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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 Medifill Program. The BP NonMedicare-Eligible Program is described in this handbook.

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

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<th>Program</th>
<th>If you are eligible to participate in the BP Retiree Medical Plan:</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.</td>
</tr>
<tr>
<td>Described in this handbook</td>
<td>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.</td>
</tr>
<tr>
<td>Described in a separate handbook</td>
<td></td>
</tr>
</tbody>
</table>

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 no one in a covered family unit is eligible for Medicare (the so-called “NonMedicare-Eligible Option” or “NMEO”). If you or any covered family member is eligible for Medicare, and you choose to enroll in the BP Retiree Medical Plan, you must instead enroll in the “Medicare-Eligible Option” or “MEO”, 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 from the date you become Medicare eligible. For rate details and enrollment procedures, contact the BP HR & Benefits Center.

- **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
Throughout this summary, "you" generally refers to:

1. You (the eligible retiree, LTD Recipient or surviving spouse) when describing elections (e.g., how to enroll, how to change coverage, when coverage ends).
2. You or any eligible dependent when describing the provisions of the plan (e.g., eligible and ineligible expenses).

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 HR & Benefits Center to obtain information about the plan in which you are enrolled.

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.

Publication date: April 2019
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>
<thead>
<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>Met BP Retiree Medical Plan eligibility requirements</td>
</tr>
<tr>
<td>Did not meet BP Retiree Medical Plan eligibility requirements</td>
<td>Did not meet BP Retiree Medical Plan eligibility requirements</td>
</tr>
</tbody>
</table>

If your disability was not work-related:

- **If hired before April 1, 2004:**
  - Met BP Retiree Medical Plan eligibility requirements: Your retiree contribution percentage will be based on your age and years of vesting service in a BP retirement program.
  - Did not meet BP Retiree Medical Plan eligibility requirements: Your contribution will be the 50% retiree contribution percentage.

- **If hired on or after April 1, 2004:**
  - Met BP Retiree Medical Plan eligibility requirements: Your retiree contribution percentage will be the full premium cost but you will have access to your Retiree Reimbursement Account per the Retiree Medical Plan rules.
  - Did not meet BP Retiree Medical Plan eligibility requirements: Your retiree contribution percentage will be the full premium cost but you will have access to your Retiree Reimbursement Account per the Retiree Medical Plan rules.

**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.
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.

<table>
<thead>
<tr>
<th>If your spouse was hired before April 1, 2004 and his/her death was:</th>
<th>If your spouse was hired on or after April 1, 2004 and his/her death was:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Not work-related</strong></td>
<td><strong>Work-related</strong></td>
</tr>
<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>
</tr>
<tr>
<td><strong>Work-related</strong></td>
<td><strong>Not work-related</strong></td>
</tr>
<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. You were given immediate access to your deceased spouse's Retiree Reimbursement Account (RRA).*</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).*</td>
</tr>
</tbody>
</table>

* 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. |

*14/Jul/19 20:40* The most up-to-date information is available online at http://hr.bpglobal.com/lifebenefits/RetireeNonMedicare.
LTD recipients

If a BP employee is on a long-term disability (LTD) leave of absence from BP, and he/she dies while on such leave, 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":

- **Alternative "A":** Register your domestic partnership or civil union in accordance with registration requirements in the state in which you and your domestic partner or civil union partner reside. Your registration date is the first date you can enroll your partner as a domestic partner under the BP Medical Program; or

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

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

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

1. 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;
2. 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.;
3. 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;
4. 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;
5. 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
6. 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.
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:

1. Even if you’re enrolled in the BP Medical Program at the time you leave BP as a retiree or LTD Recipient, you will automatically default to No Coverage under the Retiree Medical Plan.
2. You will have 30 days to enroll into coverage under the Retiree Medical Plan.
3. If you do not make an election, you will remain in No Coverage under the BP Retiree Medical Plan. This will not count as your one-time “Opt out” of retiree medical coverage.

The BP HR & Benefits Center will provide you a personalized worksheet reflecting your assigned coverage and any other choices available to you. While the assigned coverage will be No Coverage, you may enroll in any available option. If you are interested in HMO coverage options, see How HMOs work.

You also have the option of continuing medical coverage under COBRA. 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’re eligible for BP Retiree Medical Plan coverage as a 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 HR & Benefits Center. There are two ways to access the BP HR & Benefits Center:

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

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

1. Personal.
2. Personal + dependents.
3. 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 HR & 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 February — are effective for the next plan year (i.e., April 1 to March 31). You must submit appropriate documentation if you are adding coverage for a dependent.

- **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 HR & 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).

