notified of the failure within 5 days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.
Ongoing course of treatment

If you have received pre-authorization for an ongoing course of treatment, you will be notified in advance if the previously authorized course of treatment is intended to be terminated or reduced so that you will have an opportunity to appeal any decision to the claims administrator and receive a decision on that appeal before the termination or reduction takes effect. If the course of treatment involves urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

Health claims — standard appeals

As an individual enrolled in the Medical Plan, you have the right to file an appeal from an Adverse Benefit Determination relating to service(s) you have received or could have received from your health care provider under the Medical Plan.

An “Adverse Benefit Determination” is defined as a denial, reduction, termination of, or failure to provide or make payment (in whole or in part) for a service, supply or benefit. Such Adverse Benefit Determination may be based on:

- Your eligibility for coverage, including a retrospective termination of coverage (whether or not there is an adverse effect on any particular benefit);
- Coverage determinations, including plan limitations or exclusions;
- The results of any Utilization Review activities;
- A decision that the service or supply is experimental or investigational; or
- A decision that the service or supply is not medically necessary.

A “Final Internal Adverse Benefit Determination” is defined as an Adverse Benefit Determination that has been upheld by the appropriate claims administrator, which is a named fiduciary of the Medical Plan, at the completion of the internal appeals process, or an Adverse Benefit Determination for which the internal appeals process has been exhausted.

Exhaustion of internal appeals process

You are required to complete all appeal processes of the Medical Plan before being able to obtain External Review or bring an action in litigation. However, if the claims administrator, or the Medical Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under applicable federal law, you are considered to have exhausted the Medical Plan’s appeal requirements (“Deemed Exhaustion”) and may proceed with External Review or may pursue any available remedies under §502(a) of ERISA or under state law, as applicable, as long as such an action is (a) filed within one (1) year of a final denial decision, and (b) any such litigation is filed in a federal court in Harris County, Texas.
Full and fair review of claim determinations and appeals

The claims administrator will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the claims administrator (or at the direction of the claims administrator), or any new or additional rationale as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is provided, to give you a reasonable opportunity to respond prior to that date.

You may file an appeal in writing or via the Aetna website to the claims administrator at the address provided in this summary, or, if your appeal is of an urgent nature, you may call the claims administrator’s Member Services Unit at the toll-free phone number on the back of your ID card (also listed at the end of this summary). Your request should include the name of your employer, your name, member ID, or other identifying information shown on the front of the Explanation of Benefits form, and any other comments, documents, records and other information you would like to have considered, whether or not submitted in connection with the initial claim.

A claims administrator representative may call you or your health care provider to obtain medical records and/or other pertinent information in order to respond to your appeal.

You will have 180 days following receipt of an Adverse Benefit Determination to appeal the determination to the claims administrator. You will be notified of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim. A copy of the specific rule, guideline or protocol relied upon in the Adverse Benefit Determination will be provided free of charge upon request by you or your authorized representative. You may also request that the claims administrator provide you, free of charge, copies of all documents, records and other information relevant to the claim.

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to the phone number included in your denial, or to the claims administrator’s Member Services, which number is on your Identification Card. You or your authorized representative may appeal urgent care claim denials either orally, in writing or via the Aetna website. All necessary information, including the appeal decision, will be communicated between you or your authorized representative and the claims administrator by telephone, facsimile, or other similar method. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with the appeal decision on an urgent care claim, you may file a second level appeal with the claims administrator. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with a pre-service or post-service appeal decision, you may file a second level appeal with the claims administrator within 60 days of receipt of the level one appeal decision. The claims administrator will notify you of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received.

If you do not agree with the Final Internal Adverse Benefit Determination on review, you have the right to bring a civil action under Section 502 (a) of ERISA, if applicable. However, you may not file a civil action unless you have exhausted the Medical Plan’s claims and appeals procedures. Any such suit must be filed with a federal court located in Harris County, Texas, and may not be filed any later than one (1) year following a final denial pursuant to the Medical Plan’s claims and appeals procedures.
Health claims — voluntary appeals

External review

“External Review” is a review of an Adverse Benefit Determination or a Final Internal Adverse Benefit Determination by an Independent Review Organization/External Review Organization (ERO) or by the State Insurance Commissioner, if applicable.

A “Final External Review Decision” is a determination by an ERO at the conclusion of an External Review.

You must complete all of the levels of standard appeal described above before you can request External Review, other than in a case of Deemed Exhaustion. Subject to verification procedures that the Medical Plan may establish, your Authorized Representative may act on your behalf in filing and pursuing this voluntary appeal.

You may file a voluntary appeal for External Review of any Adverse Benefit Determination or any Final Internal Adverse Benefit Determination that qualifies as set forth below.

The notice of Adverse Benefit Determination or Final Internal Adverse Benefit Determination that you receive from the Claims Administrator will describe the process to follow if you wish to pursue an External Review, and will include a copy of the Request for External Review Form.

You must submit the Request for External Review Form to the Claims Administrator within 123 calendar days of the date you received the Adverse Benefit Determination or Final Internal Adverse Benefit Determination notice. If the last filing date would fall on a Saturday, Sunday or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or federal holiday. You also must include a copy of the notice and all other pertinent information that supports your request.

If you file a voluntary appeal, any applicable statute of limitations will be tolled while the appeal is pending. The filing of a claim will have no effect on your rights to any other benefits under the Medical Plan. However, the appeal is voluntary and you are not required to undertake it before pursuing legal action.

If you choose not to file for voluntary review, the Medical Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

Request for external review

The External Review process under this Medical Plan gives you the opportunity to receive review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted pursuant to applicable law. Your request will be eligible for External Review if the following are satisfied:

- The Claims Administrator, or the Medical Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under federal law;
- The standard levels of appeal have been exhausted; or
- The appeal relates to a rescission, defined as a cancellation or discontinuance of coverage which has retroactive effect.

An Adverse Benefit Determination based upon your eligibility is not eligible for External Review.

If upon the final standard level of appeal, the coverage denial is upheld and it is determined that you are eligible for External Review, you will be informed in writing of the steps necessary to request an External Review.

An independent review organization refers the case for review by a neutral, independent clinical reviewer with appropriate expertise in the area in question. The decision of the independent external expert reviewer is binding on you, the Claims Administrator and the Medical Plan unless otherwise allowed by law.

Preliminary review

Within 5 business days following the date of receipt of the request, the Claims Administrator must provide a preliminary review determining: you were covered under the Medical Plan at the time the service was requested or provided, the determination does not relate to eligibility, you have exhausted the internal appeals process (unless Deemed Exhaustion applies), and you have provided all paperwork necessary to complete the External Review.

Within one business day after completion of the preliminary review, the Claims Administrator must issue to you a notification in writing. If the request is complete but not eligible for External Review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will...
describe the information or materials needed to make the request complete and the Claims Administrator must allow you to perfect the request for External Review within the 123 calendar days filing period or within the 48-hour period following the receipt of the notification, whichever is later.

Referral to ERO

The Claims Administrator will assign an ERO accredited as required under federal law, to conduct the External Review. The assigned ERO will timely notify you in writing of the request’s eligibility and acceptance for External Review, and will provide an opportunity for you to submit in writing or via the Aetna website within 10 business days following the date of receipt, additional information that the ERO must consider when conducting the External Review. Within one (1) business day after making the decision, the ERO must notify you, the Claims Administrator and the Medical Plan.

