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BP Retiree Medical Plan

The BP Corporation North America Inc. Retiree Medical Plan ("the BP Retiree Medical Plan") helps retirees, surviving spouses and other eligible participants meet their health care and maintenance needs.

The BP Retiree Medical Plan is currently composed primarily of two separate sub-programs — the BP NonMedicare-Eligible Program and the BP Medicare-Eligible Program. Additionally, certain "grandfathered" BP America heritage retirees and their dependents are eligible for a closed program — the BP MediFill Program. The BP Medicare-Eligible Program is described in this handbook.

The BP Retiree Medical Plan is primarily made up of the following programs:

<table>
<thead>
<tr>
<th>Program</th>
<th>Eligibility Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BP NonMedicare-Eligible Program</strong></td>
<td>You are eligible for coverage under the BP NonMedicare-Eligible Program if you and all of your covered eligible dependents are NOT eligible for Medicare. If you are eligible for Medicare, but one of your dependents is not Medicare-eligible, the dependent who is not Medicare-eligible can be covered under the BP NonMedicare-Eligible Program.</td>
</tr>
<tr>
<td><strong>BP Medicare-Eligible Program</strong></td>
<td>You are eligible for coverage under the BP Medicare-Eligible Program if, due to age or disability, you or any of your covered dependents are eligible for Medicare. The Medicare-Eligible Program includes two separate options: the BP Medicare Advantage Preferred Provider Organization (PPO) with an Extended Service Area (ESA) and the BP Medicare-Eligible Option. The BP Medicare Advantage PPO ESA is open to new members. The BP Medicare-Eligible Option is closed to new members effective January 1, 2019. Only certain existing &quot;grandfathered&quot; members may continue to participate in the Medicare-Eligible Option. New over-65 retirees must enroll in the Medicare Advantage PPO ESA plan. If not already eligible for and enrolled in Medicare, they may temporarily enroll in the NonMedicare-Eligible Program and will then have 12 months to attain Medicare eligibility and transition to the Medicare Advantage PPO ESA plan.</td>
</tr>
</tbody>
</table>

If you are eligible to participate in the BP Retiree Medical Plan due to the eligibility criteria contained elsewhere, then:

If you are eligible to enroll in the BP Retiree Medical Plan, benefits will differ depending on whether or not you and/or your covered dependents are eligible for Medicare. The benefits described in this document outline just the benefits available when you and/or another covered family member is eligible for Medicare.

To enroll in the “BP Medicare Advantage PPO ESA” plan, both you and your eligible family members must enroll in both Medicare Parts A and B.

If no one in a covered family unit is eligible for Medicare, you must instead enroll in the so-called "Non-Medicare Eligible Option" or "NMEO," which is described in a separate handbook.

BP MEO Eligibility

Once you or a covered dependent become eligible for Medicare and enroll in Medicare Part A and Part B, the only available option is the BP Medicare Advantage Plan. Unless you are not eligible for Medicare, you must transition to the Medicare Advantage Plan no later than 12 months after becoming eligible. If you do not transition, you and, if applicable, your dependents will lose coverage under the BP Retiree Medical Plan and this will count as your one-time drop.

If you are currently enrolled in BP retiree medical coverage, you will have 12 months to enroll in the Medicare Advantage Plan.
If you are not currently enrolled in BP retiree medical coverage, you must wait until the next annual enrollment period to complete your enrollment, unless you have a valid qualifying status change prior to the enrollment period.

Once you turn age 65, you have 12 months to satisfy the eligibility requirements for the Medicare Advantage Plan (being eligible for Medicare; enrolled in both Medicare Part A and Part B). If you fail to satisfy the eligibility requirements after 12 months, you and, if applicable, your dependents will be dropped from BP retiree medical coverage and this drop will count as your one-time drop. (See Limits on re-enrollment in the How to enroll section.)

If you are over age 65 but are not eligible for Medicare because you reside permanently in a foreign country (or for certain other reasons such as not having enough work credits), you may remain in the BP NonMedicare-Eligible Program indefinitely as long as you remain ineligible for Medicare.

If you are in a Medicare split family scenario (at least one member is Medicare eligible/over age 65 and one member is not Medicare eligible/under age 65), your options will split into two separate medical elections — one in the BP NonMedicare-Eligible Program and one in the BP Medicare-Eligible Program. Please contact the BP Benefits Center for more information on your available options.

Note: Due to various Medicare enrollment rules, if you have questions or are delayed from enrolling in the appropriate plan, you should contact the BP Benefits Center to obtain information about the plan in which you are enrolled.

Throughout this summary, "you" generally refers to:

- You (the eligible retiree, LTD Recipient or surviving spouse) when describing elections (e.g., how to enroll, how to change coverage, when coverage ends).
- 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.

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

Learn about the eligibility rules governing the BP Retiree Medical Plan

BP participants

Eligibility provisions under the BP Retiree Medical Plan vary based on:

- Your status as a BP participant or the surviving spouse of a BP participant; and
- The provisions of the applicable plan in effect at the time of your eligibility event.

BP Participants include eligible BP retirees, LTD recipients and surviving spouses.

Note: You cannot be covered under the Retiree Medical Plan if you’re an active BP employee. If you’re enrolled in retiree medical coverage and are rehired by BP, your retiree medical coverage will end. See Qualifying status changes that allow, but do not require, you to enroll yourself and your eligible dependents for details.

Retirees

A BP participant whose eligibility event was retirement is eligible for the BP Retiree Medical Plan if at retirement he/she was:

- Employed by a participating employer;
- Part of a classification of employees eligible for coverage under the applicable plan;
- Not classified as a member of an excluded group under the applicable plan; and
- Satisfied the eligibility provisions of a BP retiree medical plan.

In general, you are eligible for coverage under the BP Retiree Medical Plan when you reach age 50 with at least 10 years of vesting service under a US-based BP retirement plan, or age 55 with at least 5 years of vesting service under a US-based BP retirement plan and you are a full-time or part-time employee working for a participating BP employer group that offers its employees eligibility under the BP Retiree Medical Plan.

LTD recipients

If you work for a BP employer who offers coverage in the BP Retiree Medical Plan, and you are on employer-approved leave as a result of a disability, the following applies to your eligibility for coverage under the BP Retiree Medical Plan.

If you are receiving BP LTD Plan benefits for less than 24 months

You are considered on a BP approved leave of absence and you will continue to accrue service for BP Retiree Medical Plan eligibility; however, you are not yet eligible to participate in the BP Retiree Medical Plan due to your status as an active employee.

If you are receiving BP LTD Plan benefits after 24 months

If you leave BP as a result of a long-term disability for which you are receiving benefits from the BP Long-Term Disability Plan, 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 remain eligible for BP LTD plan benefits after 24 months.
In this case, your eligibility for BP Retiree Medical Plan coverage will commence the first of the month following the date above.

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.

If your disability was not work-related:

<table>
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<tr>
<th>If hired before April 1, 2004:</th>
<th>If hired on or after April 1, 2004:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Met BP Retiree Medical Plan eligibility requirements</td>
<td>Did not meet BP Retiree Medical Plan 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 50% retiree contribution percentage.</td>
</tr>
</tbody>
</table>

If your disability is work-related and your U.S. hire date was before April 1, 2004, your contribution for the BP Retiree Medical Plan will be the 30% retiree contribution percentage, based on the schedule for employees hired before April 1, 2004. If your disability is work-related and your U.S. hire date was on or after April 1, 2004, you will be eligible to receive your accumulated Retiree Reimbursement Account regardless of satisfying the normal Retiree Medical eligibility rules.

See What coverage costs for information on contribution rates.
Eligible dependents

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

- Spouse, including a legally separated spouse. **Note:** 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.
- 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.

See Domestic partners below for information on domestic partner eligibility under the BP Retiree Medical Plan.

Except for COBRA continuation and a surviving disabled dependent (as described below), you must participate in the BP Retiree Medical Plan in order 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.

The most up-to-date information is available online at http://hr.bpglobal.com/lifebenefits/RetireeMedicare.
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 participant. You may do either of the following:

- Each of you may enroll for "Personal" 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. "Personal" coverage is not available for the spouse/domestic partner covered as a dependent.

**Surviving spouses**

Surviving spouses and eligible dependents of eligible BP retirees and STD/LTD recipients may continue coverage following the death of the BP retiree or STD/LTD recipient in certain circumstances. **Note:** This coverage is not available for a surviving domestic partner of a retiree or STD/LTD recipient, nor for that partner’s dependents (unless they are also surviving dependent children of the retiree or STD/LTD recipient).

The contribution for coverage will depend on several factors, including the deceased person's employee classification and status; whether he/she worked for a group that offered retiree medical coverage; his/her date of hire, age and years of vesting service in a U.S.-based BP retirement program; and whether his/her death was work-related.

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<tr>
<th>Not work-related</th>
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<th>Not work-related</th>
<th>Work-related</th>
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<tbody>
<tr>
<td>If your deceased spouse met the BP Retiree Medical Plan eligibility requirements at the time of death, you and any eligible dependent children were immediately eligible for BP Retiree Medical Plan coverage. Your contribution percentage* for retiree medical coverage is based on your spouse’s age and years of vesting service in a BP retirement program at the time of death.</td>
<td>Regardless of your deceased spouse’s age or years of vesting service in a BP retirement plan, you and any eligible dependent children were immediately eligible for coverage under the BP Retiree Medical Plan at the minimum retiree contribution percentage.*</td>
<td>If your deceased spouse met the BP Retiree Medical Plan eligibility requirements at the time of his/her death, you and any eligible dependent children were immediately eligible for BP Retiree Medical Plan coverage. You were given immediate access to your deceased spouse’s Retiree Reimbursement Account (RRA).* ** When the RRA is depleted, you will no longer be eligible for reimbursement of any qualifying expenses.</td>
<td>Regardless of your deceased spouse’s age or years of vesting service in a BP retirement plan, you and any eligible dependent children were immediately eligible for BP Retiree Medical Plan coverage. You were given immediate access to your deceased spouse’s Retiree Reimbursement Account (RRA).* ** When the RRA is depleted, you will no longer be eligible for reimbursement of any qualifying expenses.</td>
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* See If you were hired before April 1, 2004 for contribution percentages.

** See If you were hired April 1, 2004 or later for information on RRAs.

If you are a surviving spouse of an STD/LTD recipient, the following rules apply:

**STD recipients**

If a BP employee is on a short-term disability (STD) leave of absence from BP as a result of a terminal illness, and he/she dies as a direct result of that terminal illness before being eligible to receive benefits from the BP Long-Term Disability Plan, the surviving spouse and dependent children of that employee are immediately eligible to begin coverage under the BP Retiree Medical Plan, subject to the other terms of the BP Retiree Medical Plan (including but not limited to dependent child age maximums and benefit coverage provisions). Premiums for such coverage shall be based on the schedule in the LTD recipients section above.
If the deceased STD/LTD recipient was hired on or after April 1, 2004, the surviving spouse will have immediate access to the deceased employee’s Retiree Reimbursement Account (RRA), if any, even though the deceased employee may not have reached the eligibility threshold to access that at the time of death (either 50 years of age with 10 years of service, or 55 years of age with 5 years of service). The RRA can be used for any tax-qualified medical expense. No additional monies will be eligible to be put into the RRA, and once it is depleted, a surviving spouse will no longer be eligible for reimbursement of any qualifying expenses from the RRA (although this will not affect eligibility for the BP Retiree Medical Plan). If there is no surviving spouse but instead surviving dependent children, such children will also have immediate access to the deceased employee’s RRA, subject to the same restrictions. (Note: The RRA is not available for employees hired before April 1, 2004.)

See What coverage costs for information on the RRA.

Domestic partners

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

1. **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

2. **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 Medicare HMOs may impose more restrictive criteria. Contact the Medicare 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.

BP reserves the right to amend or terminate a plan at any time without advance notice.
Who is not eligible

Regardless of an individual’s classification as a BP Participant, the BP Participant is not eligible to participate in the BP Retiree Medical Plan if, as of the date of the eligibility event, the BP Participant was:

- Not considered to be an employee of BP (or a predecessor employer) on the participating employer’s payroll regardless of whether subsequently determined to be a common-law employee;
- In a status excluded from eligibility under the applicable plan, including:
  - Inpat;
  - Temporary;
  - Term contract;
  - At-site retail employee of BP Products North America Inc., with the exception of a salaried employee hired before April 1, 2004 who either (1) satisfied plan eligibility provisions for retiree medical as of the date of his/her separation, provided that the employee had continuously remained an eligible employee under the BP Medical Plan after that date until his/her separation, or (2) had already satisfied plan eligibility provisions for retiree medical as of March 31, 2004; or
  - Air BP non-union hourly employee other than at Dulles or Cleveland, Hopkins Airports, etc.;
- An employee of BP Products North America Inc. employed in the Elite Customer Solutions Center USA (now called GBS Americas) after June 30, 2005, with the exception of an employee who (1) was an employee eligible to participate in the BP Medical Plan as of June 30, 2005, (2) has continuously remained an eligible employee under that plan after June 30, 2005, and (3) became employed by ECSC/GBS before January 1, 2008;
- A salaried employee of BP Products North America Inc. below Level I hired after August 31, 2005, in support of U.S. Convenience Operations site payroll and benefits;
- An employee who was covered under a collective bargaining agreement that did not provide for coverage under the applicable plan as of the eligibility event; or
- Eligible for other BP-offered retiree medical coverage — including, but not limited to:
  - AFFC Retiree Medical Plan;
  - All Anaconda retiree medical plans;
  - BP America Comprehensive Medical Plan for Kennecott Retirees – Post-87;
  - BP America Comprehensive Medical Plan for Kennecott Retirees – Pre-87;
  - BP America Comprehensive Medical Plan for Kennecott Retirees – Smelter;
  - BP America Comprehensive Medical Plan for Kennecott Retirees – Surviving Spouses;
  - BP Retiree Medical – Carborundum A Plan;
  - BP Retiree Medical – Carborundum B Plan;
  - BP Retiree Medical – Comprehensive 80 Plan;
  - BP Retiree Medical – Comprehensive 90 Plan;
  - BP Retiree Medical – Comprehensive Basic Plan;
  - BP Retiree Medical – Comprehensive MediFill Plan; or
  - BP Retiree Medical – Kitt Energy Plan.