For the rules related to enrolling in the HealthPlus and Health+Savings Options, refer to the BP Wellness Program detailed elsewhere in the SPD.
All coverage under the 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.
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 were covered under the BP Medical Program at the time you left BP and you enroll in the BP Retiree Medical Plan within 30 days.</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.</td>
</tr>
<tr>
<td>You enroll during annual enrollment.</td>
<td>The first day of the new plan year (April 1 following the end of annual enrollment).</td>
</tr>
<tr>
<td>You have a qualifying status change and make the change within 30 days of the qualifying event.</td>
<td>On the date of the qualifying status change.</td>
</tr>
<tr>
<td>You are enrolled in the BP NonMedicare-Eligible Option (NMEO), 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” coverage, the date the BP HR &amp; Benefits Center is notified of the request.</td>
</tr>
<tr>
<td>You or your covered eligible dependent cease to be eligible for the Medicare-eligible-only portion of the BP Retiree Medical Plan (the BP Medicare-Eligible Program) and you are already enrolled in that portion of the plan.</td>
<td>The first of the month in which you or your covered eligible dependent cease to be Medicare-eligible.</td>
</tr>
<tr>
<td>You or your covered eligible dependent cease to be eligible for the Medicare-eligible-only portion of the BP Retiree Medical Plan (the BP Medicare-Eligible Program) and you are NOT already enrolled in that portion of the plan.</td>
<td>The following April 1, provided you enroll during the next annual enrollment period. You may not enroll midyear.</td>
</tr>
</tbody>
</table>

Publication date: April 2019
What coverage costs

In general, you and BP share in the cost of coverage. 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 an 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:

- Your age, and
- 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.

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 April 1, 2004 or later

Full-time and part-time employees hired April 1, 2004 or later 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.

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 40</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:

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

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

OR

I 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. 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 HR & Benefits Center from the LifeBenefits homepage, or call the BP HR & Benefits Center at 1-800-890-4100.

**Using your RRA with the Health+Savings options (PPO or Out-of-Area)**

If you are enrolled in one of the Health+Savings options with the Health Savings Account (HSA) for retiree medical coverage before you become eligible for Medicare, your RRA may be used only for certain types of expense, as follows:

- **Until you meet your deductible**, your RRA can be used only for certain types of expenses, including Medicare premiums and eligible out-of-pocket vision, dental and preventive care expenses. Note: Medicare premiums can only be for your spouse or eligible dependent, as you cannot be covered under Medicare and also contribute to an HSA. Your RRA cannot be used to reimburse you for your deductible. You can use your HSA to pay for all out-of-pocket eligible medical expenses. You cannot be reimbursed from both accounts for the same expense.

- **Once you meet your deductible**, the RRA can reimburse you for all eligible medical expenses you and your eligible spouse and dependents incur.

**If you moved within BP**

If you moved from a BP employer who offered coverage in the BP Retiree Medical Plan to one who did not, and you met the eligibility requirements for the BP Retiree Medical Plan while at the participating employer, you will continue to receive annual 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 participating employer, your annual credits were based on your age and your total vesting service in a BP retirement plan.
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 April 1, 2004 or later 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
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, 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, 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.

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 2019
Paying for coverage

Contributions for coverage are due monthly. Each month, the BP HR & 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 HR & Benefits Center.
When you can change coverage

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

At any time during the plan year, you may:

- Change from “Personal + dependents” 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 HR & 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 HR & Benefits Center online or call the BP HR & Benefits Center and speak with a representative. 

Note: If you are enrolling a dependent, you will need to provide proof of his/her eligibility for coverage.
Qualifying status changes that require action

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

<table>
<thead>
<tr>
<th>You must disenroll a dependent within 30 days if you ...</th>
<th>Restrictions/notes ...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need to <strong>remove</strong> an individual who is no longer an eligible dependent due to:</td>
<td>You may not switch medical 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 HR & Benefits Center of the event within 30 days:

- You will not be refunded any contributions for dependent coverage. Once you notify the BP HR & 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 HR & 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 HR &amp; Benefits Center within 30 days if you ...</th>
<th>Restrictions/notes ...</th>
</tr>
</thead>
<tbody>
<tr>
<td>You are rehired.</td>
<td>If you are enrolled in the <strong>BP NonMedicare-Eligible Program</strong> 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 if you are rehired as a full-time, part-time, term-contract or temporary employee.</td>
</tr>
<tr>
<td></td>
<td>- Retiree medical coverage <strong>will end</strong> for you and your covered dependents if you are rehired as an occasional employee of BP.</td>
</tr>
<tr>
<td>You want to <strong>enroll</strong> yourself in coverage, or <strong>add</strong> an eligible dependent to your coverage if you are already enrolled because:</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 are newly eligible.</td>
<td></td>
</tr>
<tr>
<td>- Marriage <em>(not applicable if you’re covered as a surviving spouse).</em></td>
<td></td>
</tr>
<tr>
<td>- Your establishment of your domestic partnership.</td>
<td></td>
</tr>
<tr>
<td>- Birth/adoption/legal guardianship of your child.</td>
<td></td>
</tr>
</tbody>
</table>

Contact the BP HR & Benefits Center for a domestic partner affidavit for establishment of a domestic partnership before enrolling.

If you already have coverage but are adding an eligible dependent, you may switch BP Retiree Medical Plan options.

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” coverage.