The ERO will review all of the information and documents timely received. In reaching a decision, the assigned ERO will review the claim and not be bound by any decisions or conclusions reached during the Medical Plan’s internal claims and appeals process. In addition to the documents and information provided, the assigned ERO, to the extent the information or documents are available and the ERO considers them appropriate, will consider the following in reaching a decision:

- Your medical records;
- The attending health care professional’s recommendation;
- Reports from appropriate health care professionals and other documents submitted by the Medical Plan or issuer, you, or your treating provider;
- The terms of your Medical Plan to ensure that the ERO's decision is not contrary to the terms of the Medical Plan, unless the terms are inconsistent with applicable law;
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
- Any applicable clinical review criteria developed and used by the Claims Administrator, unless the criteria are inconsistent with the terms of the Medical Plan or with applicable law; and
- The opinion of the ERO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The assigned ERO must provide written notice of the Final External Review Decision within 45 days after the ERO receives the request for the External Review. The ERO must deliver the notice of Final External Review Decision to you, the Claims Administrator and the Medical Plan.

After a Final External Review Decision, the ERO must maintain records of all claims and notices associated with the External Review process for six years. An ERO must make such records available for examination by the claimant, the Medical Plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

Upon receipt of a notice of a Final External Review Decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Medical Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

 Expedited external review

The Medical Plan must allow you to request an expedited External Review at the time you receive:

- An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- A Final Internal Adverse Benefit Determination, if you have a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

Immediately upon receipt of the request for expedited External Review, the Claims Administrator will determine whether the request meets the reviewability requirements set forth above for standard External Review. The Claims Administrator must immediately send you a notice of its eligibility determination.

Referral of expedited review to ERO
Upon a determination that a request is eligible for External Review following preliminary review, the Claims Administrator will assign an ERO. The ERO shall render a decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the ERO receives the request for an expedited External Review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned ERO must provide written confirmation of the decision to you, the Claims Administrator and the Medical Plan.
Process for formal claims relating to eligibility to participate

You may make a verbal inquiry to the BP Benefits Center if you have a claim related to such issues as:

- Eligibility to enroll in the plan;
- Enrollment elections; or
- Qualifying status changes.

In many cases, the inquiry will resolve your issue.

If you believe that the response to your inquiry was based on inaccurate information or that additional information may clarify the issue, you may submit a written request for reconsideration to:

Claims and Appeals Management -- BP
P.O. Box 1407
Lincolnshire, IL 60069-1407

You should receive a decision on your request for reconsideration within 30 days.

If you are not satisfied with the reconsideration decision, you may file a formal claim with the claims administrator by submitting a claim to the claims administrator in care of:

ERISA Claims and Appeals
P.O. Box 941644
Houston, TX 77094-8644

A formal claim related to eligibility cannot be filed with the claims administrator in care of ERISA Claims and Appeals until an inquiry and a request for reconsideration have been completed.

If you file a formal claim with ERISA Claims and Appeals on behalf of the claims administrator, it will be reviewed subject to the same timeframes applicable to formal claims for benefits. The review will be subject to the same procedures, protocols and standards.

If your claim is denied in whole or in part, you may appeal the adverse benefits determination by submitting an appeal to the claims administrator for appeals in care of ERISA Claims and Appeals. It will be reviewed subject to the same timeframes applicable to formal appeals for benefits. The review will be subject to the same procedures, protocols and standards.

If following exhaustion of the plan's appeal procedure, you still believe that you are entitled to either participate in the plan or to a benefit under the plan, you may file a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). You may not file a civil action unless you have exhausted the plan's claims and appeals procedure. However, any such suit must be filed with a federal court of proper jurisdiction located in Harris County, Texas, no later than one (1) year following a final denial pursuant to the plan's appeal procedure.

Publication date: April 2020
Leaving BP

What happens to benefits if you leave BP

When you leave BP, you may be eligible for coverage under the BP Retiree Medical Plan or for COBRA continuation coverage under the BP Medical Program. COBRA continuation coverage information is below. See the separate retiree medical information available on LifeBenefits for details on the BP Retiree Medical Plan.

COBRA coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985 (referred to as “COBRA”) allows you and your eligible dependents to elect a temporary continuation of group health coverage, under certain circumstances, when coverage would otherwise end. For purposes of BP health care programs, domestic partners and civil union partners are offered continuation coverage comparable to the coverage offered to covered spouses under COBRA. For convenience, this summary plan description refers to the continuation coverage generally as “COBRA” coverage.

If you or one of your eligible dependents loses group health coverage because of a qualifying event, you may elect to continue your current group health coverage under COBRA for up to 18, 29 or 36 months, depending on the qualifying event. You or your eligible dependent must call the BP Benefits Center within 60 days of the loss of coverage due to the qualifying event or the date a COBRA notice is sent by the BP Benefits Center, whichever is later.

Qualifying events

You may elect COBRA coverage if your coverage would otherwise end because:

1. Your work hours are reduced and you are no longer eligible for that coverage; or
2. You leave BP.

If your eligible dependent has BP coverage, he/she may elect COBRA coverage if coverage would otherwise end because:

1. Your work hours are reduced and you are no longer eligible for group health coverage;
2. You leave BP;
3. You and your spouse divorce or your domestic partnership/civil union ends;
4. Your dependent no longer qualifies as an eligible dependent;
5. You become entitled to Medicare; or
6. You die.
**Maximum period of COBRA coverage**

Your maximum period of COBRA coverage begins on the date group health coverage would otherwise be lost because of a qualifying event and ends 18, 29 or 36 months later, as summarized in the following schedule:

<table>
<thead>
<tr>
<th>Who</th>
<th>Length of Coverage</th>
<th>Qualifying Event</th>
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</table>
| You and/or your eligible      | 18 months         | I Your work hours are reduced.  
                             | dependents                   | I You leave BP.                                                                 |
|                               | 29 months         | I You or one of your eligible dependents is disabled (as defined by the Social    |
|                               |                   | Security Administration) at the time your work hours are reduced or you leave BP,|
|                               |                   | or within 60 days of the beginning of COBRA coverage.                            |
| Your eligible dependents      | 36 months         | I You and your spouse divorce.  
                             |                               | I Your dependent no longer qualifies as an eligible dependent.  
                             |                               | I You become entitled to Medicare.  
                             |                               | I You die.                      |

* The 36-month period is measured from the date you become entitled to Medicare benefits even if that event does not trigger loss of group coverage.

If you have HMO coverage, state law may provide for an additional period of coverage beyond the COBRA Continuation periods. Contact the HMO directly for more information.

**Electing COBRA coverage**

The COBRA election process is a three-step process:

1. You or your covered dependent must experience a qualifying event that triggers COBRA eligibility. A subsequent qualifying event (such as disability, death, divorce or loss of a dependent child’s eligibility status) that occurs during an initial 18- or 29-month period of COBRA coverage can also trigger an extension of COBRA coverage, up to the maximum allowed.

2. You or your dependent must notify the BP Benefits Center within 60 days of a qualifying event such as disability, death, divorce or loss of a dependent child’s eligibility status. The BP Benefits Center will then mail COBRA enrollment materials to the affected family member. For certain qualifying events, such as your leaving BP or your reduction in hours causing loss of benefits eligibility, the BP Benefits Center will send COBRA materials, without any required action by you.

3. You or your affected dependent must contact the BP Benefits Center to elect COBRA within 60 days of the loss of coverage due to the qualifying event or the date the COBRA notice is sent by the BP Benefits Center, whichever is later. Notify the BP Benefits Center if the COBRA materials are not timely received.