If, under the terms of the applicable plan, you failed to maintain eligibility, you are no longer eligible under the BP Retiree Medical Plan. For example, if the applicable plan required that you maintain continuous coverage and you failed to satisfy that requirement when such rules were in effect, you are not eligible for the BP Retiree Medical Plan.

Publication date: April 2020
How to enroll

Learn more about how to enroll in the BP Retiree Medical Plan

Coverage under the BP Retiree Medical Plan for you and your covered eligible dependents is not automatic.

If you are age 65 or older and are either:

- enrolled in Active medical coverage at the time of retirement, or
- had previously retired and are enrolled in the NonMedicare-Eligible Option of the Retiree Medical Plan,

the BP Benefits Center will provide you a welcome packet, including a personalized worksheet reflecting any choices available to you, which will include the Medicare Advantage Plan and possibly Medicare HMOs, if available in your area. The packet may also include an informational kit from the plan administrator (insurance carrier).

If you do not immediately satisfy the eligibility requirements of the Medicare Advantage Plan (being eligible for Medicare; enrolled in both Medicare Part A and Part B), you may temporarily enroll in, or continue enrollment in, the BP NonMedicare-Eligible Program. You will have 12 months to satisfy the requirements for the Medicare Advantage Plan. If you fail to satisfy the requirements after 12 months, you will be dropped from BP retiree medical coverage.

You also have the option of continuing medical coverage under COBRA after your retirement. This will not count as your one-time "Opt out" of retiree medical coverage. Upon termination of COBRA, you can enroll in the BP Retiree Medical Plan.

If you are age 65 or older but are not enrolled in Active medical coverage at the time of retirement, you will default to No Coverage under the Retiree Medical Plan. This will count as your one-time "Opt out" of retiree medical coverage.

Generally, if you or any of your covered eligible dependents are eligible for Medicare, your available coverage is the BP Medicare Advantage PPO ESA, for you and all covered dependents who are enrolled in both Medicare Parts A and B. As noted above, you may have temporary coverage under the BP NonMedicare-Eligible Program for up to 12 months while you satisfy the eligibility requirements of the Medicare Advantage Plan. Failure to satisfy the requirements will result in being dropped from BP retiree medical coverage.

**Note:** If you are over age 65 but are not eligible for Medicare because you reside permanently in a foreign country (or for certain other reasons such as not having enough work credits), you may enter or remain in the BP NonMedicare-Eligible Program indefinitely, as long as you remain ineligible for Medicare. You may not enter the BP Medicare-Eligible Option (BP MEO), as that plan is not accepting new entrants as of January 1, 2019.

The BP Medicare Advantage PPO ESA and the BP MEO are both administered by Aetna. If you are interested in Medicare HMO coverage options, see Medicare HMOs.

If you’re eligible for BP Retiree Medical Plan coverage as an LTD Recipient or surviving spouse, you can enroll within 30 days of the date of the BP Participant’s death. If you miss this deadline, you can’t enroll until the next annual enrollment period, unless you have a qualifying status change. (See When you can change coverage for information on qualifying status changes.)

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

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<thead>
<tr>
<th>Online</th>
<th>By phone</th>
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<tbody>
<tr>
<td>The BP Benefits Center online:</td>
<td>Through the BP Benefits Center:</td>
</tr>
<tr>
<td><a href="http://www.bp.com/lifebenefits">http://www.bp.com/lifebenefits</a></td>
<td><a href="1-800-890-4100">Within the U.S.: 1-800-890-4100</a></td>
</tr>
<tr>
<td>You can:</td>
<td><a href="+1-312-843-5290">Outside the U.S.: +1-312-843-5290</a></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:](Monday – Friday, 7:00 A.M. – 7:00 P.M., Central time)</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</td>
</tr>
<tr>
<td>I Find out which network providers are located near your</td>
<td></td>
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</table>

The most up-to-date information is available online at [http://hr.bpglobal.com/lifebenefits/RetireeMedicare](http://hr.bpglobal.com/lifebenefits/RetireeMedicare).
When you enroll, you can elect coverage for yourself and your eligible dependents. Your coverage choices are:

- Personal.
- Personal + dependents.
- Dependent only (applies only to Medicare split family situations).

If you elect “Personal + dependents” 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:

- **When you first become eligible.** If you do not enroll within 30 days of your initial eligibility (generally, your termination date or the date of the BP Participant’s death), you and your dependents will not be able to enroll until a future enrollment opportunity (i.e., annual enrollment or a qualifying status change). You must submit appropriate documentation if you are electing coverage for a dependent. **Note:** For any eligible dependents not covered by the BP Medical Program at the time you leave BP, you are allowed to enroll these eligible dependents only during annual enrollment or as the result of a qualified status change and not at your termination from BP.
- **During annual enrollment.** The choices you make during each annual enrollment period — generally held each November — are effective for the next plan year (i.e., January 1 to December 31). You must submit appropriate documentation if you are adding coverage for a dependent.
- **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 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.

### Limits on Re-enrollment

Effective April 1, 2014, medical eligibility rules changed. If you are enrolled in the BP Retiree Medical Plan and leave the BP plan of benefits after that date for any reason, you will have only one opportunity to re-enroll in the plan either during annual enrollment or if you have a qualifying status change.

If you were dropped from the BP Retiree Medical Plan due to failure to satisfy the Medicare Advantage Plan eligibility rules during the 12 months after you became Medicare eligible, that drop counts as your one-time opt-out. You will have only one opportunity to re-enroll.

If you have not utilized your one-time re-enrollment opportunity and you die, your surviving spouse may enroll in the plan whether or not he/she is covered at the time of death. However, if you are enrolled in the plan and have exhausted your one-time re-enrollment opportunity, your spouse must be covered at the time of your death in order to receive survivor benefits. As well, current survivors of retirees are not permitted to re-enroll should they ever drop enrollment.

Special rules apply in some cases:

- Survivors of active participants are not subject to the limits on re-enrollment, assuming they are eligible for retiree medical at the time of the participant's death. They can drop and re-enroll as many times as they choose.
- If retiree medical coverage is dropped due to non-payment, and is reinstated within six months of the first missed payment with payment made in full, a first such occurrence does not count as your one opportunity to drop coverage and re-enroll. Any later occurrence is counted as your first opt-out. You will have only one more opportunity to drop coverage and re-enroll. Should you drop coverage again, you may not re-enroll in BP retiree medical coverage.
- If you retire from BP and are later rehired, upon retiring again your opt-out status restarts as if you were retiring for the first time.
- If you are not eligible for Medicare when you first turn age 65, you will be temporarily enrolled in the NMEO.
Plan but must transition to the Medicare Advantage Plan no later than 12 months after becoming eligible. If you do not transition, you and, if applicable, your dependents will lose coverage under the BP Retiree Medical Plan and this will count as your one-time drop.

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.

Even if you are eligible for coverage under the BP Retiree Medical Plan when you leave BP, you and any covered dependents still have the option to elect COBRA continuation coverage under the BP Medical Program. **Note:** If you elect COBRA continuation coverage instead of the BP Retiree Medical Plan at the time of retirement, this enrollment does not count as your one (and only) opportunity to leave the plan and re-enroll. You will be able to enroll in the BP Retiree Medical Plan upon termination of COBRA medical coverage. At that time, the normal opt-out rules will apply (you will have one opportunity to opt-out and one opportunity to re-enroll).

All coverage under the BP Retiree Medical Plan 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.

Publication date: April 2020
## When coverage begins

### Find out when your coverage is effective

The date your BP Retiree Medical Plan coverage begins depends on when you enroll.

<table>
<thead>
<tr>
<th>If ...</th>
<th>Your coverage begins ...</th>
</tr>
</thead>
<tbody>
<tr>
<td>You are automatically enrolled by the BP Benefits Center because you were covered under the BP Medical Program at the time you left BP, and you are age 65 or above.</td>
<td>The first day of the month following retirement. (For example, if your last day of employment is April 30, your BP Retiree Medical Plan coverage begins May 1.)</td>
</tr>
<tr>
<td>You were not covered under the BP Medical Program at the time you left BP and you enroll when you first become eligible (and within your 30-day enrollment window).</td>
<td>The first day of the month following the month in which you left BP. Coverage under a BP-offered Medicare HMO will become effective as of the first day of the month following the date that you and your covered dependents have satisfied all applicable enrollment conditions (such as the return of any required enrollment forms) which may have been imposed by either the Medicare HMO or the plan administrator. In no event will coverage under a Medicare HMO be retroactive.</td>
</tr>
<tr>
<td>You enroll during annual enrollment.</td>
<td>The first day of the new plan year (January 1).</td>
</tr>
<tr>
<td>You switch from the BP Medicare Advantage PPO ESA or the BP Medicare-Eligible Option (BP MEO) to a BP-offered Medicare HMO, or switch BP-offered Medicare HMOs.</td>
<td>Coverage under a BP-offered Medicare HMO will become effective as of the first day of the month following the date that you and your covered dependents have satisfied all applicable enrollment conditions (such as the return of any required enrollment forms) which may have been imposed by either the Medicare HMO or the plan administrator. In no event will coverage under a Medicare HMO be retroactive.</td>
</tr>
<tr>
<td>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, except for coverage under a Medicare HMO. If a BP Participant has Medicare HMO coverage and gets married, the new spouse will have coverage through the Medicare HMO as of the first day of the month following the date that the spouse satisfies all applicable enrollment conditions (such as the return of any required enrollment forms) imposed by either the Medicare HMO or the plan administrator. In no event will coverage under a Medicare HMO be retroactive.</td>
</tr>
<tr>
<td>You are enrolled in the BP Medicare Advantage PPO ESA or the BP MEO, you acquire a new dependent and enroll the new dependent after 30 days of acquiring the new dependent.</td>
<td>If you already have “Personal + dependents” or “Split family” coverage, the date the BP Benefits Center is notified of the request.</td>
</tr>
<tr>
<td>You or your covered eligible dependent becomes Medicare-eligible — due to age or disability — and you are already enrolled in the BP NonMedicare-Eligible Program.</td>
<td>The first of the month in which you or your covered eligible dependent becomes Medicare-eligible.</td>
</tr>
<tr>
<td>You or your covered eligible dependent becomes Medicare-eligible — due to age or disability — and you are NOT already enrolled in the BP Retiree Medical Plan.</td>
<td>The following January 1, provided you enroll during the next annual enrollment period. You may not enroll midyear.</td>
</tr>
</tbody>
</table>
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: Cost information for surviving spouses and LTD recipients is shown under Eligibility and participation.

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 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 a percentage of the applicable full premium for retiree coverage, as determined by BP.

As outlined in the chart below, your contribution is determined by:

1. Your age, and
2. Your years of service at the time you leave BP.

Premium amounts can vary from time to time; you will be notified of your applicable premium.

<table>
<thead>
<tr>
<th>Age</th>
<th>5</th>
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<th>7</th>
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</table>

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:** Two of the BP employers who do not offer coverage in the BP Retiree Reimbursement Account Program are BP GBS Americas and BP Solar International Inc. Eligible employees of these companies who are/were hired on or after April 1, 2004, will be eligible only for the medical portion of the BP Retiree Medical Plan.

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:

- Pay the expense.
- Print the RRA claim form from the Aetna website.
- Mail your claim request (with the appropriate receipts) to:

  Aetna
  P.O. Box 4000
  Richmond, KY 40476-4000

  **OR**

  - 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)

Note: The Health+Savings options are not available to Medicare-eligible retirees or LTD participants.

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.

The most up-to-date information is available online at http://hr.bpglobal.com/lifebenefits/RetireeMedicare.
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 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.

Publication date: April 2020
Paying for coverage

Contributions for coverage are due monthly. Each month, the BP Benefits Center will send to your address on file an invoice reflecting the date payable and the amount due (unless you are a retiree grandfathered with a pension deduction for your medical coverage). Monthly payments are due on the fifth day of each month.