The most up-to-date information is available online at [hr.bpglobal.com/lifebenefits/RetireeNonMedicare](http://hr.bpglobal.com/lifebenefits/RetireeNonMedicare).
OR

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

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

<table>
<thead>
<tr>
<th>Restrictions/notes ...</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Marriage, if you/your dependents will be covered under your new spouse's employer's plan.</td>
</tr>
<tr>
<td>• Establishment of a domestic partnership, if you/your dependents will be covered under your new domestic partner's employer's plan.</td>
</tr>
<tr>
<td>• Birth/adoption/legal guardianship, if you and/or your dependents will be covered under your spouse's/domestic partner's employer's plan.</td>
</tr>
<tr>
<td>• 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.</td>
</tr>
<tr>
<td>• Mid-year plan enrollment in spouse's/domestic partner's plan that is not on an April 1 – March 31 basis.</td>
</tr>
</tbody>
</table>
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></td>
<td>• Within 30 days of acquiring the dependent.</td>
</tr>
<tr>
<td></td>
<td>• After 30 days of acquiring the dependent, provided you have “Personal + dependents” coverage.</td>
</tr>
<tr>
<td></td>
<td>• The date the qualifying status change occurs.</td>
</tr>
<tr>
<td></td>
<td>• The date you contact the BP HR &amp; Benefits Center to enroll the dependent.</td>
</tr>
<tr>
<td>Drop coverage for an individual who is no longer an eligible dependent.</td>
<td>The last day of the month in which the qualifying status change occurs and for which required contributions were received.</td>
</tr>
<tr>
<td>Cancel coverage.</td>
<td>The last day of the month in which you contact the BP HR &amp; Benefits Center to cancel coverage and for which required contributions were received.</td>
</tr>
</tbody>
</table>

Publication date: April 2019
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).

Publication date: April 2019
BP NonMedicare-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 a separate 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 this handbook.

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

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

  Together, the HealthPlus, Standard and Health+Savings PPO and OOA Options are referred to as the NonMedicare-Eligible Option (NMEO).

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

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

Note: Behavioral health services are now covered the same as other medical services.

Publication date: April 2019
The PPO Options are available only if you live in an area where the Aetna Choice POS II network is available. In addition to the options described below, you may want to consider the Health+Savings PPO Option.

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

### PPO Options (HealthPlus and Standard) summary chart

<table>
<thead>
<tr>
<th></th>
<th>HealthPlus PPO Option</th>
<th>Standard PPO Option</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2019/2020 Plan Year</td>
<td>2019/2020 Plan Year</td>
</tr>
<tr>
<td></td>
<td>Network</td>
<td>Network</td>
</tr>
<tr>
<td></td>
<td>Out-of-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td><strong>General information</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan year deductible</td>
<td>$300/person; $900/family maximum</td>
<td>$900/person; $2,700/family maximum</td>
</tr>
<tr>
<td>Plan year out-of-pocket maximum</td>
<td>$3,000/person; $6,000/family maximum</td>
<td>$8,000/person; $16,000/family maximum</td>
</tr>
<tr>
<td>Lifetime maximum benefit</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

### Prescription drug (administered by Express Scripts)

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

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

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

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

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

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

<table>
<thead>
<tr>
<th></th>
<th>Generic</th>
<th>Brand name (preferred)</th>
<th>Brand name (non-preferred)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100% after $12 copay</td>
<td>100% after $65 copay</td>
<td>100% after $125 copay</td>
</tr>
<tr>
<td></td>
<td>100% after $12 copay</td>
<td>80% covered — you pay 20% ($65 minimum; $130 maximum)</td>
<td>60% covered — you pay 40% ($125 minimum; $250 maximum)</td>
</tr>
<tr>
<td>Brand name (when generic is available)</td>
<td>Brand name copay plus the difference in cost between the brand name and the equivalent generic</td>
<td>Brand name coinsurance plus the difference in cost between the brand name and the equivalent generic</td>
<td></td>
</tr>
</tbody>
</table>
For the following covered treatments and services, the PPO Options pay:

### Doctor visits (other than preventive care)*

<table>
<thead>
<tr>
<th>Service</th>
<th>PPO Options Pay</th>
<th>Medicare Pay</th>
<th>Medicare Pay 60%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care office visit</td>
<td>100% after $20 copay, no deductible</td>
<td>60%</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td>Note: surgery is covered at 80% after deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist office visit</td>
<td>100% after $30 copay, no deductible</td>
<td>60%</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td>Note: surgery is covered at 80% after deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral health office visit</td>
<td>100% after $20 copay, no deductible</td>
<td>60%</td>
<td>80%</td>
</tr>
<tr>
<td>Maternity services</td>
<td>100%, no deductible/copay (prenatal); 80% after deductible (post-natal)</td>
<td>60%</td>
<td>100%, no deductible/copay (prenatal); 80% after deductible (post-natal)</td>
</tr>
<tr>
<td>Lab and X-ray</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
</tr>
</tbody>
</table>

### Preventive care*<sup>a</sup>,<sup>h</sup>

<table>
<thead>
<tr>
<th>Service</th>
<th>PPO Options Pay</th>
<th>Medicare Pay</th>
<th>Medicare Pay 60%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine physicals</td>
<td>100%, no copay, no deductible</td>
<td>60%</td>
<td>100%, no copay, no deductible</td>
</tr>
<tr>
<td>Annual well-woman exams</td>
<td>100%, no copay, no deductible</td>
<td>60%</td>
<td>100%, no copay, no deductible</td>
</tr>
<tr>
<td>Mammograms (routine)</td>
<td>100%, no copay, no deductible</td>
<td>60%</td>
<td>100%, no copay, no deductible</td>
</tr>
<tr>
<td>Gestational diabetes screening</td>
<td>100%, no copay, no deductible</td>
<td>60%</td>
<td>100%, no copay, no deductible</td>
</tr>
<tr>
<td>Prostate Specific Antigen (PSA)</td>
<td>100%, no copay, no deductible</td>
<td>60%</td>
<td>100%, no copay, no deductible</td>
</tr>
<tr>
<td>tests (routine)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colorectal screenings (routine)</td>
<td>100%, no copay, no deductible</td>
<td>60%</td>
<td>100%, no copay, no deductible</td>
</tr>
<tr>
<td>Well-child care (routine)</td>
<td>100%, no copay, no deductible</td>
<td>60%</td>
<td>100%, no copay, no deductible</td>
</tr>
</tbody>
</table>