If notice of the qualifying event is not received by the BP Benefits Center within 60 days of the event, the affected family members will not be allowed to elect COBRA coverage.

**Paying for COBRA coverage**

The cost of COBRA coverage equals 100% of the total cost of coverage plus a 2% administrative fee, for a total of 102%.

For the additional 11 months of coverage due to disability, the cost of COBRA continuation coverage equals 100% of the total cost of coverage plus a 50% administrative fee, for a total of 150%.

If you or an affected dependent elects COBRA coverage, the BP Benefits Center will send a monthly bill to that individual. That person will have 45 days from the date of the election to make the first payment. All future payments will be due in full on the fifth of each month, with a 30-day grace period.
Extending COBRA coverage

Your eligible dependents can extend coverage for up to an additional 18 months (for a total of 36 months) if one of the following qualifying events occurs during the initial 18-month COBRA coverage period:

- You and your spouse divorce or your domestic partnership or civil union ends.
- Your dependent no longer qualifies as an eligible dependent.
- You become entitled to Medicare.
- You die.

You or your dependents must notify the BP Benefits Center in writing within 60 days of the second qualifying event to elect extended COBRA coverage.

For disability

You and your eligible dependents may be eligible to extend COBRA coverage for up to an additional 11 months (for a total of 29 months) if:

- You or your eligible dependent is eligible for Social Security disability benefits when coverage first begins (or you or your eligible dependent becomes disabled within the first 60 days of COBRA coverage).
- The disability continues throughout the COBRA continuation period.

To be eligible for this 11-month extension, you or your eligible dependent must notify the BP Benefits Center of the person’s disability within 60 days after you or your eligible dependent receives a written determination of disability — for Social Security purposes — but before the end of your initial 18-month COBRA coverage period.

The extension of COBRA coverage applies to all family members of the disabled person, even those family members who are not disabled.

End of COBRA coverage

COBRA coverage will end on the earliest of the following dates:

- The last day of the maximum period of COBRA coverage.
- The last day of the month for which the last contribution was made within the required time period.
- The last day of the month in which the covered person becomes covered under another group health plan during the COBRA coverage period, unless that plan contains an enforceable clause for pre-existing health conditions.
- The last day of the month in which a covered person ceases to be considered disabled under the Social Security Act if the COBRA continuation period has been extended for up to 11 months due to the disability.
- The last day of the month preceding the month in which the covered person first becomes entitled to Medicare during the COBRA coverage period.
- The date BP stops providing group health benefits.

Publication date: April 2020
If you die

Your surviving spouse may be eligible for coverage under the BP Retiree Medical Plan if you die while actively employed at BP. While your domestic partner is not eligible for survivor coverage under the BP Retiree Medical Plan, your domestic partner can elect continuation coverage under the BP Medical Program. See Leaving BP for more details. Eligibility depends on several factors, including your employee classification and status, whether you worked for a group that offers retiree medical coverage, your date of hire, your age, your years of vesting service in a BP retirement program and whether your death was work-related.

<table>
<thead>
<tr>
<th>If hired before April 1, 2004 and death was:</th>
<th>If hired on or after April 1, 2004 and death was:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Not work-related</strong></td>
<td><strong>Work-related</strong></td>
</tr>
<tr>
<td>If you meet the BP Retiree Medical Plan eligibility requirements at the time of your death, your surviving spouse and any eligible dependent children are immediately eligible for BP Retiree Medical Plan coverage. Your surviving spouse's contribution percentage for retiree medical coverage will be based on your age and your years of vesting service in a BP retirement program at the time of death. If you do not have a surviving spouse, but eligible dependent children survive you, and they were enrolled in the BP Medical Program at the time of your death, they are eligible to continue BP Medical Program coverage under COBRA for up to 36 months. Their contribution for the first 12 months will be the same as for an active employee’s coverage. For the remaining 24 months, they must pay the applicable COBRA premium. If you do not meet the BP Retiree Medical Plan eligibility requirements at the time of your death, and your spouse and/or dependent children were enrolled in the BP Medical Program at the time of your death, your covered spouse and/or dependent children are eligible to continue BP Medical Program coverage under COBRA for up to 36 months. Their contribution for the first 12 months will be the same as for an active employee’s coverage. For the remaining 24 months, they must pay the applicable COBRA premium.</td>
<td>Regardless of your age or years of vesting service in a BP retirement plan, your surviving spouse is immediately eligible for coverage under the BP Retiree Medical Plan at the minimum retiree contribution percentage. See the separate retiree medical information available on LifeBenefits for more information on retiree contribution percentages. If you do not have a surviving spouse, but eligible dependent children survive you, and they were enrolled in the BP Medical Program at the time of your death, they are eligible to continue BP Medical Program coverage under COBRA for up to 36 months. Their contribution for the first 12 months will be the same as for an active employee’s coverage. For the remaining 24 months, they must pay the applicable COBRA premium. If you meet the BP Retiree Medical Plan eligibility requirements at the time of your death, your surviving spouse and any eligible dependent children are immediately eligible for BP Retiree Medical Plan coverage.</td>
</tr>
<tr>
<td><strong>Work-related</strong></td>
<td></td>
</tr>
<tr>
<td>Regardless of your age or years of vesting service in a BP retirement plan, your surviving spouse is immediately eligible for coverage under the BP Retiree Medical Plan at the minimum retiree contribution percentage. See the separate retiree medical information available on LifeBenefits for more information on retiree contribution percentages. If you do not have a surviving spouse, but eligible dependent children survive you, and they were enrolled in the BP Medical Program at the time of your death, they are eligible to continue BP Medical Program coverage under COBRA for up to 36 months. Their contribution for the first 12 months will be the same as for an active employee’s coverage. For the remaining 24 months, they must pay the applicable COBRA premium.</td>
<td>A surviving spouse will have immediate access to the deceased employee’s Retiree Reimbursement Account (RRA). When the RRA is depleted, a surviving spouse will no longer be eligible for reimbursement of any qualifying expenses. If you do not have a surviving spouse, but eligible dependent children survive you, and they were enrolled in the BP Medical Program at the time of your death, they are eligible to continue BP Medical Program coverage under COBRA for up to 36 months. Their contribution for the first 12 months will be the same as for an active employee’s coverage. For the remaining 24 months, they must pay the applicable COBRA premium. An eligible dependent child will have immediate access to the deceased employee’s RRA. The RRA can be used for any qualified medical expense. If you do not meet the BP Retiree Medical Plan eligibility requirements at the time of your death, and your spouse and/or dependent children were enrolled in the BP Medical Program at the time of your death, your covered spouse and/or dependent children are eligible to continue BP Medical Program coverage under COBRA for up to 36 months. Their contribution for the first 12 months will be the same as for an active employee’s coverage. For the remaining 24 months, they must pay the applicable COBRA premium. An eligible dependent child will have immediate access to the deceased employee's RRA. The RRA can be used for any qualified medical expense.</td>
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</tbody>
</table>

* See the separate retiree medical information available on LifeBenefits for more information on RRAs.
they must pay the applicable COBRA premium.

* See the separate retiree medical information available on LifeBenefits for more information on RRAs.
STD/LTD recipients

If you involuntarily separate from the company while on a disability leave, you are eligible for BP Retiree Medical Plan coverage if:

- You were a full-time or part-time salaried employee of a BP employer group that offers BP Retiree Medical Plan coverage at the onset of your long-term disability; and
- You are considered to be totally and permanently disabled by the BP LTD plan after 24 months; or
- You are terminated as a result of a company-induced severance program, merger or divestiture while on a disability leave.