If you fail to submit monthly payments within 30 days of the due date, your BP Retiree Medical Plan coverage will end retroactive to the last day of the last month for which payment was received. You may not enroll for coverage until the next annual enrollment.

For added convenience and to avoid accidental loss of coverage due to a missed payment, you may choose to have BP withdraw your monthly health care payments electronically from your personal checking or savings account. To request an authorization application, log on to the LifeBenefits Network or call the BP Benefits Center.

Publication date: April 2020
When you can change coverage

Normally the choices you make during enrollment stay in effect for the entire plan year (January 1 to December 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.

At any time during the plan year, you may:

- Change from “Personal + dependents” or “Split family” coverage to “Personal” coverage.
- Cancel your coverage.

Coverage ends at the end of the month in which you cancel your coverage. **You may not re-enroll until the next annual enrollment period.** Note: If you cancel your coverage, certain limits apply to re-enrollment as described in the How to enroll section.

You can make certain other 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.

The most up-to-date information is available online at http://hr.bpglobal.com/lifebenefits/RetireeMedicare.
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 remove an individual who is no longer an eligible dependent due to:</td>
<td>You may not switch medical 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>

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

- 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.
- You are liable for claims incurred.
- The plan administrator may impose sanctions against you — including potential loss of your coverage.
- 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).

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.</td>
<td>If you are enrolled in the BP Medicare-Eligible Program and are subsequently rehired by BP:</td>
</tr>
<tr>
<td></td>
<td>- You and your covered dependents will automatically be enrolled in the BP Medical Program for active Core employees if you are rehired as a full-time, part-time, term-contract or temporary employee.</td>
</tr>
<tr>
<td></td>
<td>- Retiree medical coverage will end for you and your covered dependents if you are rehired as an occasional employee of BP.</td>
</tr>
<tr>
<td></td>
<td>Regardless of the employment classification into which you are rehired, you maintain your eligibility for retiree medical coverage once you satisfy the eligibility requirements.</td>
</tr>
<tr>
<td>You want to enroll yourself in coverage, or add an eligible dependent to your coverage if you are already enrolled because:</td>
<td>Contact the BP Benefits Center for a domestic partner affidavit for establishment of a domestic partnership before enrolling.</td>
</tr>
<tr>
<td>- You are newly eligible.</td>
<td>If you already have coverage but are adding an eligible dependent, you may switch BP Retiree Medical Plan options.</td>
</tr>
<tr>
<td>- Marriage (not applicable if you’re covered as a surviving spouse).</td>
<td>If you miss the 30-day enrollment window, you may add a new eligible dependent to your BP Retiree Medical Plan coverage if you already have “Personal + dependents” or “Split family” coverage.</td>
</tr>
<tr>
<td>- Your establishment of your domestic partnership.</td>
<td>If your new spouse is enrolled in a Medicare HMO and you are enrolled in the BP Medicare Advantage PPO ESA or the BP Medicare-Eligible Option (BP MEO), you can:</td>
</tr>
<tr>
<td>- Birth/adoption/legal guardianship of your child.</td>
<td></td>
</tr>
</tbody>
</table>

The most up-to-date information is available online at http://hr.bpglobal.com/lifebenefits/RetireeMedicare.
OR

An eligible dependent experiences a non-voluntary loss of eligibility under another (non-BP) plan (including moving outside a Medicare HMO’s service area).

- Cover your spouse under the BP Medicare Advantage PPO ESA (if your new spouse is enrolled in both Medicare Parts A and B) or the BP NMEO (if your new spouse is not enrolled in both Medicare Parts A and B), with coverage effective the first of the month after your spouse’s disenrollment from the Medicare HMO; or
- Enroll yourself and your new spouse in a BP-offered Medicare or companion HMO, with coverage effective the first day of the month following the date you and your spouse satisfy all applicable enrollment conditions (such as the return of any enrollment forms) imposed by the Medicare HMO or the plan administrator.

<table>
<thead>
<tr>
<th>Your spouse/domestic partner’s employer’s plan does not have a January 1 plan year start date.</th>
<th>If you already have coverage but are adding an eligible dependent, you may not switch BP Retiree Medical Plan options.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your child becomes eligible again under the BP Retiree Medical Plan (for example, the child is newly eligible under federal health care reform rules).</td>
<td>You may elect the BP Medicare Advantage PPO ESA or, if you are eligible for another BP-offered Medicare HMO, you may elect another Medicare HMO.</td>
</tr>
<tr>
<td>You are in a BP-offered Medicare HMO and you move outside the HMO service area.</td>
<td></td>
</tr>
</tbody>
</table>

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

- 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/adoptive/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.
- Mid-year plan enrollment in spouse’s/domestic partner’s plan that is not on a January 1 – December 31 basis.
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>1. The date the qualifying status change occurs, except under a Medicare HMO* in the case of marriage.</td>
</tr>
<tr>
<td>- After 30 days of acquiring the dependent, provided you have “Personal + dependents” or “Split family” coverage.</td>
<td>1. The date you contact the BP Benefits Center to enroll the dependent.</td>
</tr>
</tbody>
</table>

* Coverage under a BP-offered Medicare HMO will become effective as of the first day of the month following the date that you or your covered dependents have satisfied all applicable enrollment conditions (such as the return of any required enrollment forms) which may have been imposed by either the Medicare HMO or the plan administrator. In no event will coverage under a Medicare HMO be retroactive.

If your new spouse is enrolled in a Medicare HMO and you are enrolled in the BP Medicare Advantage PPO ESA or the BP Medicare-Eligible Option (BP MEO), you can:

- Cover your spouse under the BP Medicare Advantage PPO ESA (if your new spouse is enrolled in both Medicare Parts A and B) or the BP NMEO (if your new spouse is not enrolled in both Medicare Parts A and B), with coverage effective the first of the month after your spouse’s disenrollment from the Medicare HMO; or
- Enroll yourself and your new spouse in a BP-offered Medicare HMO with coverage effective as stated above.

Switch from the BP Medicare Advantage PPO ESA or the BP MEO to a BP-offered Medicare HMO, or switch BP-offered Medicare HMOs.

Coverage under the BP-offered Medicare HMO will become effective as of the first day of the month following the date that you and your covered dependents have satisfied all applicable enrollment and disenrollment conditions (such as the return of any enrollment forms) which may have been imposed by either the Medicare HMO or the plan administrator. In no event will coverage under a Medicare HMO be retroactive.

Drop coverage for an individual who is no longer an eligible dependent.

The last day of the month in which the qualifying status change occurs and for which required contributions were received.

Cancel coverage.

The last day of the month in which you contact the BP Benefits Center to cancel coverage and for which required contributions were received.

Publication date: April 2020
When coverage ends

Your coverage under the BP Retiree Medical Plan ends on the earliest of the following dates:

- The last day of the month in which you drop coverage.
- 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 BP Retiree Medical Plan.

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.
- The last day of the month in which your covered dependent is no longer eligible for coverage under the BP Retiree Medical Plan, whether or not you report your dependent's change in eligibility status.

* 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 Retiree Medical Plan coverage would otherwise end, you and your covered dependents may be eligible to continue medical coverage under COBRA (see How to continue BP Retiree Medical Plan coverage).
BP Medicare-Eligible Program options

The medical portion of the BP Retiree Medical Plan includes:

- The Medicare-Eligible Program, which applies if you or any of your enrolled dependents are eligible for Medicare. The Medicare-Eligible Program is described in this handbook.
- The NonMedicare-Eligible Program, which is available if you and all your enrolled dependents are not eligible for Medicare. The NonMedicare-Eligible Program is described in a separate handbook.

The Medicare-Eligible Program options available to you are based on whether you are enrolled in Medicare Parts A and B and on your address of record. Options include:

- The BP Medicare Advantage PPO ESA, available to you and all covered dependents who are enrolled in both Medicare Parts A and B. The BP Medicare Advantage PPO ESA is administered by Aetna. This option is open to new members and is the only choice for participants who satisfy all eligibility requirements of the Medicare Advantage plan (other than a Medicare HMO, if available).
- The BP Medicare-Eligible Option (BP MEO), available to past retirees and their covered dependents who satisfied certain eligibility requirements at the time of enrollment. The BP MEO is administered by Aetna. This plan is closed to new members effective January 1, 2019, but existing members may continue to participate.
- A BP-offered Medicare Health Maintenance Organization (Medicare HMO), if available in your area. (See Medicare HMOs).

Note: Behavioral health services are now covered the same as other medical services.
You and all covered family members who are enrolled in both Medicare Parts A and B are eligible for coverage under the BP Medicare Advantage PPO ESA. If you or any covered family members are eligible for Medicare but are not enrolled in Medicare Parts A and B, you cannot enroll in the Medicare Advantage PPO ESA. Instead, you may be eligible for temporary coverage under the BP NonMedicare-Eligible Program for up to 12 months while you satisfy the requirements for the Medicare Advantage Plan. Depending on where you live, there may also be a Medicare HMO option available to you.

**How the BP Medicare Advantage PPO ESA works**

The BP Medicare Advantage PPO ESA is a fully-insured Aetna Medicare Advantage option. The plan lets you use doctors and hospitals in or out of the Aetna Medicare network without paying greater out-of-network costs, as long as they are appropriately licensed and accept Aetna and Medicare patients. If a provider is out-of-network and not contracted with Medicare, the plan will not cover the cost of services and you will generally be responsible for payment. To find out if your doctor accepts the plan, please contact Aetna Medicare Member Services at 1-855-427-5623.

Under the BP Medicare Advantage PPO ESA option, you will still have Medicare, but you'll get your Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) benefit coverage through Aetna, not Original Medicare. You do not have to send claims to Medicare – all claims go to Aetna. In addition, your prescription drug coverage will be a Medicare Part D-qualified plan administered by Express Scripts. See the Prescription drug coverage section for more information.

Full details about the coverage available under the BP Medicare Advantage PPO ESA are available in the Evidence of Coverage document. Be sure to review this document carefully to understand what's covered, how to use the plan, what you pay and other important plan information. This document is updated each year.
Medicare eligibility and enrollment rules

To be enrolled in the BP Medicare Advantage PPO ESA plan option, a covered participant must be enrolled in both Medicare Parts A and B. If you are so enrolled, you may only participate in the BP Medicare Advantage PPO ESA plan option.

If a family member is not Medicare-eligible

The non-Medicare-eligible dependent can enroll in the BP NMEO and move to the BP Medicare Advantage PPO ESA when he/she becomes Medicare-eligible, provided he/she enrolls in both Medicare Parts A and B within 12 months of becoming eligible.

If a family member is not enrolled in Medicare Parts A and B

Under the eligibility rules for the BP Retiree Medical Plan, you must be enrolled in both Medicare Parts A and B to participate in the BP Medicare Advantage PPO ESA. If you or your spouse (or another eligible dependent) is not eligible for Medicare Parts A and B, the ineligible participant will be covered under the BP NMEO, while the eligible participant will be covered under the BP Medicare Advantage PPO ESA.

If you and your spouse are both Medicare-eligible, you cannot choose to have split coverage (i.e., one enrolled in the BP NMEO and one enrolled in the BP Medicare Advantage PPO ESA) – you must both be covered under the same plan option. When you or your eligible dependent becomes Medicare-eligible, you can enroll in Medicare Parts A and B in the following ways:

2. By calling Social Security at 1-800-772-1213 (TTY: 1-800-325-0778), 7 a.m. to 7 p.m., Monday through Friday.
3. In person at your local Social Security office.

You cannot be enrolled in more than one Medicare Advantage Plan. If you have coverage through another carrier that is a Medicare Advantage Plan, you cannot enroll in the BP Medicare Advantage PPO ESA – or you must drop the other coverage to be eligible to enroll in this plan.

More about the BP Medicare Advantage PPO ESA

The BP Medicare Advantage PPO ESA is subject to the same rules regarding health care claims that apply to the BP Medicare-Eligible Program. Therefore, the Medicare Advantage PPO ESA’s rules and procedures must be no less beneficial to Medicare Advantage PPO ESA participants than the rules that apply to claimants under the BP Medicare-Eligible Program. Contact Aetna for its rules and procedures regarding health care claims.

What else you should know about the BP Medicare Advantage PPO ESA

The Medicare Advantage PPO ESA is insured and administered by Aetna, and is an independent business entity. The Medicare Advantage PPO ESA — and not BP — is fully responsible for providing benefits and coverage once the applicable premium has been paid. If you do not timely pay any required contributions for BP coverage, BP will cease providing Aetna with premiums relating to your (and your dependent's, if applicable) coverage. However, you will not be disenrolled from the Medicare Advantage PPO ESA unless and until Aetna communicates to you that your coverage has terminated.

Neither BP nor the plan administrator can interfere in medical or administrative decisions made by the Medicare Advantage PPO ESA or direct the Medicare Advantage PPO ESA in any way regarding benefits or coverage. Therefore, if you and a Medicare Advantage PPO ESA medical provider do not agree on a course of treatment, you must personally pursue the matter through the Medicare Advantage PPO ESA’s appeals process. The Medicare Advantage PPO ESA is responsible for paying its network provider for services you receive. Additional financial assistance from BP will not be provided to you or your provider or supplier.