### Emergency services*<sup>e</sup>

<table>
<thead>
<tr>
<th>Service</th>
<th>PPO Options Pay</th>
<th>Medicare Pay</th>
<th>Medicare Pay 60%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency room (applies to facility charges only)&lt;sup&gt;i&lt;/sup&gt;</td>
<td>80% after $150 copay, no deductible</td>
<td>80% after $150 copay, no deductible</td>
<td>80% after $150 copay, no deductible</td>
</tr>
<tr>
<td>Ambulance</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Urgent care facility (applies to facility charges only)</td>
<td>100% after $30 copay, no deductible</td>
<td>60%</td>
<td>80%</td>
</tr>
</tbody>
</table>

### Outpatient services*<sup>e</sup> (services provided other than in a doctor’s office)

14/Jul/19 20:40The most up-to-date information is available online at http://hr.bpglobal.com/lifebenefits/RetireeNonMedicarePage 26 of 209
<table>
<thead>
<tr>
<th>Service Description</th>
<th>80%</th>
<th>60%</th>
<th>80%</th>
<th>60%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient surgery facility</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Hospital outpatient services</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Doctor/surgeon and related professional fees</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Behavioral health outpatient treatment (other than office visit)</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Lab</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>X-ray</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Radiation therapy/chemotherapy</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Inpatient hospital services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Room and board (semi-private room)</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Inpatient behavioral health stay, including residential treatment and partial hospitalization</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Doctor hospital visits</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Lab and X-ray</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Alternatives to inpatient hospital care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled nursing facility (up to 60 days/plan year)</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Home health care (limited to 120 visits/plan year)</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Hospice care</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Outpatient private duty nursing (up to 70 shifts/plan year)</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Other covered services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractic care (including lab/X-ray provided by a chiropractor); up to 20 visits/plan year</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Contraceptive administration (includes coverage for all contraceptive devices including the associated office visit)</td>
<td>100%, no deductible</td>
<td>60%</td>
<td>100%, no deductible</td>
<td>60%</td>
</tr>
<tr>
<td>Durable medical equipment, orthotics, consumable medical supplies</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Prosthetic appliances (including external breast prostheses, wigs)</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Breast pumps and supplies (electronic breast pump limited to one per 36 months)</td>
<td>100%, no deductible</td>
<td>60%</td>
<td>100%, no deductible</td>
<td>60%</td>
</tr>
<tr>
<td>Lactation consultation</td>
<td>100%, no deductible/copay for first 6 visits; then primary care/specialist</td>
<td>60%</td>
<td>100%, no deductible/copay for first 6 visits; then 80% after</td>
<td>60%</td>
</tr>
</tbody>
</table>
### Benefits are subject to recognized charge limits.

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

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

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

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

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

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

Except for routine physicals, which are covered annually, preventive care benefits are subject to age restrictions/limitations as determined under guidelines established by Aetna. For additional information about covered preventive care benefits, contact Aetna Member Services at 1-866-436-2606.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>80%</th>
<th>60%</th>
<th>80%</th>
<th>60%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infertility treatment (limited to diagnostic testing and corrective surgery)</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Sterilization (female tubal ligation)</td>
<td>100% covered, no deductible/copay; includes ancillary services</td>
<td>60%</td>
<td>100% covered, no deductible/copay; includes ancillary services</td>
<td>60%</td>
</tr>
<tr>
<td>Sterilization (male vasectomy)</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Outpatient rehabilitation (physical/speech/occupational therapy) and cardiac rehabilitation (A combined maximum of 60 visits per plan year applies, with no medical review required. Additional visits are not allowed.)</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Coverage for autism spectrum disorders, including physical therapy/occupational therapy/speech therapy (PT/OT/ST visit limit applies)</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Applied Behavioral Analysis (ABA) (requires precertification)</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>TMJ (medical treatment for TMJ covered; TMJ-related dental services and orthodontic appliances not covered)</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
</tbody>
</table>

a Benefits are subject to recognized charge limits.

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

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

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

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

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

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

h Except for routine physicals, which are covered annually, preventive care benefits are subject to age restrictions/limitations as determined under guidelines established by Aetna. For additional information about covered preventive care benefits, contact Aetna Member Services at 1-866-436-2606.

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

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

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

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

m Deductible waived for diabetic insulin pumps and tubing.

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

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

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

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

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

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

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

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

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

Primary doctors

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

Primary doctors are:

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

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

How to choose a network provider

The most up-to-date information is available online at http://hr.bpglobal.com/lifebenefits/RetireeNonMedicarePage 30 of 209
To learn more about the providers who participate in the Aetna Choice POS II Network, access BP’s custom DocFind website or call Aetna Member Services at 1-866-436-2606.