In this case, your eligibility for BP Retiree Medical Plan coverage will commence the first of the month following the date of the events indicated above. If you work for a BP employer who offers coverage in the BP Retiree Medical Plan, the contribution rates you pay for coverage depend on whether your disability was work-related, when you were hired and whether or not you met the eligibility requirements for the BP Retiree Medical Plan at the onset of your disability.

<table>
<thead>
<tr>
<th>If hired before April 1, 2004 and disability was not work-related:</th>
<th>If hired on or after April 1, 2004 and disability was not work-related:</th>
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<tbody>
<tr>
<td>Met eligibility requirements</td>
<td>Did not meet eligibility requirements</td>
</tr>
<tr>
<td>Your retiree contribution percentage will be based on your age and years of vesting service in a BP retirement program.</td>
<td>Your contribution will be the maximum retiree contribution percentage.</td>
</tr>
</tbody>
</table>

**If your disability is work-related**, your contribution to the BP Retiree Medical Plan will be the minimum retiree contribution percentage, based on the schedule for employees hired before April 1, 2004, regardless of your hire date or whether you satisfy normal BP Retiree Medical Plan eligibility requirements.

See the separate retiree medical information available on LifeBenefits for more information on retiree contribution percentages.

Publication date: April 2020
Retiree medical coverage

When you leave BP, you may be eligible for coverage under the BP Retiree Medical Plan, which is a separate plan described elsewhere on LifeBenefits. If you are subsequently rehired as a BP employee, your Retiree Medical Plan coverage will end. Contact the BP Benefits Center for more information.

Note: You may not be enrolled in the Retiree Medical Plan and be a BP employee at the same time.

To view BP Retiree Medical Plan information, you can use the BP Benefit Finder at the top of the screen to navigate to the applicable LifeBenefits pages, or you can download the information in PDF format. To do so:

- Click here if you or ANY of your enrolled dependents are eligible for Medicare.
- Click here if you and ALL of your enrolled dependents are NOT eligible for Medicare.

What coverage costs

During annual enrollment each year, you will be notified of the required contribution for your available coverage options for the upcoming plan year.

Note: This information won’t apply if you’re covered under the Retiree Medical Plan as a surviving spouse or STD/LTD Recipient. See the separate Retiree Medical SPD for details.

For BP Participants or surviving spouses with an eligibility event under a heritage retiree medical plan, the rules of the heritage plan apply.

Retirees

Your eligibility for coverage under the BP Retiree Medical Plan depends on:

- Your U.S. date of hire;
- Your age;
- Your years of vesting service in a U.S.-based BP retirement program when you left BP; and
- The BP business unit for which you worked.

If you enroll in a Medicare HMO option available to you under the BP Retiree Medical Plan, you may pay a higher percentage of the cost than if you enroll in any other medical option.
If you were hired before April 1, 2004

The following table reflects contribution percentages under the BP Retiree Medical Plan. Your contribution is 50% or less of the cost of retiree coverage, as determined by BP, depending on your age and your years of service when you left BP.

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If you were hired before April 1, 2004 and your employment is terminated due to a reduction in force, outsourcing, the sale or disposition of all or part of your employer to another company — and at termination, you are eligible for coverage under the BP Retiree Medical Plan — you will be eligible for the minimum retiree contribution percentage.

The applicable contribution percentage for coverage applies whether you choose coverage for yourself only or you and your dependents. Your cost may vary based on the plan option in which you enroll.

**Note:** If you worked at TNK-BP and then returned to work at BP prior to separating from BP, your service with TNK-BP counts toward the years of service calculation for purposes of determining the applicable participant premium percentage.

**If you moved within BP**

If you moved from a BP employer who offered coverage in the BP Retiree Medical Plan to one that did not, and you met the eligibility requirements before your move, your age and vesting service in a BP retirement plan when you left BP determined your retiree contribution percentage.

If you moved from a BP employer that did NOT offer coverage in the BP Retiree Medical Plan to one that did, and you met retiree medical eligibility at the time you left the participating employer, your age and total vesting service in a BP retirement plan were used to determine your retiree contribution percentage.
If you were hired on or after April 1, 2004 and before January 1, 2020

Full-time and part-time employees hired on or after April 1, 2004, and before January 1, 2020, by a BP employer who offered coverage in the BP Retiree Medical Plan are eligible to participate in the BP Retiree Reimbursement Account Program. Note: One of the BP employers who do not offer coverage in the BP Retiree Reimbursement Account Program is BP GBS Americas. Eligible employees of this company who are/were hired on or after April 1, 2004, will be eligible only for the medical portion of the BP Retiree Medical Plan. Please see the GBS Medical SPD for more details on transfers between Core and GBS.

A retiree reimbursement account (RRA) is designed to help eligible retirees who are not eligible for a reduced premium contribution pay for any qualifying medical expense. If you are eligible to participate in the BP Retiree Medical Plan when you leave BP, your accumulated RRA credits can be used to reimburse you for any “qualifying” medical expense. A medical care expense under an RRA will be considered to be “qualifying” if it meets federal tax law standards. Examples are health plan premiums, deductibles, coinsurance and copays.

If eligible, you will receive an annual “credit” in your RRA based on your age and years of service, with the term “annual” meaning the plan year. This “credit” is actually a bookkeeping entry, and there is no vested ownership in such entries by any participant. You do not make any contributions to your RRA, and it accrues no interest.

Once your RRA is depleted, you will no longer be eligible for reimbursement of any qualifying expenses; however, this would not impact your eligibility for coverage under the medical portion of the BP Retiree Medical Plan.

Annual credits accumulated from your date of hire range from $7,500 to $10,500 as shown in the chart below. Your points determine the amount of your annual credit.

<table>
<thead>
<tr>
<th>Points = Age + Years of Service</th>
<th>Annual Credit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 41</td>
<td>$7,500</td>
</tr>
<tr>
<td>41 – 50</td>
<td>$8,250</td>
</tr>
<tr>
<td>51 – 60</td>
<td>$9,000</td>
</tr>
<tr>
<td>61 – 70</td>
<td>$9,750</td>
</tr>
<tr>
<td>71 or more</td>
<td>$10,500</td>
</tr>
</tbody>
</table>

Note: Monthly prorating applies when you are hired by, or if you leave, BP in the middle of a plan year. In order to get credit for a month, you must work the entire month in order to obtain credit. For example, if your final day of work is January 31, you will receive credit for January, but if your final day of work is January 15, you will not receive that month's credit. Also, the monthly credit will be based on your above point calculation as of the end of the month, even if the applicable point calculation changes in the middle of the month.

How to use your RRA

When you have a qualified medical expense:

1. Pay the expense.
2. Print the RRA claim form from the Aetna website.
3. Mail your claim request (with the appropriate receipts) to:

   Aetna
   P.O. Box 4000
   Richmond, KY 40476-4000

   OR

1. You may fax the form and receipts to 1-888-238-3539.

If your claim is approved, you will receive tax-free reimbursement up to the amount in your RRA.

What retiree medical expenses are eligible?
Qualified medical expenses include certain health insurance premiums and other out-of-pocket medical expenses that the Internal Revenue Service (IRS) lists as eligible (i.e., the amounts you spend on deductibles, copayments, prescriptions, some over-the-counter medications, etc.). Consider using the RRA to help with medical premiums up to the time you are eligible for Medicare.