Publication date: April 2020
Prescription drug coverage

Under the BP Medicare Advantage PPO ESA and the BP MEO, the Prescription Drug Program is a group Medicare Part D plan and is administered by Express Scripts Medicare.

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

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

You will receive a separate Express Scripts Medicare ID card. Each time you fill a prescription at an Express Scripts network retail pharmacy, simply show your ID card so the pharmacist knows you are covered under the program.

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 coinsurance (a percentage of the cost) for each prescription filled.

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

**Note:** Your Medicare Part D enrollment will be processed during BP’s annual enrollment period. You do not need to complete separate enrollment forms with Medicare for this coverage.

Also, Medicare allows participants to be enrolled in only one Medicare Part D plan at a time. If you wish to enroll in a different Medicare Part D plan than the one provided under this coverage, you have to opt out of BP retiree coverage. Keep in mind, if you choose to opt out of BP-sponsored prescription drug benefit coverage, you are also choosing to drop your BP-sponsored medical coverage. BP’s plans do not permit you to opt out of BP prescription drug coverage and still remain enrolled in BP-sponsored medical coverage.
How the Prescription Drug Program works

Your prescription drug program, Express Scripts Medicare, is a Medicare Part D plan that is administered by Express Scripts Medicare.

Just present your Express Scripts Medicare prescription drug ID card when you have your prescription filled at an Express Scripts participating pharmacy. If you have not met the Prescription Drug Program plan year deductible, you pay 100% of the negotiated cost of the medication until the deductible is met. After that, you pay only your share of the cost. There are no claim forms to file.

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 four levels of medications: generic drugs, brand name preferred drugs, brand name non-preferred drugs and specialty brand name 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, non-preferred drugs and specialty drugs.
  - Preferred drugs are drugs that Express Scripts considers preferred choices, based on their effectiveness and cost, and are on the Express Scripts formulary drug list.
  - Non-preferred drugs are those that are not on the Express Scripts formulary drug list.
  - Specialty drugs are certain drugs that treat chronic health conditions such as hemophilia, rheumatoid arthritis, multiple sclerosis and cancer. These types of drugs may be injected, infused or taken by mouth. They often require special handling and storage.

**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 coinsurance (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.

### Prescription drug summary chart

<table>
<thead>
<tr>
<th>Prescription Drug</th>
<th>Retaila</th>
<th>Home Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rx Deductible</td>
<td></td>
<td>$150/person; $450/family</td>
</tr>
<tr>
<td><strong>Coinsurance</strong>b</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>20% coinsurance ($5 min./$10 max.)</td>
<td>20% coinsurance ($10 min./$25 max.)</td>
</tr>
<tr>
<td>Brand name (preferred)</td>
<td>20% coinsurance ($30 min./$50 max.)</td>
<td>20% coinsurance ($75 min./$125 max.)</td>
</tr>
<tr>
<td>Brand name (non-preferred)</td>
<td>20% coinsurance ($60 min./$100 max.)</td>
<td>20% coinsurance ($150 min./$250 max.)</td>
</tr>
<tr>
<td>Specialty brand name</td>
<td>20% coinsurance ($60 min./$150 max.)</td>
<td>20% coinsurance ($180 min./$450 max.)</td>
</tr>
</tbody>
</table>

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

b You always pay the lesser of the actual cost of your prescription or the coinsurance.
Covered prescription drug expenses

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 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 coinsurance.

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

- Coinsurance.
- Prescriptions filled at a non-network pharmacy when an Express Scripts network pharmacy is available.
- Prescriptions not covered under the Prescription Drug Program.

Switching between medical programs midyear

If you and your eligible dependents are enrolled in the BP Retiree Medical Plan and, due to a change in your or your covered dependent's Medicare-eligibility, your coverage under the plan is switched to or from the BP NonMedicare-Eligible Program, the BP Medicare-Eligible Program, or the BP Medical Plan for active employees, any amounts credited toward your plan year prescription drug deductible will apply to the corresponding deductible under your new option for the remainder of the plan year. There is no crediting if you transfer to or from a BP-offered HMO or Medicare HMO, or to the BP Medicare Advantage PPO ESA.

Inpatient care and your prescription benefit

Prescription drugs to be taken home after 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.
To use your prescription drug benefit, present your Express Scripts Medicare ID card when you have your prescription filled.

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

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 Express Scripts Medicare 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 Express Scripts Medicare and submit it with your original itemized receipt. You must first meet the Prescription Drug Program plan year deductible before you receive any reimbursement. Express Scripts will reimburse you for your cost, less the appropriate coinsurance. In processing your claim incurred while traveling abroad, Express Scripts uses the conversion rate posted on www.oanda.com as of the date the prescription was filled.
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 the Express Scripts 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 Express Scripts Medicare or the LifeBenefits website). Return the form, your prescription from your doctor as well as any remaining Prescription Drug Program deductible and the appropriate coinsurance. You may contact Express Scripts 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. Express Scripts 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 Express Scripts 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 Express Scripts network.
- Another that you can send to the home delivery program for an additional supply.

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

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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 Express Scripts 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.

Accredo will contact you if the medication you’re taking is 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.
Medicare Part D Medication Therapy Management Program

Express Scripts Medication Therapy Management Program (MTMP) is designed to enhance targeted members' overall health and reduce wasteful health care spending.

Targeting criteria

Beneficiaries must meet all of the following criteria for enrollment in the MTMP. They must have:

1. At least three of the following chronic conditions (based on prescription claims data):
   - Hypertension.
   - Diabetes.
   - Dyslipidemia.
   - Chronic Heart Failure (CHF).
   - Asthma/Chronic Obstructive Pulmonary Disease (COPD).
   - Depression.
   - Osteoporosis.
   - End-Stage Renal Disease (ESRD).
2. At least seven, chronic, Part D covered medications.
3. An annual drug spend for Part D covered medications that equals or exceeds the specified CMS cost threshold.

Targeting frequency

Claims data will be analyzed on a weekly basis to identify members qualifying for MTMP.

Enrollment method

Targeted beneficiaries will be enrolled into the program using an opt-out only method.

Interventions

1. Once a member is enrolled in the plan, they will receive an Intro letter welcoming them to the plan and inviting them to participate in a Comprehensive Medication Review (CMR) by returning the appointment card or calling a toll-free number.
2. Once a member has scheduled a CMR, they have a one-on-one consultation with a pharmacist or licensed pharmacy intern under the supervision of a pharmacist to discuss medication usage (including over-the-counter medications), identify medication-related problems, and discuss disease management questions for the conditions for which they qualified. After the one-on-one consultation, the beneficiary is mailed the CMS standardized post-CMR letter, which includes an updated summary and action plan (with recommendations) based on the consultation with the pharmacist as a “take-away.”
3. Regardless if the beneficiary completes a CMR, Express Scripts performs Targeted Medication Reviews (TMR), which are performed at least quarterly and can be as often as weekly, based on member specific alerts. TMRs focus on cost savings, treatment guidelines, safety issues, and elderly issues. TMRs are categorized and triaged. Some alerts are acted on immediately, and some are held for quarterly contact. Express Scripts contacts the beneficiaries by letter or by telephone, depending on the alert level.
4. Prescriber outreach is made via fax or by telephone, based on information from the TMRs. These communications can include requests to add or change drug therapy, information about drug-drug interactions, or safety issues. Express Scripts can also provide FYI communications to the providers when we have given a communication to the beneficiary such as cost-savings opportunities or adherence issues.
5. Long-term care (LTC) beneficiaries are offered the same services as non-LTC members. TMRs are performed weekly and CMRs are performed at least annually.

Outcomes measured and reported

Express Scripts provides monthly reporting to clients which includes:

- Service Summary Report.
- Beneficiary Detail.
- Intervention Detail.
Express Scripts provides CMS required elements for reporting on a yearly basis. The reports will be reflective of all CMS guidance and based on the technical specifications.
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).

In addition, the following expenses are covered under the medical provisions of the BP Medicare-Eligible Option (MEO) 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 Medicare-Eligible Option (MEO) for all other limitations and exclusions.

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

Your Prescription Drug Program is a Medicare Part D plan and is administered by Express Scripts Medicare. It is a feature of your BP-sponsored medical coverage. If you choose to opt out of this prescription coverage, then you are also choosing to drop your BP-sponsored medical coverage.

Medicare allows a participant to be enrolled in only one Medicare Part D plan at a time. If you wish to enroll in a different Medicare Part D plan than the one provided under this coverage, you would have to opt out of BP-sponsored retiree medical and prescription drug coverage.

Publication date: April 2020
Medicare HMOs

Under a Medicare HMO, you must coordinate your care through a primary doctor

In many locations, you may be eligible to select from at least one BP-offered Medicare HMO. Medicare HMOs are HMOs that have been approved by the federal government to provide health care coverage to people eligible for Medicare. Medicare HMOs are different from regular HMOs in that they must meet Medicare coverage requirements and quality standards established by the Centers for Medicare & Medicaid Services (CMS), the agency responsible for administering the Medicare program.

That means Medicare HMOs must provide all services covered by Medicare Part A (Hospital Insurance) and Part B (Supplemental Physicians/Medical Insurance), such as doctor visits, hospital care, tests and other services.

Many Medicare HMOs also provide coverage after a copay for prescription drugs, vision and hearing benefits. However, specific Medicare HMO benefits vary. Contact your Medicare HMO's member services department with your benefit questions. You may also request a booklet describing your Medicare HMO's general rules and services. Covered services and treatments may vary from Medicare HMO to Medicare HMO.

To participate in a BP-offered Medicare HMO, you and all your Medicare-eligible family members whom you wish to cover must be enrolled in Medicare Part A and Part B (or already be enrolled in a Medicare HMO). Each non-Medicare-eligible covered person must be enrolled in a companion HMO.

How Medicare HMOs work

With a Medicare HMO, you must receive all of your medical care from the HMO's network of providers in order to receive benefits. When you enroll, you must select a primary care physician (PCP) from the HMO's network for yourself and for each family member you cover. Your PCP may be a family practice doctor, a general practitioner or an internist. You may change PCPs later on if you wish.

You must consult with your PCP each time you need care. Your PCP will treat you directly or refer you to a specialist within the Medicare HMO network for care. You will not receive benefits if you see a health care provider who is not affiliated with the Medicare HMO or if you receive medical care without the proper referrals. Exceptions may be made for care provided in emergencies or for urgently needed services when you are outside your plan service area, including out-of-area renal dialysis or for treatment from a specialist not available through the Medicare HMO's provider network. In addition to being covered in the United States, emergency and urgently needed services are covered worldwide.

How to choose a Primary Care Physician (PCP)

To select a PCP or to learn more about the providers who participate in a Medicare HMO's network, you can call the Medicare HMO. If your PCP leaves the network, you will have to select another PCP who participates in the HMO's network. To change to a different PCP, you need to contact your Medicare HMO.

Medicare HMO networks

You should be aware that Medicare HMO networks may have fewer member doctors than their companion HMO counterparts. This means that even though a doctor participates in a particular HMO's network, he/she may or may not participate in that same company's Medicare HMO network. Also keep in mind that HMO providers occasionally change, so you will want to make sure the PCP you choose is still in the Medicare HMO's network. For the most up-to-date information, including whether a PCP is accepting new patients, call the provider.

What a Medicare HMO pays

Most covered office visits, emergency room visits and prescription drug costs are covered by the Medicare HMO after you pay a copay. Prescription drug coverage may have annual limits as well. Most other benefits also have a copay. Generally, Medicare HMOs do not require you to pay a deductible or coinsurance. They also do not have out-of-pocket maximums or lifetime benefit maximums. However, benefits vary by Medicare HMO.

For your Medicare HMO's benefits, call your Medicare HMO or review the informational material provided to you by your Medicare HMO.

While you are traveling

The most up-to-date information is available online at http://hr.bpglobal.com/lifebenefits/RetireeMedicare.
Medicare HMOs limit coverage for medical services provided outside their service areas. Generally, coverage is limited to emergency or urgently needed medical care, as defined by the federal Centers for Medicare & Medicaid Services (CMS). Therefore, coverage may be limited while you are traveling.

**Moving**

If you move outside your Medicare HMO’s service area, you will want to change immediately to another BP-offered medical plan option available in your area. To do so, call the BP Benefits Center and speak with a Participant Services Representative to update your address. The representative will counsel you on the medical options available based on your new address and explain how to disenroll in your current Medicare HMO and enroll in your new one.

If you move outside your Medicare HMO’s service area and enroll in the BP Medicare Advantage PPO ESA or the BP MEO, any Medicare HMO expenses you incurred during the plan year will not count toward the BP Medicare Advantage PPO ESA or BP MEO deductible or plan maximums.

Keep in mind that coverage under your Medicare HMO will continue until you are properly disenrolled from that Medicare HMO — effective as of the first day of the month following the date that you have satisfied all applicable conditions for switching coverage or disenrolling from that Medicare HMO.
Special rules for Medicare HMO coverage

Because Medicare HMO coverage is a substitute for “Original Medicare,” coverage under Medicare HMOs is highly regulated by the federal government (CMS — Centers for Medicare & Medicaid Services). As a result, there are special rules applying to BP-offered Medicare HMO coverage, and the Medicare HMO option’s enrollment and disenrollment features do not mirror those of the BP Medicare Advantage PPO ESA or the BP Medicare-Eligible Option (BP MEO) described earlier in this handbook. The special rules relating to Medicare HMO coverage are highlighted below.