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

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

If your dependents live away from home

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

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

Transition care benefits

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

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

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

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

Network providers

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

- Covered office visit expenses are covered at:
  - 100% after you pay a copay, with no deductible, by the HealthPlus PPO Option.
  - 80% after the deductible by the Standard PPO Option.
  - 100% after you pay a copay, and after you meet the deductible, by the Health+Savings PPO Option.

- Under all PPO Options, in-network preventive care is covered at 100% with no copay and no deductible.

- Emergency room facility charges are paid at:
  - 80% after a copay, with no deductible, by the HealthPlus and Standard PPO Options.
  - 80% after a copay, and after you meet the deductible, by the Health+Savings PPO Option.

- Most other covered in-network services are paid at 80% of the contracted rate for other covered expenses after you meet the individual or family plan year deductible, and you pay the remaining portion of the charges (the coinsurance).

- Once you meet the plan year network out-of-pocket maximum, the PPO Options pay 100% of the contracted rate for covered expenses for the rest of the plan year.

See the applicable summary chart (HealthPlus and Standard PPOs or Health+Savings PPO) for more information.

Out-of-network providers

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

Once you meet the plan year out-of-network out-of-pocket maximum, each PPO Option pays 100% of recognized charges for most covered expenses for the rest of the plan year.

If you use a network hospital or doctor in Aetna’s NAP for a covered expense, you may receive the advantage of contracted rates, however, if those providers are not in the Aetna Choice POS II Network, the charges will be considered out-of-network. (See National Advantage Program (NAP).)
**Deductibles**

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

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

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

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

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

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

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

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

**Expenses excluded from the deductibles**

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

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

**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, 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 Medicare HMO, or to the BP Medicare Advantage PPO ESA.

14/Jul/19 20:40 The most up-to-date information is available online at http://hr.bpglobal.com/lifebenefits/RetireeNonMedicarePage 33 of 209
A “copay” is a fixed dollar amount you pay in lieu of a deductible and coinsurance at the time you receive medical services. When you see a network provider, copays apply to:

### Office visits for non-preventive care under the HealthPlus and Health+ Savings PPO Options

<table>
<thead>
<tr>
<th>Note: Under the Health+Savings PPO Option only, you must satisfy the applicable individual or family deductible first before the office visit copay will apply for these services. (The individual deductible applies if you have Personal coverage. The family deductible applies if you have Personal + dependents coverage.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The office visit copay includes:</td>
</tr>
<tr>
<td>- The doctor office visit.</td>
</tr>
<tr>
<td>- Diagnostic laboratory tests or X-rays performed in a doctor’s office and billed as part of the visit.</td>
</tr>
<tr>
<td>- Injections administered in a doctor’s office as part of the visit (including allergy injections).</td>
</tr>
<tr>
<td>The office visit copay does not apply to:</td>
</tr>
<tr>
<td>- Office visits if a surgical procedure as defined by Aetna is performed as part of the visit (for example, if a mole is removed or a broken bone is set during the office visit).</td>
</tr>
<tr>
<td>- Prenatal maternity-related office visits (except for the first office visit to confirm the pregnancy). These visits are included in the delivery charge. However, post-natal maternity services are covered at 80% after the deductible.</td>
</tr>
<tr>
<td>- Routine and diagnostic laboratory tests or X-rays performed:</td>
</tr>
<tr>
<td>- In a doctor’s office, but not at the time of the visit.</td>
</tr>
<tr>
<td>- In a facility other than the doctor’s office.</td>
</tr>
<tr>
<td>- By an entity other than the doctor’s office.</td>
</tr>
<tr>
<td>(Ask your doctor whether the lab facilities he/she uses are in the network.)</td>
</tr>
<tr>
<td>- Chiropractic visits.</td>
</tr>
</tbody>
</table>

### Emergency room facility charges

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

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

### Urgent care facility charges under the HealthPlus and Health+Savings PPO Options

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

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

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

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

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

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

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

Publication date: April 2019
Out-of-pocket maximums

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

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

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

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

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

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

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, 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.

Publication date: April 2019
The HealthPlus, Standard and Health+Savings Options include special plan provisions. These important features include preventive care, recognized charge limits, precertification requirements and more. More information about each of these features is outlined in this section.

- Preventive care
- Emergency care
- Recognized charge limits
- Aetna's National Advantage Program (NAP)
- Transplant services
- Precertification requirements
- Coverage while traveling
- Alternatives to physician office visits
- Teladoc
- Enhanced Aetna Concierge

Publication date: April 2019
Preventive care

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

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

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

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

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

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

Publication date: April 2019
Emergency care

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

Emergency medical condition

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

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

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

Emergency services

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

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

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

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

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

Publication date: April 2019
Recognized charge limits

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

Recognized charge limits do not apply to:

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

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

- What the provider bills or submits for that service or supply; and
- The charge the claims administrator determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made, billed or coded.
  - For non-facility charges:
    - PPO Options: The 85th percentile of the Prevailing Charge Rate, for the Geographic Area where the service is furnished.
    - OOA Options: Twice the 95th percentile of the Prevailing Charge Rate, for the Geographic Area where the service is furnished.
  - For facility charges:
    - PPO Options: 150% of the Medicare Fee Schedule for the Geographic Area where the service is furnished.
    - OOA Options: Aetna uses the charge Aetna determines to be the usual charge level made for it in the Geographic Area where it was furnished.