If the expense is covered under any other plan, you cannot be reimbursed through the RRA until the expense has been considered by the other plan.


**Keeping track of your RRA**

You can track your RRA balance and reimbursements online. Use the secure Aetna website at http://www.aetna.com or http://www.payflex.com. You can also print RRA claim forms and receive general health information.

You can also verify your balance by calling Aetna Customer Service at 1-866-436-2606 (if hearing impaired, call 1-877-703-5572). You may also receive paper statements on a regular basis.

If you want to learn what your RRA balance was on the day you retired, or how BP calculated your credits, go online to the BP Benefits Center from the LifeBenefits homepage, or call the BP Benefits Center at 1-800-890-4100.

**Using your RRA with the Health+Savings options (PPO or Out-of-Area)**

If you are enrolled in one of the Health+Savings options with the Health Savings Account (HSA) for retiree medical coverage before you become eligible for Medicare, your RRA may be used only for certain types of expense, as follows:

- **Until you meet your deductible**, your RRA can be used only for certain types of expenses, including Medicare premiums and eligible out-of-pocket vision, dental and preventive care expenses. Note: Medicare premiums can only be for your spouse or eligible dependent, as you cannot be covered under Medicare and also contribute to an HSA. Your RRA cannot be used to reimburse you for your deductible. You can use your HSA to pay for all out-of-pocket eligible medical expenses. You cannot be reimbursed from both accounts for the same expense.

- **Once you meet your deductible**, the RRA can reimburse you for all eligible medical expenses you and your eligible spouse and dependents incur.

**If you moved within BP**

If you moved from a BP employer who offered coverage in the BP Retiree Medical Plan to one who did not, and you met the eligibility requirements for the BP Retiree Medical Plan while at the participating employer, your notional RRA balance will be frozen at the time of transfer. You will not accrue additional RRA credits while employed at the non-participating employer.

If you moved from a BP employer who did NOT offer coverage in the BP Retiree Medical Plan to one that did, and you met BP Retiree Medical Plan eligibility at the time you left the non-participating employer, your annual credits were based on your age and your total vesting service in a BP retirement plan.
If you were hired January 1, 2020 or later

Note: Effective January 1, 2020, employees who originally entered BP U.S. benefit programs as Inpatriates but became localized U.S. employees at a later time will be eligible only for access to retiree medical coverage as described in this section, regardless of whether their U.S. hire date is before or after January 1, 2020.

You will become eligible for BP retiree medical coverage if you satisfy the retiree medical requirements of the BP business unit in which you work via a combination of age and service. Generally, you must either be age 50 or above with at least 10 years of vesting service in a BP retirement plan, or age 55 or above with at least five years of vesting service in a BP retirement plan.

However, you will pay the entire cost of retiree medical coverage for yourself and your eligible dependents. During annual enrollment each year, you will be notified of the required contribution for your available coverage options for the upcoming plan year. You will not be eligible for either a subsidized premium or participation in the BP Retiree Reimbursement Account Program, as described in preceding sections.

If you moved within BP

If you moved from a BP employer who offered coverage in the BP Retiree Medical Plan to one who did not, and you met the eligibility requirements for the BP Retiree Medical Plan while at the participating employer, you will continue to be eligible for access to retiree medical coverage at the time of retirement.

If you moved from a BP employer who did NOT offer coverage in the BP Retiree Medical Plan to one that did, and you met BP Retiree Medical Plan eligibility at the time you left the non-participating employer, you will become eligible for access to retiree medical coverage based on your age and your total vesting service in a BP retirement plan.
If you transfer within BP to a non-participating group

Occasionally, a BP employee may transfer within BP to a non-participating BP entity (a business unit that does not offer retiree medical coverage). In this case, the following special rules apply. All other retiree medical rules/rehire rules continue to apply. **Note:** You can retire from the non-participating BP group and receive BP retiree medical coverage if you meet the stated requirements — you are not required to return to a participating BP group first.

If you are retiree medical eligible when you transfer to a non-participating group

If, when you transfer, you are either age 50 with 10 years of vesting service, or age 55 with 5 years of vesting service:

1. **And** you were hired before April 1, 2004:
   - Your service in the non-participating unit counts for purposes of calculating your retirement subsidy.
2. **And** you were hired on or after April 1, 2004, and before January 1, 2020:
   - You do not accrue any additional RRA credits while serving in the non-participating group.
   - You can retire at any time and keep the RRA credits that accrued before you transferred.
   - If you return to a participating BP group, your RRA credits will resume, using all relevant service recognized by the U.S. retirement plan.
3. **And** you were hired January 1, 2020, or later:
   - You will only be eligible for access to the BP Retiree Medical Program. You will not be eligible for either a subsidized premium or participation in the BP Retiree Reimbursement Account Program, as described in preceding sections.

If you are not retiree medical eligible when you transfer to a non-participating group

If, when you transfer, you are not either age 50 with 10 years of vesting service, or age 55 with 5 years of vesting service:

1. **And** you were hired before April 1, 2004:
   - If you had at least 5 or 10 years of service with a participating BP group at the time of the transfer, you may become retiree medical eligible if you fulfill the eligibility rules of age and service (reaching age 50/55 as applicable), while still employed with a BP group.
   - Only vesting service accrued with the participating group will be used to calculate your retirement subsidy.
2. **And** you were hired on or after April 1, 2004, and before January 1, 2020:
   - If you had at least 5 or 10 years of service with a participating BP group at the time of the transfer, you do not accrue any additional RRA credits while serving in the non-participating group, but you can make a claim for your RRA balance at the time you transferred if you fulfill the eligibility rules of age and service (reaching age 50/55 as applicable), while still employed with a BP group (i.e., you accrue service time but not RRA credits).
3. **And** you were hired January 1, 2020, or later:
   - You will continue to accrue service for retiree medical eligibility, but you will only be eligible for access to the BP Retiree Medical Program if you satisfy the eligibility requirements. You will not be eligible for either a subsidized premium or participation in the BP Retiree Reimbursement Account Program, as described in preceding programs.

If you transferred to a non-participating group and wish to retire under the above provisions, you need to coordinate with HR and BP Benefits to request retiree medical coverage. Coverage is not automatic.

If you are rehired

Occasionally, retired BP employees are rehired. Active employees are not eligible for Retiree Medical Coverage, so you would temporarily lose this coverage while employed. Please note the following, which would apply upon your subsequent retirement.

**If you were eligible for the subsidized premium upon your first retirement**, as indicated in the If you were hired before April 1, 2004 section above, you would not lose that subsidy. Instead, your additional service will be used to calculate whatever new subsidy might apply. For example, if you were age 50 with ten years of service when you first retired, your subsidy would have been set at the 50% level at that time. If you return and then later retire at age 58 with five years of additional service, you would then be eligible to pay 30% of the applicable premium at that time.

**If you were eligible for the RRA at the time of your first retirement**, as indicated in the If you were hired on or after April 1, 2004 and before January 1, 2020 section above, your additional service time while you are re-employed will be used to calculate the amount of credits to your RRA balance until your next retirement. Note that the RRA is not available to you to cover medical expenses while you are an active employee.

There is often confusion when people were originally hired prior to April 1, 2004 but rehired later. If
1. Your original U.S. hire date with BP was before April 1, 2004;
2. You were rehired on or after April 1, 2004, and before January 1, 2020; and
3. You were vested in a U.S.-based BP retirement plan as of your original termination date;

then you are eligible for the subsidized premium upon meeting the BP Retiree Medical Plan eligibility rules and are not eligible for the RRA.