Eligibility for coverage under a Medicare HMO

In order to enroll in a BP-offered Medicare HMO:

1. A BP Participant or surviving spouse must be eligible for coverage under the BP Retiree Medical Plan;
2. Each Medicare-eligible covered person in the family unit under the plan must:
   - Be entitled to Medicare Part A;
   - Be enrolled in Medicare Part B;
   - Not be determined to have end-stage renal disease;
   - Permanently reside in the Medicare HMO’s service area; and
   - Elect Medicare HMO during a Medicare HMO election period (described below);
   - No person may be enrolled under more than one Medicare HMO plan at any one time; and
3. Each nonMedicare-eligible covered person in the family unit under the plan must enroll in a companion HMO, if offered. If the Medicare HMO does not offer a companion HMO option, the BP Participant or surviving spouse may not enroll in the Medicare HMO through BP.

Enrolling in a Medicare HMO

When you enroll in a Medicare HMO, your Medicare Part A and Part B coverage is managed by the HMO. You must continue to pay your Medicare Part B premiums unless directed otherwise by the HMO. Because of the special rules relating to Medicare HMO coverage, you may be required to complete and return a written enrollment application for the Medicare HMO coverage — even when you switch from one Medicare HMO to another. Enrollment forms (if necessary) can be obtained from, and must be returned to, the BP Benefits Center.

Disenrolling from a Medicare HMO

Because of the special rules relating to Medicare HMO coverage, you may be required to complete and return a written disenrollment application when you want to switch from one Medicare HMO to another or if you want to drop Medicare HMO coverage in favor of Original Medicare. Disenrollment forms (if necessary) can be obtained from, and must be returned to, the BP Benefits Center. If you have lost coverage under the BP Retiree Medical Plan for any reason — including non-payment of required premiums — you will need to deal directly with your Medicare HMO to disenroll from the Medicare HMO.

You can re-enroll in — and disenroll from — a Medicare HMO at any time.

When coverage under a Medicare HMO is effective

Coverage under a Medicare HMO will become effective as of the first day of the month following the date that you and your Medicare-eligible covered dependents have satisfied all applicable enrollment conditions (such as the return of any required enrollment forms) imposed by either the Medicare HMO or the plan administrator. Except where authorized by the Medicare HMO under CMS rules, coverage under a Medicare HMO will not be retroactive. Coverage under a companion HMO (if applicable) will be effective on the same date that the Medicare HMO coverage takes effect. The BP Benefits Center will forward a confirmation of coverage reflecting each covered individual and the effective date of coverage.

If you are hospitalized as of the effective date of coverage under a Medicare HMO, the HMO will only provide services relating to Part B of Medicare; Original Medicare will cover the Part A hospitalization expenses until you are released from inpatient care.

When disenrollment from a Medicare HMO is effective

Coverage under a Medicare HMO will end on the last day of the month following the date that you have satisfied all of the applicable disenrollment conditions (such as the return of any required disenrollment forms) which may have been imposed by either the Medicare HMO or the plan administrator. Except where authorized under CMS rules, disenrollment from the Medicare HMO will not be retroactive. Coverage
under a BP-offered companion HMO (if applicable) will end on the date that coverage under the related BP-offered Medicare HMO ends.

**Companion HMOs and nonMedicare-eligible participants**

Any covered family member who is not Medicare-eligible must enroll in a companion HMO. If no companion HMO is available, your Medicare-eligible family members may not enroll in a BP-offered Medicare HMO. For a list of the HMOs available to you, call the BP Benefits Center.

**Special enrollment periods (SEP)**

There are certain circumstances that may impact your ability to continue your Medicare HMO coverage:

- **Decision by Medicare HMO not to renew its CMS contract SEP** — If the Medicare HMO in which you are enrolled decides not to renew its contract with CMS to be a Medicare HMO, you will be given 90 days advance notice.

- **Decision by BP not to renew its contract with Medicare HMO** — If BP decides not to offer the Medicare HMO in which you are enrolled, you can decide to switch to another BP-offered Medicare HMO (if applicable) or drop Medicare HMO coverage in favor of Original Medicare.

**More about Medicare HMOs**

Medicare HMOs are subject to the same rules regarding health care claims that apply to the BP Medicare-Eligible Program. Therefore, the Medicare HMO’s rules and procedures must be no less beneficial to Medicare HMO participants than the rules that apply to claimants under the BP Medicare-Eligible Program. Contact your Medicare HMO for its rules and procedures regarding health care claims.

<table>
<thead>
<tr>
<th>What else you should know about HMOs</th>
</tr>
</thead>
</table>

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. If you do not timely pay any required contributions for BP coverage, BP will cease providing the Medicare HMO with premiums relating to your (and your dependent's, if applicable) coverage. However, you will not be disenrolled from a Medicare HMO unless and until the Medicare HMO communicates to you that your coverage has terminated. Companion HMO coverage can and is terminated when premium payment ceases.

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. HMOs are responsible for paying its network provider for services you receive. Additional financial assistance from BP will not be provided to you or your provider or supplier.

Publication date: April 2020
BP Medicare-Eligible Option (BP MEO) - CLOSED TO NEW ENTRANTS

This option is closed to new entrants as of January 1, 2019. Only certain "grandfathered" retirees and their dependents who are ineligible for coverage under the Medicare Advantage PPO ESA are eligible to continue participation in this option.

You and all covered family members who are eligible for Medicare but are not enrolled in both Medicare Parts A and B are eligible for the BP MEO. The BP MEO is administered by Aetna.

<table>
<thead>
<tr>
<th>General information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan year deductible</td>
</tr>
<tr>
<td>Plan year out-of-pocket maximum</td>
</tr>
<tr>
<td>Lifetime maximum benefit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prescription drug (administered by Express Scripts Medicare)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription drug plan year deductible (separate from and in addition to your medical plan deductible)</td>
</tr>
</tbody>
</table>

**Retail Pharmacy Network (up to a 31-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>Prescription category</th>
<th>Coinurance after deductible is met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>20% coinsurance ($5 min./$10 max.)</td>
</tr>
<tr>
<td>Brand name (preferred)</td>
<td>20% coinsurance ($30 min./$50 max.)</td>
</tr>
<tr>
<td>Brand name (non-preferred)</td>
<td>20% coinsurance ($60 min./$100 max.)</td>
</tr>
<tr>
<td>Specialty brand name</td>
<td>20% coinsurance ($60 min./$150 max.)</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Prescription category</th>
<th>Coinurance after deductible is met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>20% coinsurance ($10 min./$25 max.)</td>
</tr>
<tr>
<td>Brand name (preferred)</td>
<td>20% coinsurance ($75 min./$125 max.)</td>
</tr>
<tr>
<td>Brand name (non-preferred)</td>
<td>20% coinsurance ($150 min./$250 max.)</td>
</tr>
<tr>
<td>Specialty brand name</td>
<td>20% coinsurance ($180 min./$450 max.)</td>
</tr>
</tbody>
</table>

For the following covered treatments and services, the options pay

<table>
<thead>
<tr>
<th>Treatment/service</th>
<th>Coverage after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor visits (other than preventive care)</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Primary care/specialist office visit</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Maternity services</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Lab and X-ray</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Behavioral health office visit</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Preventive care</td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td>---</td>
</tr>
<tr>
<td>Routine physicals</td>
<td>80%, no deductible; limited to $300/plan year</td>
</tr>
<tr>
<td>Annual well-woman exam</td>
<td>80%, no deductible</td>
</tr>
<tr>
<td>Mammograms (routine)</td>
<td>80%, no deductible</td>
</tr>
<tr>
<td>Prostate Specific Antigen (PSA) tests (routine)</td>
<td>80%, no deductible</td>
</tr>
<tr>
<td>Colorectal screenings (routine)</td>
<td>80%, no deductible</td>
</tr>
<tr>
<td>Well-child care (through age 6 without limitations; for ages 7 – 18, a $300 plan year maximum applies)</td>
<td>80%, no deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital emergency room/urgent care center</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Ambulance</td>
<td>80% after deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatient services (services provided other than in a doctor's office)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient surgery facility</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Doctor/surgeon and related professional fees</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Lab and X-ray</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Radiation therapy/chemotherapy</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Behavioral health outpatient treatment (other than office visit)</td>
<td>80% after deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inpatient hospital services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Room and board (semi-private room), other facility services and supplies</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Doctor hospital visits, surgery and related professional fees (including maternity and newborn care)</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Lab, X-ray and anesthesia</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Mental health/substance abuse, including residential treatment and partial hospitalization</td>
<td>80% after deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Alternatives to inpatient hospital care</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled nursing facility (up to 60 days/plan year)</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Home health care (limited to 100 visits/plan year)</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Hospice care</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Outpatient private duty nursing ($50,000/per person lifetime maximum)</td>
<td>80% after deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other covered services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic care (up to 20 visits/plan year)</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Durable medical equipment, orthotics, consumable medical supplies ($50,000/per person lifetime maximum)</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Prosthetic appliances (including external breast prostheses, wigs)</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Infertility treatment (limited to diagnostic testing, corrective surgery and drug therapy)</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Outpatient rehabilitation (physical/speech/occupational therapy); (limitations on length of coverage apply) (not to exceed 60 days/plan year for each type of therapy)</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Cardiac rehabilitation (up to 20 visits/plan year)</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>TMJ (medical treatment for TMJ covered; TMJ-related dental services and orthodontic appliances)</td>
<td>80% after deductible</td>
</tr>
</tbody>
</table>
For Medicare-eligible participants, the Medicare-Eligible Option will pay benefits only up to the amount of benefits it would have paid if you were covered by Medicare Parts A and B.

Benefits are subject to allowable charges limits.

You may need to pay the full amount and submit a claim for reimbursement to Aetna.

Preventive care benefits are subject to age restrictions/limitations as determined under guidelines established by Aetna. For additional information, contact Aetna Member Services at 1-866-436-2606.

Precertification required for NonMedicare-eligible participants; benefits may be reduced or denied if precertification not obtained. (Precertification is not required if the expense is incurred while you are outside the United States.)

Deductible waived for diabetic insulin pumps and tubing.

BP Medicare Advantage PPO ESA

You and all covered family members who are enrolled in both Medicare Parts A and B are eligible only for the BP Medicare Advantage PPO ESA instead of the BP MEO, unless a Medicare HMO option is available, in which case you would also be eligible for the HMO coverage. The BP Medicare Advantage PPO ESA is administered by Aetna.

BP-offered Medicare HMOs

Depending on where you live, there may also be a Medicare HMO option available to you. Contact your Medicare HMO’s member services department with your benefit questions. You may also request a booklet describing your Medicare HMO’s general rules and services.

Publication date: April 2020
Understanding medical coverage under the BP Medicare-Eligible Option (BP MEO) and Medicare

Note: This section describes how the BP MEO coordinates care with Medicare. Please see the Aetna Medicare Advantage PPO ESA Evidence of Coverage document for information on how that plan coordinates care with Medicare.

Coverage for medical expenses will be adjusted for any person who is eligible for coverage under Medicare Parts A and B (a "Medicare-eligible participant") but is not so covered because the person refused Medicare coverage, dropped it or failed to make a proper request for it.

Here is how non-prescription drug benefits are calculated for Medicare-eligible participants:

1. The total amount of "regular benefits" under the BP MEO will be calculated. (This will be the amount that would be payable if there were no Medicare benefits.) If this benefit is more than the amount Medicare provides for the expenses involved, the BP MEO will pay only the difference. Otherwise, the BP MEO will pay no benefits. This will be done for each claim.
2. Charges used to satisfy a participant’s Part B deductible under Medicare will be applied under the BP MEO in the claim order received by Aetna.
3. Medicare Part A and Part B benefits will be taken into account for any person while he/she is Medicare-eligible. This will be done whether or not he/she is receiving Medicare benefits.
4. Any rule for coordinating “other plan” benefits with those under the BP MEO will be applied after the BP MEO's benefits have been calculated under the above rules. Any benefit payable under Medicare will not be deemed to be an allowable expense under the BP MEO.
5. Coverage will be adjusted at any time when compliance with federal law requires the BP MEO’s benefits to be calculated before benefits are calculated under Medicare.
6. If you incur medical expenses outside the United States, the BP MEO will consider full plan benefits without adjusting them for Medicare.

For participants who are not Medicare-eligible, benefits under the BP MEO are calculated without regard to Medicare.