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

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

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

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

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

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

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

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

NAP ancillary providers include:

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

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

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

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

Publication date: April 2019
Transplant services

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

For the PPO Options:

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

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

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

Out-of-country care

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

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

Publication date: April 2019
The decision to receive care is between you and your provider. If you do not precertify care when you are required to do so, your benefits will be reduced, or in some instances, not paid at all.

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

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

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

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

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

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

- **Enhanced clinical review (NOTE: Applies only to Aetna PPO Options).** Certain services (listed below) are subject to enhanced clinical review through a separate independent company. This company uses medical specialists and diagnostic tools to review your doctor’s request, applying national medical standards, with the initial review accomplished typically within 24 hours of the request. Your doctor should submit a request for clinical review for the following services:

  - Cardiac imaging, including non-urgent outpatient diagnostic catheterization and echo stress tests.
  - Cardiac rhythm implantable devices.
  - Sleep studies.
  - Radiation oncology therapy.
  - High-tech radiology, including MRI/MRA, CT scan, PET scan and nuclear imaging.
  - Outpatient interventional pain management.
  - Hip and knee replacements (inpatient and outpatient).

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

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

- **Partial hospitalization or a day program.** Outpatient care focused on psychiatric, eating disorder care and/or substance abuse care that is generally four or more hours per day and includes individual, group and family therapies must be precertified in advance by calling the claims administrator at the toll-free precertification number shown on your medical option ID card.
Electroconvulsive therapy treatment (ECT). ECT is systematic use of electric shocks to produce convulsions. Care must be precertified in advance by calling the claims administrator at the toll-free precertification number shown on your medical option ID card.

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

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

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

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

Precertification penalties

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

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

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

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

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

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

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

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

Walk-in clinic visits

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

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

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

- In a group setting for screening and counseling services.

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

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

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

How to use Teladoc

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

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

Publication date: April 2019
Enhanced Aetna Concierge

How the Enhanced Aetna Concierge program works

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

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

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

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

How to reach Enhanced Aetna Concierge

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

Publication date: April 2019
The medical plans all offer prescription drug coverage. Under the HealthPlus, Standard and Health+Savings Options, the Prescription Drug Program is administered by Express Scripts (ESI).

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

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

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

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

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

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

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

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

The ESI formulary excludes certain drugs from coverage. However, ESI provides preferred alternatives to all non-covered drugs that achieve similar results.

Excluded products are not covered by the plan. An exception process exists for participants, but you will need a qualified medical necessity, which must be evidenced in writing from your doctor. If you believe you are in need of this exception following a denial, you will be provided a form to appeal this decision along with the denial. If you have any questions about this process, please contact Express Scripts at the number listed later in this document or the BP HR & Benefits Center.

The Prescription Drug Program includes a Generic Preferred Program, which is designed to encourage use of generic medications to lower prescription drug costs.

If a generic equivalent drug is available and you choose the brand name medication rather than the generic option, you will pay the brand name copay/coinsurance plus the difference between the cost of the brand name medication and the equivalent generic medication. The additional cost applies regardless of whether your doctor prescribes a brand name drug. Note: For the Health+Savings Option, you will still be required to satisfy the medical deductible first before you pay your applicable prescription drug copay.
If a prescription drug does not have a generic equivalent available, you will be charged the brand name copay (preferred or non-preferred, depending on the drug). Please note that the information on the formulary drug list is not BP-specific, and not all of the preferred drugs covered may be listed nor does BP cover all the drugs that may be listed. If you do not see your drug listed, contact Express Scripts for coverage information.

**Drug utilization management**

The Prescription Drug program also includes a Drug Utilization Management Program, designed to help you make more cost-effective drug choices. The program has three components: prior authorization, step therapy and drug quantity management:

**Prior authorization**

Prior authorization is a program that monitors certain prescription drugs and their costs to get you the medication you require while reducing costs. If you’re prescribed a certain medication, that drug may need a “prior authorization.” This program helps to make sure you’re getting a prescription that is covered by your pharmacy benefit.

Your own medical professionals are consulted, since your plan will cover it only when your doctor prescribes it to treat a medical condition that will promote your health and wellness. When your pharmacist tells you that your prescription needs a prior authorization, it simply means that more information is needed to see if your plan covers the drug. Only your physician can provide this information and request a prior authorization.

**Step therapy**

Step therapy is designed for people who regularly take prescription drugs to treat ongoing medical conditions, such as arthritis, asthma or high blood pressure.

**How does step therapy work?** Prescription medications are grouped into categories:

- **Step 1 medications** are generic drugs that have been approved by the U.S. Food & Drug Administration (FDA). This program will look to see if these medications are prescribed first, since many generics can provide the same health benefits as more-expensive medications but at a lower cost.

- **Step 2 medications** are brand-name drugs such as those you see advertised on TV. They’re approved for coverage only if a Step 1 medication doesn’t work for you. Step 2 medications almost always cost more.