If you were not vested in a U.S.-based BP retirement plan as of your original retirement date, or any subsequent retirement date, and your rehire date was on or after April 1, 2004, and before January 1, 2020, then upon meeting the BP Retiree Medical Plan eligibility rules you would be eligible for the RRA and not the subsidized premium, and your RRA would start with a zero balance. However, if your prior service counts as vesting service for a U.S.-based BP retirement plan, then that service will be taken into account when calculating the applicable RRA annual credit for your most recent rehire period.

Note: For all rehires on and after September 1, 2014, and before January 1, 2020, if you were not eligible for the BP Retiree Medical Plan upon your most recent termination date prior to September 1, 2014, then you will only be eligible for RRA credits upon your rehire regardless of your prior vested status in a U.S.-based BP retirement plan. If your prior service counts as vesting service for a U.S.-based BP retirement plan, then that service will be taken into account when calculating the applicable RRA annual credit for your most recent rehire period.

Note: For all rehires on and after January 1, 2020, you will only have access to the BP Retiree Medical Plan. If you have an RRA balance on file, and were retirement eligible (50/10 or 55/5) at the time of your initial termination, that balance will remain available to you but you will not accrue any additional RRA credits. If you were not retirement eligible at the time of your initial termination, that balance was forfeited and you will not be eligible for the RRA.

For purposes of this section, the term “U.S.-based BP retirement plan” refers to either a 401(k) or pension plan that was sponsored by BP as of the time of your retirement. If you vested in a retirement plan and terminated from an employer that BP acquired after your termination date from that employer, that employment period will not be taken into account when determining whether your original date was pre- or post-April 1, 2004. However, if a U.S.-based BP retirement plan counts such prior service as vesting service, then that service will be taken into account when calculating either the amount of subsidized premium or the RRA annual credit, as applicable.
## Administrative information

### Detailed information about plan administration and your rights

<table>
<thead>
<tr>
<th>Name of plan</th>
<th>BP Medical Plan, a component benefit program of the BP Corporation North America Inc. Consolidated Welfare Benefit Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of plan</td>
<td>Welfare benefit plan including:</td>
</tr>
<tr>
<td></td>
<td>- BP Medical Plan (“the plan” — medical care, hospitalization, surgical care, behavioral health care, employee assistance program, prescription drugs) — self-insured.</td>
</tr>
<tr>
<td></td>
<td>- Health Maintenance Organization (HMOs) — insured.</td>
</tr>
<tr>
<td>Plan number</td>
<td>504</td>
</tr>
<tr>
<td>Plan year</td>
<td>April 1 – March 31</td>
</tr>
</tbody>
</table>
| Plan sponsor and identification number | BP Corporation North America Inc.  
501 Westlake Park Blvd.  
Houston, TX 77079  
Employer ID#: 36-1812780 |
| Plan administrator | Director, Health & Welfare  
BP Corporation North America Inc.  
501 Westlake Park Blvd  
Houston, TX 77079  
1-800-890-4100 |
| Sources of contributions | The BP Corporation North America Inc. Consolidated Welfare Benefit Plan is funded by participants’ and participating employers’ contributions and by investment earnings. 
Participant contributions are set by BP and may be adjusted from time to time. If participant contributions and investment earnings are insufficient to pay plan costs or expenses, the balance of the cost of the plan (if any) is paid by BP. 
Benefits may be paid through the BP Welfare Benefits Trust-III (“VEBA”). |
| VEBA trustee | JPMorgan Chase Bank  
Worldwide Securities Services  
4 New York Plaza  
New York, NY 10005 |
| Claims administrators | See Claims administrators. |
| Agent for service of legal process | For disputes arising from the plans, legal process may be served on:  
BP Legal  
BP Corporation North America Inc.  
P.O. Box 940669  
Houston, TX 77094-7669  
Legal process may be made upon the plan administrator. |

Publication date: April 2020
All of the coverage options include behavioral health services and prescription drug coverage.

- The HealthPlus, Standard and Health+Savings Options, including behavioral health care, are all administered by Aetna.
- The Prescription Drug Program is administered by Express Scripts, Inc. (ESI). Specialty drug coverage is administered by Accredo. MCMC is the final claims fiduciary for prescription drug appeals.
- The claims administrator for an HMO option is the HMO.
- The medical coverage claims administrator (Aetna) determines incapacity for a dependent child to continue as an eligible dependent child beyond otherwise applicable age limits.

<table>
<thead>
<tr>
<th>Administrator</th>
<th>Online</th>
<th>By phone</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BP Medical Plan:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aetna</td>
<td>Aetna</td>
<td>Note: The phone numbers below include the Enhanced Aetna Concierge program</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.aetna.com">www.aetna.com</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td>BP's custom DocFind website</td>
<td>Within the U.S.: 1-866-436-2606</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.aetna.com/dsepublic/#/contentPage">www.aetna.com/dsepublic/#/contentPage</a>?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>page=providerSearchLanding&amp;site_id=bp</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Outside the U.S.: Dial the AT&amp;T access number of the country you are in; when prompted, dial 1-866-436-2606</td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>HMOs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>For questions or to submit claims to a BP-offered HMO, contact your HMO directly. The phone number is on your HMO medical option ID card or available by contacting the BP Benefits Center.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prescription Drug Program for the PPO or OOA Options, including the Health+Savings PPO and OOA Options:</strong></td>
<td><a href="http://www.express-scripts.com">www.express-scripts.com</a></td>
<td>1-800-216-6506</td>
</tr>
<tr>
<td>Express Scripts, Inc. (ESI)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Note: MCMC is the final claims fiduciary for prescription drug appeals.</td>
</tr>
</tbody>
</table>

Publication date: April 2020
The plan administrator has the authority to control and manage the operation and administration of the plan. In this capacity, the plan administrator (or his/her authorized delegates) generally has several rights, powers and duties, including:

- Selecting and contracting with a claims administrator and other service providers.
- Determining expenses that can be paid from plan assets.
- Determining, in his/her discretion, whether an individual is eligible for or entitled to benefits.
- Interpreting plan provisions.
- Establishing rules and procedures for plan administration.

The plan administrator has designated the various claims administrators to manage the day-to-day operations of the plans, including processing and paying all claims for benefits.

In addition to the rights and duties described above, the plan administrator has the authority to:

- Refuse payment or reimbursement for claims incurred by any covered person or other person who has engaged in improper conduct with respect to the BP Corporation North America Inc. Consolidated Welfare Benefit Plan.
- Terminate a covered person’s participation in the plan if he/she has engaged in improper conduct.

In order to determine whether a participant has engaged in improper conduct by covering an ineligible dependent, the plan administrator has the right to conduct internal or external audits of covered dependents at any time. In this regard, a participant may be asked to provide information and documentation supporting a covered dependent’s status as an eligible dependent. Such documentation may include birth and marriage certificates, civil union or domestic partner registration materials, driver’s licenses, passports, divorce decrees, court orders, tax records or other documents or materials supporting eligible dependent treatment. If selected for audit, the participant has the burden of establishing eligible dependent status to the satisfaction of the plan administrator. If a participant fails to respond timely to a request for information or materials, the plan administrator may take action, including but not limited to, increasing the participant’s cost for dependent coverage or terminating the dependent’s coverage.