Example

Let's say you go to the doctor, and the doctor charges $250. You have already met your plan and Medicare deductibles. Here is what you would pay for the doctor visit:

<table>
<thead>
<tr>
<th>What your doctor charges</th>
<th>If Your Doctor Accepts Medicare Assignment</th>
<th>If Your Doctor Does NOT Accept Medicare Assignment</th>
</tr>
</thead>
<tbody>
<tr>
<td>$250</td>
<td>$250</td>
<td>$250</td>
</tr>
<tr>
<td>$200</td>
<td></td>
<td>$200</td>
</tr>
<tr>
<td>$160</td>
<td></td>
<td>$160</td>
</tr>
<tr>
<td>$40</td>
<td></td>
<td>$40</td>
</tr>
<tr>
<td>$0</td>
<td></td>
<td>$0</td>
</tr>
</tbody>
</table>

Total doctor’s charges

| What Medicare pays       | $200*                                    | $250                                            |
| What the BP MEO pays     | $160                                     | $160                                           |
| What you pay for doctor charges | $40                                       | $90                                           |

* The $250 doctor charge was reduced to $200 because the doctor had agreed to accept the Medicare-allowed amount as total payment.

Note: The BP MEO will not make any payment because its benefit is equal to the benefit payable by Medicare. However, if you had already met the BP MEO’s annual out-of-pocket maximum, the BP MEO would have paid the entire portion of the doctor charge not payable by Medicare.
What the BP Medicare-Eligible Option (BP MEO) pays

With the BP MEO, you can choose any health care provider or eligible supplier you wish whenever you need medical care. The BP MEO covers a broad range of medical services and supplies, including preventive care and emergency care. It also includes a Prescription Drug Program, administered by Express Scripts Medicare.

The BP MEO generally pays 80% of allowable charges for most covered expenses after you meet the individual or family plan year deductible (except preventive care, which is paid at 80%, with no deductible). You pay the remaining percentage (the coinsurance) and any costs above allowable charges limits. (See Allowable charges limits.)

Once you meet the individual or family plan year out-of-pocket maximum, the BP MEO pays 100% of allowable charges for most covered expenses for the rest of the plan year. The lifetime maximum benefit is $2 million per person.

Lower charges available for expenses that are not covered by Medicare

In many locations, Aetna has negotiated discounted fees with doctors, hospitals and other health care providers who participate in Aetna’s National Advantage Program (NAP). These lower fees are available for expenses that are covered under the BP MEO but not covered by Medicare.

You can save money when you use National Advantage providers, because your share of the cost is based on a lower charge and you will not be responsible for any charges in excess of allowable amounts. To find a NAP provider in your area, contact Aetna.

Publication date: April 2020
Deductibles

For most medical services and supplies you receive while enrolled in the BP MEO, you pay the first $300 of allowable charges for most covered expenses incurred by you and each covered dependent during the plan year, to a family maximum deductible of $900, before the plan begins paying benefits. The deductible is waived for eligible preventive care expenses.

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 medical deductible for that plan year before benefits are paid.

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.

Expenses excluded from the deductibles

The following expenses do not apply to the medical coverage plan year deductibles:

- Expenses under the Prescription Drug Program.
- Expenses for diabetic insulin pumps and tubing.
- Charges above allowable charge limits.
- Penalties for noncompliance with precertification provisions.
- Expenses not covered by the BP MEO.

Switching between medical programs midyear

If you and your eligible dependents are enrolled in the BP Retiree Medical Plan and, due to a change in your or your covered dependent’s Medicare-eligibility, your coverage under the plan is switched to or from the BP NonMedicare-Eligible Program, the BP Medicare-Eligible Program, or the BP Medical Plan for active employees, any amounts credited toward your plan-year medical deductible will apply to the corresponding deductible under your new option for the remainder of the plan year. There is no crediting if you transfer to or from a BP-offered HMO or a Medicare HMO, or to the BP Medicare Advantage PPO ESA.

Publication date: April 2020
Out-of-pocket maximums

You pay a certain amount of covered expenses each plan year before the BP MEO begins paying 100% of allowable charges for most covered services. This is your medical coverage plan year out-of-pocket maximum. The out-of-pocket maximum — which includes the amounts you pay toward the deductible — is $2,000 per covered person and $4,000 per family.

Any medical expense that counts toward an individual’s plan year out-of-pocket maximum counts automatically 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.

Expenses applied to the out-of-pocket maximums

The following expenses apply to the BP MEO’s medical out-of-pocket maximums:

- Deductibles.
- Coinsurance.

Expenses excluded from the out-of-pocket maximums

The following expenses do not apply to the BP MEO’s medical out-of-pocket maximums and are payable by you even after the out-of-pocket maximum has been met:

- Expenses under the Prescription Drug Program.
- Charges in excess of allowable charges limits.
- Penalties for noncompliance with precertification provisions.
- Expenses not covered by the BP MEO.

Switching between medical programs midyear

If you and your eligible dependents are enrolled in the BP Retiree Medical Plan and, due to a change in your or your covered dependent’s Medicare-eligibility, your coverage under the plan is switched to or from the BP NonMedicare-Eligible Program, the BP Medicare-Eligible Program, or the BP Medical Plan for active employees, any amounts credited toward your plan-year out-of-pocket maximums will apply to the corresponding out-of-pocket maximums under your new option for the remainder of the plan year. There is no crediting if you transfer to or from a BP-offered HMO or Medicare HMO, or to the BP Medicare Advantage PPO ESA.
**Lifetime maximum benefit**

There is a lifetime maximum benefit under the BP MEO of $2 million per covered person. The lifetime maximum is calculated beginning from the time a participant becomes covered under the BP MEO, whether or not they are eligible for Medicare.

Benefits provided under the Prescription Drug Program do not apply to the lifetime maximum benefit.

Publication date: April 2020
Important plan provisions

The BP MEO includes special plan provisions. These important features include case management, preventive care, allowable charges limits, precertification requirements and more. More information about each of these features is outlined in this section.

- Case management
- Preventive care
- Emergency care
- Allowable charges limits
- Aetna's National Advantage Program (NAP)
- Transplant services
- Precertification requirements
- Coverage while traveling
- Alternatives to physician office visits

Publication date: April 2020
This program is available to NonMedicare-eligible participants and to Medicare-eligible participants whose Medicare benefits have been exhausted.

Aetna’s Case Management Program is offered to certain individuals with serious or chronic medical conditions. With this program, Aetna tries to collaborate with the patient and his/her family and health care providers to provide a process that focuses on education, advocacy and a return to an optimal level of health. The Case Management Program strives to enhance the patient’s quality of life, promote continuity of care, facilitate provision of services in the appropriate setting and maximize the patient’s available benefits to promote quality, cost-effective outcomes.

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

The BP MEO provides coverage for the following preventive care services:

- Routine physicals (once every 24 months between age 18 and your 65th birthday and once every 12 months for ages 65 and above).*
- Well-child care (until the child’s 18th birthday).*
- Annual well-woman exams.*
- Routine mammograms.
- Routine Prostate Specific Antigen (PSA) tests.
- Colorectal screenings.
- 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”).

* Includes all tests (e.g., lab work, X-rays) associated with the visit and all office-based procedures.

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.

Preventive care benefits are paid at 80% without having to first meet the plan year deductible. The following services have a benefit maximum of $300 per plan year per person:

- Routine physicals.
- Well-child care between ages 7 – 18 (services up to age 6 do not have a maximum benefit).

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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.

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.

NonMedicare-eligible participants who are admitted to the hospital are required to certify the hospitalization within 48 hours (or two business days) of the emergency admission. Instructions on how to contact your claims administrator are provided on your medical option ID card.
Allowable charges limits

Benefits under the BP MEO are based on allowable charges limits. The BP MEO does not cover otherwise eligible expenses above allowable charges limits — they are your responsibility. For example, if you incur a $200 doctor expense, but only $180 of the charge is within allowable charges limits, only $180 will be considered an eligible expense under the plan.

Allowable charges limits are determined by Aetna or Medicare depending on whether the covered participant is Medicare-eligible and whether the expense is covered by Medicare.

- **For Medicare-eligible participants**, the allowable charges limit is based on Medicare’s approved amount — not on Aetna’s allowable charges amount.
  - If your provider accepts Medicare assignment, you will not be expected to pay any charges above the Medicare-approved amount.
  - If your provider does NOT accept Medicare assignment, the BP MEO does not cover charges above the Medicare-approved amount — they are your responsibility.
  - If an expense is covered by the BP MEO but not by Medicare, the allowable charges limit is the billed amount, subject to recognized charge limits described below where applicable.

- **For NonMedicare-eligible participants**, the allowable charges limit is the billed amount, subject to recognized charge limits described below where applicable.

The BP MEO does not cover charges above the allowable charges limit — they are your responsibility.

If the expense is not covered by Medicare, your provider does not accept Medicare assignment, or you or a covered dependent are not Medicare-eligible, you may find out whether your provider’s charges fall within allowable charges limits for a specific service before you receive care by asking your provider for:

- The amount of the charge;
- The numeric code that your provider will assign to the service provided; and
- Your provider’s billing office ZIP code.

You should call Aetna with this information well in advance of receiving the service. Aetna will let you know whether the charges are within allowable charges limits. Keep in mind that allowable amounts can change over time.
Recognized charge limits

For expenses not covered by Medicare, 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: Twice the 95th percentile of the Prevailing Charge Rate, for the Geographic Area where the service is furnished.
  - For facility charges: 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.

**When allowable/recognized limits do not apply**

Services received from Aetna National Advantage Program (NAP) providers are not subject to allowable/recognized charges limits, provided the service is covered by the plan and is not covered by Medicare. To find out whether an Aetna NAP provider is available near you, you can access Aetna’s website or call Aetna.
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 eligible expenses provided by Aetna NAP providers.

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.

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Transplant services

This program is available to NonMedicare-eligible participants and to Medicare-eligible participants whose Medicare benefits have been exhausted.

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.

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 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.

NonMedicare-eligible participants must precertify all inpatient admissions (including inpatient skilled nursing and hospice facilities) and certain outpatient procedures with Aetna.

Precertification is not required if the expense is incurred while you are outside the United States. In addition, Medicare-eligible participants are not required to precertify care.

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.
- **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.

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Coverage while traveling

Eligible medical expenses incurred while traveling within or outside the U.S. are covered. 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., 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).

When you are traveling outside the U.S., benefits for Medicare-eligible participants will not be reduced by the amount Medicare would have paid for eligible services had the services been provided in the United States. In processing your claim incurred while outside the U.S., the claims administrator uses the conversion rates posted on www.oanda.com as of the date the service or supply was received or the prescription was filled.
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 Note:

- 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.

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Eligible/ineligible expenses

Find out more about what medical care is covered and what is not

The BP Medicare-Eligible Option (MEO) 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 Medicare-Eligible Option (MEO)
- Expenses not covered under the BP Medicare-Eligible Option (MEO)

Publication date: April 2020
Expenses covered under the BP Medicare-Eligible Option (MEO)

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 MEO, call Aetna. For more details about prescription drug expenses covered under the BP MEO’s Prescription Drug Program, call ESI.
Expenses covered under the BP MEO

The BP MEO covers a broad range of medical services and supplies that are medically necessary, subject to any applicable deductibles, coinsurance, exclusions and limits. It does not provide benefits for all medical care.

I Acupuncture in lieu of anesthesia.
I 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.
I 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.
I Biofeedback.
I Chiropractic care (up to 20 visits/plan year).
I 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.
I Durable medical equipment, orthotics and consumable medical supplies, including diabetic insulin pumps and tubing ($50,000/per person lifetime maximum).
I Emergency services, including:
  - Ambulance services (ground, air or water).
  - Hospital emergency room/urgent care center.
I Home health care expenses (up to 100 visits/plan year) provided:
  - 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.
Home health care expenses are charges for:
  - 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.
For home health care expenses to be covered by the plan, the home health care must be a substitution for a medically necessary confinement in a hospital or extended care facility, as determined by the claims administrator. Custodial or convalescent care is not covered by the plan.
I Hospice care, including:
  - Charges made by a hospital, hospice or skilled nursing facility for:
    n 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
    n Services and supplies furnished on an outpatient basis.
  - Charges made on an outpatient basis by a Hospice Care Agency for:
    n Part-time or intermittent nursing care by an R.N. or L.P.N for up to eight hours a day;
    n Part-time or intermittent home health aide services for up to eight hours a day;
    n Medical social services under the direction of a physician. These include but are not limited to:
      n Assessment of your social, emotional and medical needs, and your home and family situation;
      n Identification of available community resources; and
      n 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).

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 (limitations on length of coverage will vary).

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.

Pervasive Development Disorder expenses, up to 10 speech therapy visits (additional visits will be allowed if medically necessary), including:

- Autism.
- Rett syndrome.
- Childhood disintegrative syndrome.

Asperger’s Syndrome.

Prerequisite mental health screening for treatment of obesity.

Preventive care in accordance with the claims administrator's standards, including:

- Routine physicals (once every 24 months between age 18 and your 65th birthday and once every 12 months for ages 65 and above).
- Well-child care (until the child's 18th birthday).
- Annual well-woman exams.
- Routine mammograms.
- Routine PSA tests.
- Colorectal screenings (routine).

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 ($50,000/per person lifetime maximum).

Prosthetic appliances (including external breast prostheses following a mastectomy).

Skilled nursing facility (up to 60 days/plan year).

Temporomandibular Joint Dysfunction (TMJ) syndrome (limited to medical treatment).