**What if your doctor prescribes a Step 2 medication?** Ask if a generic (Step 1) medication may be right for you. Please share your formulary – the list of prescription drugs covered by your plan – with your doctor. The pharmacy will not automatically change your prescription; your doctor must write a new prescription for you to change from a Step 2 medication to a Step 1 medication, or indicate that a generic can be substituted for the brand name drug, as many providers already do. If a Step 1 medication is not a good choice for you, your doctor can request prior authorization from Express Scripts to determine if a Step 2 medication will be covered by your plan.

**Drug quantity management**

Certain drugs will have quantity limits in order to help promote economical use. The program follows guidelines developed by the U.S. Food and Drug Administration (FDA).

Here is how the program works at the pharmacy:

- When your pharmacist attempts to fill your prescription, the pharmacist will get a message about any applicable quantity limitations for the quantity prescribed. This could mean:
  - You are getting your refill too soon; that is, you should still have medicine left from your last supply. In this case, ask your pharmacist when it will be time to get a refill; or
  - Your physician wrote you a prescription for a quantity larger than the plan covers.

- If the quantity on your prescription is more than the plan allows, you can:
  - Have your pharmacist fill your prescription as written, for the amount the plan covers and pay the appropriate copayment or coinsurance amount. If you would like the additional quantity prescribed, you have the option to pay the full price.
  - Ask your pharmacist to call your physician. They can discuss changing your prescription to a higher strength or different quantity, if available.
  - Ask your pharmacist to contact your physician about getting a “prior authorization.” That is, your physician can call Express Scripts to request that you receive the original quantity and strength he/she prescribed. Express Scripts’ prior authorization is available to your physician, 24 hours a day, seven days a week, so a determination can be made right away.
For home delivery, the Express Scripts Home Delivery Pharmacy will try to contact your physician to discuss the prior authorization review process. If the Express Scripts Home Delivery Pharmacy does not hear back from your physician within two days, they will fill your prescription for the quantity covered by the plan. If a higher strength is not available, or the plan does not provide a prior authorization for a higher quantity, the Home Delivery Pharmacy can fill your prescription for the quantity that the plan covers. For more information about quantity limits under the plan, visit www.express-scripts.com or call Express Scripts.

You should review the medications prescribed to you with your doctor and discuss whether a generic medication may be right for you. Should your doctor determine a generic medication is not right for you, an exception process exists when you have a qualified medical necessity and at the request of your doctor. The program procedures typically take place with your doctor before you fill your prescription. You should inform your doctor of any required steps at the time he or she recommends any prescriptions to you.

### Prescription drug summary chart

<table>
<thead>
<tr>
<th>Prescription Drug</th>
<th>HealthPlus Option</th>
<th>Standard Option</th>
<th>Health+Savings Option</th>
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<tbody>
<tr>
<td></td>
<td>Retail&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Home Delivery</td>
<td>Retail&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Rx Deductible</td>
<td>No separate Rx deductible</td>
<td>$75/person; $225/family</td>
<td>No separate Rx deductible; Rx subject to medical plan deductible</td>
</tr>
<tr>
<td><strong>Copay&lt;sup&gt;b&lt;/sup&gt;/Coinsurance</strong></td>
<td></td>
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<td></td>
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<tr>
<td>Generic</td>
<td>$5 copay</td>
<td>$12 copay</td>
<td>$5 copay</td>
</tr>
<tr>
<td>Brand name (preferred)</td>
<td>$25 copay</td>
<td>$65 copay</td>
<td>20%; $25 minimum; $50 maximum</td>
</tr>
<tr>
<td>Brand name (non-preferred)</td>
<td>$45 copay</td>
<td>$125 copay</td>
<td>40%; $45 minimum; $100 maximum</td>
</tr>
<tr>
<td>Brand name (when generic is available)&lt;sup&gt;c&lt;/sup&gt;</td>
<td>Brand name copay plus the difference in cost between the brand name and the equivalent generic</td>
<td>Brand name coinsurance plus the difference in cost between the brand name and the equivalent generic</td>
<td>Deductible, then brand name copay plus the difference in cost between the brand name and the equivalent generic</td>
</tr>
</tbody>
</table>

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

<sup>b</sup> You always pay the lesser of the actual cost of your prescription or the copay.

<sup>c</sup> When paying the brand name copay/coinsurance plus the difference in cost between the brand name and equivalent generic, your cost will not exceed the negotiated cost of the brand name medication.

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

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

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

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, 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.

Inpatient care and your prescription benefit (Out-of-network facilities)

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

Prescriptions covered without deductibles or copays

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

- FDA-approved women’s contraception.
- Certain generic preventive prescriptions (applies to the Health+Savings Options only).
- Generic and over-the-counter medications that are prescribed for use in cleansing the bowel as a preparation for screening colonoscopy.
Retail pharmacy network

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

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

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

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

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

If you are enrolled in the Health+Savings Option, you may use your PayFlex Card® (your HSA debit card) to pay for eligible prescription drug expenses at a participating retail pharmacy.

Publication date: April 2019
Home delivery program

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

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

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

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

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

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

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

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

If you are enrolled in the Health+Savings Option, you may use your PayFlex Card® (your HSA debit card) to pay for eligible prescription drug expenses you incur through the home delivery program.
Specialty pharmacy

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

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

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.

Copays for specialty medications

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

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

Publication date: April 2019
Drugs not covered

The Prescription Drug Program does not pay benefits for:

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

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

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

See Expenses not covered under the BP NonMedicare-Eligible Option (NMEO) for all other limitations and exclusions.