Once it has been determined that an individual has engaged in improper conduct, the plan administrator has the authority to take any actions he/she deems appropriate to remedy such violations, including pursuing legal or equitable remedies to recoup any payments made by the BP Corporation North America Inc. Consolidated Welfare Benefit Plan to any party, regardless of when such improper conduct was taken or discovered. Such action will not preclude the company from taking other appropriate action.

If any individual loses any rights or coverage under the BP Corporation North America Inc. Consolidated Welfare Benefit Plan as a result of the plan administrator’s determination of improper conduct, coverage will be retroactively terminated as of the date of the improper conduct, and such individual will not be entitled to elect COBRA continuation coverage as may otherwise be available.

Publication date: April 2020
HIPAA privacy practices

The BP Medical Program is required by federal law (known as the “HIPAA Privacy Rules”) to maintain the privacy of participants’ “Protected Health Information” (PHI) and to provide participants with notice of its legal duties and privacy practices regarding PHI. HIPAA stands for the Health Insurance Portability and Accountability Act of 1996.

To obtain a copy of the HIPAA Notice, please click here or contact the BP Benefits Center.

Complaints

If you believe the plan has violated your privacy rights, you may file a complaint with the plan, the plan’s Privacy Officer or with the Secretary of Health and Human Services. Complaints to the plan or to the Privacy Officer should be filed in writing with:

BP HIPAA Privacy Compliance Monitor
BP Corporation North America Inc.
P.O. Box 941614
Houston, Texas 77094-8644
713-366-2000

You will not be penalized in any way for filing such a complaint.
Certificate of Group Health Coverage

If you and/or your covered dependent lose BP medical and/or dental coverage, the BP Benefits Center will provide a Certificate of Group Health Coverage. This certificate states how long you and/or your covered dependent were continuously covered under the plan. Please note that the certificate shows only the most recent 18 months of coverage. You could have been covered for years, but the certificate will not show all of your coverage history. (You and/or your covered dependent who loses coverage may also be eligible for continuation coverage under COBRA.)

You and/or your covered dependent may also request a Certificate of Group Health Coverage before coverage ends or within 24 months after losing coverage.

This certificate may help reduce the amount of time you are subject to any exclusions for pre-existing health conditions if you were to become covered under a non-BP health care plan in the future, unless you have a break in coverage of more than 63 days.
Qualified medical child support order (QMCSO)

A medical child support order (MCSO) is an order or judgment issued by a state court or an administrative notice issued by a state administrative agency that, when determined to be “qualified,” requires the plan administrator to provide a child with coverage or benefits under a group health plan, regardless of seasonal enrollment restrictions.

If an MCSO has been issued with respect to your child, you must forward all relevant documentation to the Qualified Order Team at the BP Benefits Center, which will determine whether the MCSO is qualified (QMCSO). If an MCSO is determined to be qualified, coverage will be subject to the terms of the QMCSO guidelines issued by the plan administrator from time to time.

If you have questions concerning a QMCSO or would like a copy of the applicable QMCSO procedures free of charge, contact the BP Benefits Center’s Qualified Order Team. They can be reached via fax at 1-847-442-0899 or regular mail at:

BP Qualified Order Team  
P.O. Box 1542  
Lincolnshire, IL 60069-1542

QMCSOs must be faxed or mailed to the Qualified Order Team. They may not be sent as scanned images via email. However, questions about qualified orders may be emailed to qocenter@hewitt.com.

To hear more about how to reach the Qualified Order Team, call 1-866-515-2425.

Publication date: April 2020
Power of attorney (POA) and anti-assignment matters

Power of attorney (POA)

Occasionally participants need assistance from a third party (agent) with benefits matters. If you wish to designate an agent to act on your behalf for your BP health and protection benefits, please contact the BP Benefits Center for copies of the POA Notice (submission guide) for health and protection matters and related POA form or print copies from the LifeBenefits website Forms or Policies and programs links.

The POA Notice also explains the submission process for individually designated POAs, court orders and guardianships. Third parties may request a copy of the POA Notice by calling the BP Benefits Center at 1-800-890-4100.

Please note that generally only one person or institution at a time can be recognized to act on behalf of a participant through submission of a POA, court order or guardianship. The BP Benefits Center will not process a transaction if there is a reason to believe that the person making the transaction is not the plan participant, the participant's agent under a POA or court-appointed conservator or guardian.

Anti-assignment

The rights or benefits under this plan may not be assigned by a participant or beneficiary. Any attempted assignment to a medical provider will be treated as a direction to pay benefits to such provider rather than as an assignment of rights.
Governing plan documents

In the preparation of this plan summary, effort was made to provide a clear, concise description of your benefits and to avoid contract and legal terms wherever possible. The aim has been to present a simplified overview of essential information about your benefits in words that are not obscure or likely to be misunderstood. As highlighted earlier in this summary, in the event of an inconsistency between this summary and the plan document (including insurance policies as applicable), the plan document will govern.

Employees covered by collective bargaining agreements are subject to this summary to the extent consistent with the terms of BP’s benefit programs, the applicable collective bargaining agreement and any applicable legal guidelines.

Publication date: April 2020
No right to employment

Your eligibility for or your right to benefits under BP’s benefit plans is not a guarantee of continued employment. BP’s employment practices are determined without regard to the benefits offered as part of your total compensation package. In addition, and subject to legal and contractual considerations, BP reserves the right to terminate your employment at any time or for any reason.

Publication date: April 2020
Future of the plan

The company reserves the right to change or end the BP Medical Program at any time without advance notice. The decision to do so may be the result of changes in federal or state laws governing benefits, or any other factor.

If the Medical Program is terminated, your contributions will end as of the last pay period before the program’s termination date. However, you will be able to file reimbursement claims of covered expenses incurred before the program’s termination date.

All eligible expenses will be reimbursed as long as they were incurred during the period you were covered under the BP Medical Program.
# Children's Health Insurance Program (CHIP)

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can 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, you can contact your State Medicaid or CHIP office, dial 1-877-KIDS NOW or go to www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer’s health plan is required to permit you and your dependents to enroll in the plan — as long as you and your dependents are eligible, but not already enrolled in the employer’s plan. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

If you live in one of the following States, you may be eligible for assistance with paying your employer health plan premiums. The following list of States is current as of January 31, 2020. You should contact your State for further information on eligibility.

<table>
<thead>
<tr>
<th>State</th>
<th>Program</th>
<th>Website</th>
<th>Phone</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALABAMA</td>
<td>Medicaid</td>
<td><a href="http://www.myalhipp.com">http://www.myalhipp.com</a></td>
<td>1-855-692-5447</td>
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</tr>
<tr>
<td>ALASKA</td>
<td>Medicaid</td>
<td><a href="http://myakhipp.com/">http://myakhipp.com/</a></td>
<td>1-866-251-4861</td>
<td><a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a></td>
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<td></td>
<td>The AK Health Insurance Premium</td>
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<tr>
<td></td>
<td>Payment Program</td>
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<tr>
<td>ARKANSAS</td>
<td>Medicaid</td>
<td><a href="http://myarhipp.com/">http://myarhipp.com/</a></td>
<td>1-855-MyARHIPP (855-692-7447)</td>
<td></td>
</tr>
<tr>
<td>CALIFORNIA</td>
<td>Medicaid</td>
<td><a href="https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx">https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx</a></td>
<td>1-800-541-5555</td>
<td></td>
</tr>
<tr>
<td>COLORADO</td>
<td>Health First Colorado (Colorado'</td>
<td><a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a></td>
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<td>s Medicaid Program) &amp; Child</td>
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<td>Health Plan Plus (CHP+)</td>
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<tr>
<td></td>
<td>Health First Colorado Website:</td>
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<td></td>
<td></td>
<td><a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a></td>
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<tr>
<td></td>
<td>Health First Colorado Member</td>
<td>1-800-221-3943 / State Relay 711</td>
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<td></td>
<td>Contact Center:</td>
<td></td>
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<tr>
<td></td>
<td>CHP+ Website:</td>
<td><a href="https://www.colorado.gov/pacific/hcpf/child-health-plan-plus">https://www.colorado.gov/pacific/hcpf/child-health-plan-plus</a></td>
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</tbody>
</table>