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.
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 MEO 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.
Expenses not covered under the BP Medicare-Eligible Option (MEO)

Although not expressly identified in the following list(s), an expense — even if medically necessary — will not be covered by the BP MEO if:

- The item is not expressly treated as covered under the plan.
- 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 MEO provides benefits for many medical services, some services are not covered.

- 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.
- Any biomechanical external prosthetic device or replacement of external prosthetics due to loss, theft or destruction.
- 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.
- Care provided by Christian Science Sanitariums and Practitioners.
- Charges for services not ordered by a covered provider.
- 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.
- Drugs that do not require a prescription, even if prescribed by a doctor.
- 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.
- 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.
- Expenses that are in excess of allowable charges limits, as determined by the claims administrator.
- Fees for directed blood donations — i.e., when someone designates donation of blood to a specific person.
- Injury due to a military action, unless the injury results from being an innocent bystander in the situation.
- Injury or illness covered by Workers’ Compensation or other federal, state or local laws.
- Inpatient personal services such as television rental and guest meals.
- Mental health expenses related to:
  - Chronic pain treatment without a DSM-IV diagnosis.
  - Confrontation therapy.
  - Court-ordered treatment, unless medically necessary.
  - Eating disorder and gambling programs based solely on the 12-step model.
  - Ecological or environmental diagnosis or treatment.
  - Educational training and bed and board while confined in an institution that is mainly a school or other institution for the aged or a nursing home.
  - Educational evaluation/remediation therapy and school consultations.
  - Erhard Seminar Training (EST) or similar motivational services.
  - Examinations provided for employment, licensing, insurance, school, camp, sports, adoption or other non-clinically necessary purposes and related expenses for reports, including report presentation and preparation.
  - Expressive therapies (art, poetry, movement, psychodrama).
  - Financial counseling.
  - Herbal medicine, holistic or homeopathic care, including drugs.
  - Light boxes.
  - Marriage and family counseling used for the adjudication of marital, child support and custody cases.
  - Mental and psychoneurotic disorders not listed in the International Statistic Classification of Diseases, Injuries and Causes of Death (ICD-9).
  - Mental retardation.
  - Methadone maintenance.
  - Services or supplies that are considered by the claims administrator not to be clinically necessary, including any confinement or treatment given in connection with a service or supply that is not clinically necessary.
  - Services given by a pastoral counselor.
  - Services, supplies, medical care or treatment given by one of the following members of your immediate family: spouse, child, brother, sister, parent, grandparent or domestic partner.
  - Smoking cessation programs.
° Transcendental meditation.
° Treatment that is experimental, investigational, primarily for research or not in keeping with national standards of practice and not demonstrated through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed, as determined by the claims administrator.
° Treatment of learning disabilities.
° Treatment of obesity except for requisite screenings for surgical treatment.
° Treatment of sexual dysfunction not related to organic disease.
° Vagus nerve stimulation.
° Weight loss programs.
° Wilderness programs.

I Most cosmetic surgery or treatment, unless required to correct a condition caused by an accidental injury or a medically necessary surgery.
I 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 (covered expenses limited to facility fees).
I Orthoptic or visual training or visual therapy.
I Orthotics that are store bought (not custom made).
I Outpatient rehabilitation for learning disabilities, developmental delays and autism, except as noted otherwise in this SPD.
I Outpatient rehabilitation that is considered long term and that does not result in the significant improvement of a covered person’s condition.
I Preventive care that is not described as a covered benefit.
I Reports, evaluations, examinations or hospitalizations not required for health reasons.
I Routine eye examinations, eyeglasses and contact lenses (except for the first pair following cataract/lens removal), or hearing aids, including the examination and fitting.
I Routine foot care. However, services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.
I Services of a dietician, 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).
I Services or supplies for which there is no charge.
I Services or supplies that are not medically necessary as determined by the claims administrator.
I Services provided by persons without nationally recognized licensure or which do not fall within the scope of the license.
I 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/ileostomy;
° 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.
I Services rendered by a family member.
I 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.
I Smoking deterrents, even if a doctor’s prescription is required.
I Speech therapy that is custodial or educational or is not restorative in nature.
I Speech therapy to improve speech skills that have not been fully developed or to maintain speech communication.
I Surgical correction of refractive errors, such as radial keratotomy or LASIK surgery.
I 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.
I Testing or training for educational purposes, including services associated with developmental delay or learning disabilities.
I Therapies, tests and procedures that are not medically necessary, including but not limited to:
° Aromatherapy;
° Biofeedback and bioenergetic therapy;
° Carbon dioxide therapy;
° Chelation therapy (except for heavy metal poisoning);
° Computer-aided tomography (CAT) scanning of the entire body;
° Educational therapy;
° Gastric irrigation;
- Hair analysis;
- Hyperbaric therapy, except for treatment of decompression or to promote healing of wounds;
- Hypnosis, hypnotherapy, except when performed by a physician as a form of anesthesia in connection with a covered surgery;
- Lovaas therapy;
- Massage therapy;
- Megavitamin therapy;
- Primal therapy;
- Psychodrama;
- Purging;
- Recreational therapy;
- Rolfing;
- Sensory or auditory integration therapy;
- Sleep therapy; and
- Thermograms and thermography.

- 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.
- Transgender surgery and other services for the treatment of gender dysphoria.
- 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.

- Voluntary sterilization (tubal ligation or vasectomy).
- 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 Medicare-Eligible Option (MEO).

- 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 Medicare-Eligible Option (MEO), coverage under the BP MEO 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 MEO and other group health coverage, the BP MEO 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 MEO 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.
6. 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.
7. 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 MEO is secondary.
8. If an employee or dependent of an active employee has Medicare coverage, the BP MEO 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.*
9. If a person has Medicare coverage and coverage under the BP MEO 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 MEO is the secondary plan, as long as no tertiary plan is involved. When the BP MEO is the secondary plan, the benefits paid by Medicare are subtracted from the benefits that would normally be paid by the BP MEO. 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 MEO will consider full plan benefits without applying the Medicare offset.*
10. For Medicare-eligible participants, medical benefits will be paid as described in Understanding medical coverage under the BP Medicare-Eligible Option (BP MEO) and Medicare.

With coordination of benefits, if the BP MEO 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 MEO will not pay any benefits if the primary plan’s benefits are in all cases equal to or better than the BP MEO’s benefits.

* Employees who are covered under the BP MEO while receiving LTD benefits under the BP LTD Plan due to disability based on the “any occupation” standard of disability are not considered “active” for purposes of this rule.

If you are enrolled in the BP MEO and in a non-BP-offered Medicare HMO

When you receive medical care that is not covered by a non-BP-offered Medicare HMO, the benefits paid by the BP MEO will be reduced by the benefits that would have been paid by Medicare Part A and Part B, as if you were not enrolled in the Medicare HMO. The plan will NOT
pay for any portion of an expense that Medicare Part A and Part B would have paid.

If you are enrolled in the BP Medicare Advantage PPO ESA
If you are enrolled in the BP Medicare Advantage PPO ESA, see the Evidence of Coverage document to learn how that plan coordinates benefits.

If you are enrolled in a BP-offered Medicare HMO
If you are enrolled in a BP-offered Medicare HMO, contact the Medicare HMO to learn how that plan coordinates benefits.
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 Medicare-Eligible Option (MEO), 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.

If you have other medical coverage

Periodically, BP or a claims administrator will ask you to provide information about other group health 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.
If you are Medicare-eligible

Medical claims

Medical claims must be filed with Medicare first, even if the provider or supplier does not accept Medicare assignment or services were provided outside the U.S. After Medicare processes your claim, you can then file your claim with Aetna.

To process a claim, Aetna may need:

- An itemized billing statement that includes the date of service, description of service or supply provided, diagnosis and name of the provider or supplier;
- A copy of any benefit payment or denial statement from any other group plan for that service; and
- A copy of the Explanation of Benefits (EOB) you received from Medicare.

If you are enrolled in Medicare Direct, Medicare will file your claims for Medicare Part B expenses or durable medical equipment with Aetna. If you are not enrolled in Medicare Direct or if you have Medicare Part A expenses, you are responsible for filing your claims with Medicare first.

Medicare Direct

Once you have filed your first claim with Aetna, Aetna will automatically enroll you in their Medicare Direct program. Through this program, Medicare automatically forwards your claims for Medicare Part B expenses or durable medical equipment expenses to Aetna for processing.

Currently, Medicare Direct does not apply to Medicare Part A (primarily inpatient hospital expenses), so claims for these types of expenses will need to be filed directly with Aetna. Usually your provider will file these claims on your behalf.

You will know Aetna’s Medicare Direct is in effect — usually six to eight weeks after you file your first claims with Aetna — when your EOB from Medicare includes the message, “Your claim has been forwarded to your insurance carrier.” Until this message starts appearing on your Medicare EOBs, you should file claims with Aetna for all eligible expenses.

Call Aetna if you want to disenroll from Aetna’s Medicare Direct — for instance, if you need to file claims with another medical plan before you file them with the BP MEO. Aetna will provide you the appropriate forms to complete and submit. It takes six to eight weeks from receipt of your request for your disenrollment to take effect. Note: You may want to contact your other insurance carrier to see if it offers a service similar to Medicare Direct.

Prescription drug claims

- If you have primary coverage under another plan

  You must first follow the other plan’s procedures for obtaining prescription drugs — whether obtaining the prescription drugs at a pharmacy in the other plan’s network, through the other plan’s home delivery service or seeking reimbursement through the other plan. You can make a claim for prescription drug benefits under the BP MEO only if prescription drug benefits are not payable under the other plan.

  After the other plan processes your claim, you can then file a claim for any unreimbursed expenses with Express Scripts as described below.

- If you do NOT have primary coverage under another plan

  - If you obtain prescription drugs from an Express Scripts network pharmacy or through the home delivery service, there are no claim forms to submit. You show your Express Scripts Medicare ID card and pay your share of the cost at the time the prescription is filled.

  - If you obtain prescription drugs from a pharmacy that does not participate in the Express Scripts pharmacy network, you must pay the full cost for the medication at the time the prescription is filled. You will then need to file a claim for reimbursement with Express Scripts Medicare, together with your original itemized receipt. This option is available only if an Express Scripts network pharmacy is not available within a 40-mile radius of your home or you are outside the United States. You can request claim forms from Express Scripts Medicare.
If you are NOT Medicare-eligible

Medical claims

You will have to pay for medical services and supplies at the time you receive them, and then file a claim for reimbursement.

To file a claim for reimbursement, you will need to submit the following to Aetna:

- A completed medical claim form.
- All itemized bills indicating the date of service, description of services or supplies provided, diagnosis, name of the provider or supplier and charges incurred.

You can request claim forms from Aetna.

Prescription Drug Claims

- If you have primary coverage under another plan
  
  You must first follow the other plan’s procedures for obtaining prescription drugs — whether obtaining the prescription drugs at a pharmacy in the other plan’s network, through the other plan’s home delivery service or seeking reimbursement through the other plan. You can make a claim for prescription drug benefits under the BP MEO only if prescription drug benefits are not payable under the other plan.

  After the other plan processes your claim, you can then file a claim for any unreimbursed expenses with Express Scripts as described below.

- If you do NOT have primary coverage under another plan

  - If you obtain prescription drugs from an Express Scripts network pharmacy or through the home delivery service, there are no claim forms to submit. You show your Express Scripts Medicare ID card and pay your share of the cost at the time the prescription is filled.

  - If you obtain prescription drugs from a pharmacy that does not participate in the Express Scripts pharmacy network, you must pay the full cost for the medication at the time the prescription is filled. You will then need to file a claim for reimbursement with Express Scripts Medicare, together with your original itemized receipt. This option is available only if an Express Scripts network pharmacy is not available within a 40-mile radius of your home or you are outside the United States. You can request claim forms from Express Scripts Medicare.

Publication date: April 2020
Submitting claims

To submit claims, or if you have questions about how to file a claim, here is what you need to do:

| For ...                              | Submit claims to ...                  | If you have questions about how to file a claim, call ...
|--------------------------------------|---------------------------------------|----------------------------------------------------------
| Medical claims                       | Aetna                                 | Aetna  
|                                      | P.O. Box 14586                        | 1-866-436-2606                                           |
|                                      | Lexington, KY 40512-4586               |                                                         |
| Prescription drug claims             | Express Scripts                       | Express Scripts                                           |
|                                      | P.O. Box 2872                         | Within the U.S.                                           |
|                                      | Clinton, IA 52733                      | 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.

What else you should know about claims administrators under the BP Medicare-Eligible Option (MEO)

The claims administrators for the benefits and services provided under the BP MEO 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 MEO. 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:

1. Your eligibility for coverage, including a retrospective termination of coverage (whether or not there is an adverse effect on any particular benefit);
2. Coverage determinations, including plan limitations or exclusions;
3. The results of any Utilization Review activities;
4. A decision that the service or supply is experimental or investigational; or
5. 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.

Publication date: April 2020
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.
How to continue BP Retiree Medical Plan coverage

COBRA coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985 (referred to as "COBRA") allows eligible participants 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 one of your eligible dependents loses group health coverage because of a qualifying event, your eligible dependent may elect to continue their current group health coverage under COBRA for up to 36 months. 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 BP files for bankruptcy under Title 11 of the United States Code.