13/Nov/20 06:55  The most up-to-date information is available online at http://hr.bpglobal.com/lifebenefits/Core.
<table>
<thead>
<tr>
<th>State</th>
<th>Medicaid/CHIP Information</th>
</tr>
</thead>
</table>
| **GEORGIA** – Medicaid | Website: http://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp  
Phone: 678-564-1162 ext. 2131 |
| **INDIANA** – Medicaid | 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: http://www.indianamedicaid.com  
Phone: 1-800-403-0864 |
| **IOWA** – Medicaid and CHIP (Hawki) | Medicaid Website: https://dhs.iowa.gov/ime/members  
Medicaid Phone: 1-800-338-8366  
Hawki Website: http://www.dhs.iowa.gov/hawk-i  
Hawki Phone: 1-800-257-8563 |
| **KANSAS** – Medicaid | Website: http://www.kdheks.gov/hcf/default.htm  
Phone: 1-800-792-4884 |
| **KENTUCKY** – 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 |
| **LOUISIANA** – 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) |
| **MAINE** – Medicaid | Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html  
Phone: 1-800-442-6003  
Phone (TTY): Maine relay 711 |
<table>
<thead>
<tr>
<th>State</th>
<th>Program</th>
<th>Website</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massachusetts</td>
<td>Medicaid and CHIP</td>
<td><a href="http://www.mass.gov/eohhs/gov/departments/masshealth/">http://www.mass.gov/eohhs/gov/departments/masshealth/</a></td>
<td>1-800-862-4840</td>
</tr>
<tr>
<td>Missouri</td>
<td>Medicaid</td>
<td><a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a></td>
<td>573-751-2005</td>
</tr>
<tr>
<td>Montana</td>
<td>Medicaid</td>
<td><a href="http://dphphs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphphs.mt.gov/MontanaHealthcarePrograms/HIPP</a></td>
<td>1-800-694-3084</td>
</tr>
<tr>
<td>Nebraska</td>
<td>Medicaid</td>
<td><a href="http://www.ACCESSNebraska.ne.gov">http://www.ACCESSNebraska.ne.gov</a></td>
<td>1-855-632-7633</td>
</tr>
<tr>
<td>Nevada</td>
<td>Medicaid</td>
<td><a href="http://dhcfp.nv.gov">http://dhcfp.nv.gov</a></td>
<td>1-800-992-0900</td>
</tr>
<tr>
<td>New Jersey</td>
<td>Medicaid and CHIP</td>
<td><a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a></td>
<td>609-631-2392</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a></td>
<td>1-800-701-0710</td>
</tr>
<tr>
<td>New York</td>
<td>Medicaid</td>
<td><a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a></td>
<td>1-800-541-2831</td>
</tr>
<tr>
<td>North Carolina</td>
<td>Medicaid</td>
<td><a href="https://medicaid.ncdhhs.gov">https://medicaid.ncdhhs.gov</a></td>
<td>919-855-4100</td>
</tr>
<tr>
<td>North Dakota</td>
<td>Medicaid</td>
<td><a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">http://www.nd.gov/dhs/services/medicalserv/medicaid/</a></td>
<td>1-844-854-4825</td>
</tr>
</tbody>
</table>

The most up-to-date information is available online at http://hr.bpglobal.com/lifebenefits/Core.
<table>
<thead>
<tr>
<th>State</th>
<th>Medicaid/CHIP Information</th>
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| OKLAHOMA      | Website: http://www.insureoklahoma.org  
                Phone: 1-888-365-3742 |
| OREGON        | Website (English): http://healthcare.oregon.gov/Pages/index.aspx  
                Website (Spanish): http://oregonhealthcare.gov/index-es.html  
                Phone: 1-800-699-9075 |
| PENNSYLVANIA  | Website: http://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx  
                Phone: 1-800-692-7462 |
| RHODE ISLAND  | Website: http://www.eohhs.ri.gov  
                Phone: 855-697-4347 or 401-462-0311 (Direct Rite Share Line) |
| SOUTH CAROLINA| Website: https://www.scdhhs.gov  
                Phone: 1-888-549-0820 |
| SOUTH DAKOTA  | Website: http://dss.sd.gov  
                Phone: 1-888-828-0059 |
| TEXAS         | Website: http://www.gethipptexas.com/  
                Phone: 1-800-440-0493 |
| UTAH          | Medicaid Website: https://medicaid.utah.gov/  
                CHIP Website: http://health.utah.gov/chip  
                Phone: 1-877-543-7669 |
| VERMONT       | Website: http://www.greenmountaincare.org/  
                Phone: 1-800-250-8427 |
| VIRGINIA      | Website: http://www.coverva.org/  
                Medicaid Phone: 1-800-432-5924  
                CHIP Phone: 1-855-242-8282 |
| WASHINGTON    | Website: http://www.hca.wa.gov/  
                Phone: 1-800-562-3022 |
To see if any more States have added a premium assistance program since January 31, 2020, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Publication date: April 2020
Your ERISA rights

As a participant in a BP benefit plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants have the right to:

- Examine, without charge, at the plan administrator’s office, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor.
- Obtain, upon written request to the BP Benefits Center, copies of governing plan documents. A reasonable fee for copying may be assessed. The address used to request plan documents is:

  BP Benefits Center  
P.O. Box 563944  
Charlotte, NC 28256-3944

  Participants may also download a copy of the summary plan description at no cost from the “Benefits handbook” tab on the LifeBenefits website at http://www.bp.com/lifebenefits.
- Receive a summary of the plan’s annual financial report at no charge. Each participant is automatically provided with a copy of this summary annual report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plan. The people who operate your plans are called “fiduciaries” and have a duty to operate the plans prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or discriminate against you in any way to prevent you from obtaining benefits under the plan or exercising your rights under ERISA.

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

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court within Harris County, Texas. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless they were not sent because of reasons beyond the plan administrator’s control.

The only proper venue for a lawsuit seeking enforcement of your rights under this plan is in federal court in Harris County, Texas.

If you have a claim for benefits that is denied or ignored, in whole or in part, or if you disagree with the plan’s decision or lack thereof concerning the qualified status of a Domestic Relations Order (DRO) or a Medical Child Support Order (MCSO), you may file suit in a state or federal court located in Harris County, Texas. (You can file suit only after you have exhausted the plan’s claims and appeals procedures.) If the 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 in Harris County, Texas.

The court will decide who should pay court costs and legal fees. If you’re 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.

If you have any questions about your health and protection plans, you should contact the BP Benefits Center.

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or contact:

Division of Technical Assistance and Inquiries  
Employee Benefits Security Administration  
U.S. Department of Labor  
200 Constitution Avenue N.W.