If your eligible dependent has BP coverage, he/she may elect COBRA coverage if coverage would otherwise end because:

- You and your spouse divorce or your domestic partnership/civil union ends;
- Your dependent no longer qualifies as an eligible dependent;
- You or your surviving spouse dies; or
- BP files for bankruptcy under Title 11 of the United States Code.

Maximum period of COBRA coverage

The dependent's maximum period of COBRA coverage begins on the date group health coverage would otherwise be lost because of a qualifying event and ends 36 months later. However, in the case of a qualifying event caused by the employer's bankruptcy, the maximum period of COBRA coverage is the earlier to occur of:

- The death of the covered retiree following bankruptcy; or
- If the retiree died prior to the bankruptcy, the end of the 36-month period of COBRA coverage due to the death of the retiree or surviving spouse.

If you are covered under a companion HMO, 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.
2. You or your dependent must notify the BP HR & Benefits Center within 60 days of a qualifying event such as death, divorce or loss of a dependent child’s eligibility status. The BP HR & Benefits Center will then mail COBRA enrollment materials to the affected family member.
3. You or your affected dependent must contact the BP HR & 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 HR & Benefits Center, whichever is later. Notify the BP HR & Benefits Center if the COBRA materials are not timely received.

If notice of the qualifying event is not received by the BP HR & 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%.

If you or any affected dependent elects COBRA coverage, the BP HR & 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.

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 date BP stops providing group health benefits.

Publication date: April 2020
## Administrative information

### Detailed information about plan administration and your rights

<table>
<thead>
<tr>
<th><strong>Name of plan</strong></th>
<th>BP Corporation North America Inc. Retiree Welfare Benefits Plan II (&quot;the BP Retiree Medical Plan&quot;)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of plan</strong></td>
<td>Welfare benefit plan including:</td>
</tr>
<tr>
<td></td>
<td>- BP Retiree Medical Plan (medical care, hospitalization, surgical care, behavioral health care, prescription drugs, health reimbursement account) — self-insured.</td>
</tr>
<tr>
<td></td>
<td>- BP Medicare Advantage PPO ESA — insured.</td>
</tr>
<tr>
<td></td>
<td>- Medicare Health Maintenance Organization (HMOs) — insured.</td>
</tr>
<tr>
<td><strong>Plan number</strong></td>
<td>851</td>
</tr>
<tr>
<td><strong>Plan year</strong></td>
<td>January 1 — December 31</td>
</tr>
<tr>
<td><strong>Plan sponsor and identification number</strong></td>
<td>BP Corporation North America Inc. 501 Westlake Park Blvd. Houston, TX 77079 Employer ID#: 36-1812780</td>
</tr>
<tr>
<td><strong>Plan administrator</strong></td>
<td>Director, Health &amp; Welfare  BP Corporation North America Inc. 501 Westlake Park Blvd Houston, TX 77079 1-800-890-4100</td>
</tr>
<tr>
<td><strong>Sources of contributions</strong></td>
<td>The BP Corporation North America Inc. Retiree 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 BPCNAI VEBA Master Trust (&quot;VEBA&quot;). Notwithstanding the above, benefits for the Medicare Advantage PPO ESA option of the plan are provided through an insurance contract with Aetna, who has the sole responsibility to pay all claims under that option.</td>
</tr>
<tr>
<td><strong>VEBA trustee</strong></td>
<td>JPMorgan Chase Bank Worldwide Securities Services 4 New York Plaza New York, NY 10005</td>
</tr>
<tr>
<td><strong>Claims administrators</strong></td>
<td>See Claims administrators.</td>
</tr>
<tr>
<td><strong>Agent for service of legal process</strong></td>
<td>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.</td>
</tr>
</tbody>
</table>

The most up-to-date information is available online at http://hr.bpglobal.com/lifebenefits/RetireeMedicare.
All of the coverage options include behavioral health services and prescription drug coverage.

- The BP Medicare Advantage PPO ESA is insured and administered by Aetna, who has the sole responsibility to pay all claims.
- The BP Medicare-Eligible Option (MEO) is administered by Aetna.
- The Prescription Drug Program is administered by Express Scripts Medicare. Specialty drug coverage is administered by Accredo. MCMC is the final claims fiduciary for prescription drug appeals.
- The claims administrator for a Medicare HMO option is the Medicare 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 Medicare Advantage PPO ESA:</strong> Aetna</td>
<td><a href="http://www.aetnamedicare.com">www.aetnamedicare.com</a></td>
<td>1-855-427-5623</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>24-Hour NurseLine:</strong> 1-800-556-1555</td>
</tr>
<tr>
<td><strong>BP Medicare-Eligible Option (MEO): Aetna</strong></td>
<td>Aetna <a href="http://www.aetna.com">www.aetna.com</a></td>
<td><strong>Within the U.S.:</strong> 1-866-436-2606</td>
</tr>
<tr>
<td></td>
<td>BP’s custom DocFind website <a href="http://www.aetna.com/dsepublic/#/contentPage?page=providerSearchLanding&amp;site_id=bp">www.aetna.com/dsepublic/#/contentPage?page=providerSearchLanding&amp;site_id=bp</a></td>
<td><strong>Outside the U.S.:</strong> Dial the AT&amp;T access number of the country you are in; when prompted, dial 1-866-436-2606</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>24-Hour NurseLine:</strong> 1-800-556-1555</td>
</tr>
<tr>
<td><strong>Medicare HMOs</strong></td>
<td>For questions or to submit claims to a BP-offered Medicare HMO, contact your Medicare HMO directly. The phone number is on your Medicare HMO medical option ID card or available by contacting the BP Benefits Center.</td>
<td></td>
</tr>
<tr>
<td><strong>Prescription Drug Program for the BP Medicare Advantage PPO ESA and the BP MEO:</strong> Express Scripts Medicare</td>
<td><a href="http://www.express-scripts.com">www.express-scripts.com</a></td>
<td>1-800-216-6506</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> MCMC is the final claims fiduciary for prescription drug appeals.</td>
<td></td>
</tr>
</tbody>
</table>

Publication date: April 2020
Plan administrator

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 Retiree Welfare Benefit Plan ("the BP Retiree Medical 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 Retiree Welfare Benefit Plan ("the BP Retiree Medical 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 Retiree Welfare Benefit Plan ("the BP Retiree Medical 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 Retiree Medical Plan 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.

Publication date: April 2020
Certificate of Group Health Coverage

If you and/or your covered dependent lose medical 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 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.

Medicare Part D Coverage

If you are eligible for Medicare Part D coverage but have not enrolled in a Medicare Part D plan when your coverage in the BP Medicare Advantage PPO ESA or the BP MEO ends, you should consider enrolling. Unless you have “creditable coverage” under another plan, you need to enroll within 63 days after your coverage in the BP Medicare Advantage PPO ESA or the BP MEO ends or you will be subject to a late-enrollment penalty when you enroll in Medicare Part D. In addition, if you do not enroll during the special enrollment period following your loss of creditable coverage, you may not be able to enroll in a Medicare Part D plan until the next annual enrollment period.

Each year, BP will send a notice stating whether the plan provides creditable coverage regarding Medicare Part D. You will need to provide the most recent notice to your Medicare Part D plan vendor to ensure you do not have to pay a penalty for late enrollment. If you have misplaced your notice, contact the BP Benefits Center for a copy.
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.

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.

Publication date: April 2020
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.
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 Retiree Medical Plan 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 BP Retiree Medical Plan is terminated, your contributions will end as of the day of 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 Retiree Medical Plan.

Publication date: April 2020
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>
</tr>
</thead>
<tbody>
<tr>
<td>ALABAMA</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Website: <a href="http://www.myalhipp.com">http://www.myalhipp.com</a></td>
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<tr>
<td>Phone: 1-855-692-5447</td>
<td></td>
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<tr>
<td>ALASKA</td>
<td>Medicaid</td>
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<tr>
<td>The AK Health Insurance Premium Payment Program</td>
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<tr>
<td>Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a></td>
<td></td>
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<tr>
<td>Phone: 1-866-251-4861</td>
<td></td>
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<tr>
<td>Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a></td>
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<tr>
<td>Medicaid Eligibility: <a href="http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx">http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</a></td>
<td></td>
</tr>
<tr>
<td>ARKANSAS</td>
<td>Medicaid</td>
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<tr>
<td>Website: <a href="http://myarhipp.com/">http://myarhipp.com/</a></td>
<td></td>
</tr>
<tr>
<td>Phone: 1-855-MyARHIPP (855-692-7447)</td>
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<tr>
<td>CALIFORNIA</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Website: <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></td>
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<tr>
<td>Phone: 1-800-541-5555</td>
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<tr>
<td>COLORADO</td>
<td>Health First Colorado (Colorado's Medicaid Program) &amp; Child Health Plan Plus (CHP+)</td>
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<tr>
<td>Health First Colorado Website: <a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a></td>
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<tr>
<td>Health First Colorado Member Contact Center: 1-800-221-3943 / State Relay 711</td>
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<td>CHP+ Website: <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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<tr>
<td>FLORIDA</td>
<td>Medicaid</td>
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<tr>
<td>State</td>
<td>Program Details</td>
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<tr>
<td>GEORGIA – Medicaid</td>
<td>Website: <a href="http://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp">http://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp</a></td>
</tr>
<tr>
<td>IOWA – Medicaid and CHIP (Hawki)</td>
<td>Medicaid Website: <a href="https://dhs.iowa.gov/ime/members">https://dhs.iowa.gov/ime/members</a></td>
</tr>
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<td>KANSAS – Medicaid</td>
<td>Website: <a href="http://www.kdheks.gov/hcf/default.htm">http://www.kdheks.gov/hcf/default.htm</a></td>
</tr>
<tr>
<td>KENTUCKY – Medicaid</td>
<td>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: <a href="https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx">https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx</a></td>
</tr>
<tr>
<td>LOUISIANA – Medicaid</td>
<td>Website: <a href="http://www.medicaid.la.gov">www.medicaid.la.gov</a> or <a href="http://www.ldh.la.gov/lahipp">www.ldh.la.gov/lahipp</a></td>
</tr>
<tr>
<td>MAINE – Medicaid</td>
<td>Website: <a href="http://www.maine.gov/dhhs/ofi/public-assistance/index.html">http://www.maine.gov/dhhs/ofi/public-assistance/index.html</a></td>
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<tr>
<td>State</td>
<td>Program</td>
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<tr>
<td>Massachusetts</td>
<td>Medicaid and CHIP</td>
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<td>Medicaid</td>
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<td>Medicaid</td>
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<td>New Jersey</td>
<td>Medicaid and CHIP</td>
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<td>Medicaid</td>
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<td>North Carolina</td>
<td>Medicaid</td>
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<td>North Dakota</td>
<td>Medicaid</td>
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<tr>
<td>State</td>
<td>Medicaid/CHIP Website</td>
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<tr>
<td>OKLAHOMA</td>
<td>Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a></td>
</tr>
<tr>
<td>PENNSYLVANIA</td>
<td>Website: <a href="http://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx">http://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx</a></td>
</tr>
<tr>
<td>RHODE ISLAND</td>
<td>Website: <a href="http://www.eohhs.ri.gov">http://www.eohhs.ri.gov</a> Phone: 855-697-4347 or 401-462-0311 (Direct Rite Share Line)</td>
</tr>
<tr>
<td>SOUTH CAROLINA</td>
<td>Website: <a href="https://www.scdhhs.gov">https://www.scdhhs.gov</a></td>
</tr>
<tr>
<td>SOUTH DAKOTA</td>
<td>Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a></td>
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<tr>
<td>TEXAS</td>
<td>Website: <a href="http://www.gethipptexas.com/">http://www.gethipptexas.com/</a></td>
</tr>
<tr>
<td>UTAH</td>
<td>Medicaid Website: <a href="https://medicaid.utah.gov/">https://medicaid.utah.gov/</a> CHIP Website: <a href="http://health.utah.gov/chip">http://health.utah.gov/chip</a> Phone: 1-877-543-7669</td>
</tr>
<tr>
<td>VERMONT</td>
<td>Website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a></td>
</tr>
<tr>
<td>VIRGINIA</td>
<td>Website: <a href="http://www.coverva.org/">http://www.coverva.org/</a> Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282</td>
</tr>
<tr>
<td>WASHINGTON</td>
<td>Website: <a href="http://www.hca.wa.gov/">http://www.hca.wa.gov/</a></td>
</tr>
</tbody>
</table>
### WEST VIRGINIA – Medicaid
Website: [http://mywvhipp.com/](http://mywvhipp.com/)
Phone: 1-855-MyWVHIPP (1-855-699-8447)

### WISCONSIN – Medicaid and CHIP
Website: [https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf](https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf)
Phone: 1-800-362-3002

### WYOMING – Medicaid
Website: [https://wyequalitycare.acs-inc.com/](https://wyequalitycare.acs-inc.com/)
Phone: 307-777-7531

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](http://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](http://www.cms.hhs.gov)
1-877-267-2323, Menu Option 4, Ext. 61565

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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:

1. 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.
2. 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.

3. 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.