Publication date: April 2019
A note about Medicare and prescription drug coverage

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

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

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

Publication date: April 2019
The Health+Savings PPO Option is available only if you live in an area where the Aetna Choice POS II network is available; otherwise, the Out-of-Area Option is available to you.

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

<table>
<thead>
<tr>
<th>Health+Savings PPO Option summary chart</th>
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<tbody>
<tr>
<td><strong>General information</strong></td>
<td><strong>Health+Savings PPO Option</strong></td>
<td><strong>2019/2020 Plan Year</strong></td>
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<tr>
<td>Network</td>
<td>Out-of-Network&lt;sup&gt;a,b&lt;/sup&gt;</td>
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<tr>
<td><strong>Plan year deductible&lt;sup&gt;c,d&lt;/sup&gt;</strong></td>
<td><strong>$1,500 if you have</strong></td>
<td><strong>$3,000 if you have</strong></td>
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<tr>
<td><strong>Personal coverage</strong></td>
<td><strong>Personal coverage;</strong></td>
<td><strong>Personal coverage;</strong></td>
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<tr>
<td><strong>$3,000 if you have</strong></td>
<td><strong>$6,000 if you have</strong></td>
<td><strong>$6,000 if you have</strong></td>
</tr>
<tr>
<td><strong>Personal + dependents coverage</strong></td>
<td><strong>Personal + dependents</strong></td>
<td><strong>Personal + dependents</strong></td>
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<tr>
<td><strong>See Deductibles for more information</strong></td>
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<tr>
<td><strong>Plan year out-of-pocket maximum&lt;sup&gt;c,d&lt;/sup&gt;</strong></td>
<td><strong>$3,000 if you have</strong></td>
<td><strong>$8,000 if you have</strong></td>
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<td><strong>Personal coverage;</strong></td>
<td><strong>Personal coverage;</strong></td>
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<td><strong>$6,000 if you have</strong></td>
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<td><strong>See Out-of-pocket maximums for more information</strong></td>
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<tr>
<td><strong>Lifetime maximum benefit</strong></td>
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<td>None</td>
</tr>
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</table>

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

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

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

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

**Generic – non-preventive**: After medical deductible is met, 100% after $5 copay (deductible and copay waived for certain generic preventive)

**Brand name (preferred)**: After medical deductible is met, 100% after $25 copay

**Brand name (non-preferred)**: After medical deductible is met, 100% after $45 copay

**Brand name (when generic is available)**: After medical deductible is met, brand name copay plus the difference in cost between the brand name and the equivalent generic

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

**Generic – non-preventive**: After medical deductible is met, 100% after $12 copay (deductible and copay waived for certain generic preventive)

**Brand name (preferred)**: After medical deductible is met, 100% after $65 copay

**Brand name (non-preferred)**: After medical deductible is met, 100% after $125 copay
For the following covered treatments and services, the Health+Savings PPO Option pays

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<tr>
<th>Doctor visits (other than preventive care)</th>
<th>Brand name (when generic is available)</th>
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</thead>
<tbody>
<tr>
<td>Primary care office visit</td>
<td>After medical deductible is met, brand name copay plus the difference in cost between the brand name and the equivalent generic</td>
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<tr>
<td>Specialist office visit</td>
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<tr>
<td>Behavioral health office visit</td>
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<tr>
<td>Maternity services</td>
<td></td>
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<tr>
<td>Lab and X-ray</td>
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<thead>
<tr>
<th>Preventive care</th>
<th>Brand name (when generic is available)</th>
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<tr>
<td>Routine physicals</td>
<td>After medical deductible is met, brand name copay plus the difference in cost between the brand name and the equivalent generic</td>
</tr>
<tr>
<td>Annual well-woman exams</td>
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<tr>
<td>Mammograms (routine)</td>
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<tr>
<td>Gestational diabetes screening</td>
<td></td>
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<tr>
<td>Prostate Specific Antigen (PSA) tests (routine)</td>
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<tr>
<td>Colorectal screenings (routine)</td>
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<tr>
<td>Well-child care (routine)</td>
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<thead>
<tr>
<th>Emergency services</th>
<th>Brand name (when generic is available)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency room (applies to facility charges only)</td>
<td>After medical deductible is met, brand name copay plus the difference in cost between the brand name and the equivalent generic</td>
</tr>
<tr>
<td>Ambulance</td>
<td></td>
</tr>
<tr>
<td>Urgent care facility (applies to facility charges only)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatient services</th>
<th>Brand name (when generic is available)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient surgery facility</td>
<td></td>
</tr>
<tr>
<td>Hospital outpatient services</td>
<td></td>
</tr>
<tr>
<td>Doctor/surgeon and related professional fees</td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Percent Covered</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Behavioral health outpatient treatment (other than office visit)</td>
<td>80%</td>
</tr>
<tr>
<td>Lab</td>
<td>80%</td>
</tr>
<tr>
<td>X-ray</td>
<td>80%</td>
</tr>
<tr>
<td>Radiation therapy/chemotherapy</td>
<td>80%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inpatient hospital services&lt;sup&gt;e&lt;/sup&gt;</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Room and board (semi-private room)</td>
<td>80%</td>
<td>60%&lt;sup&gt;g,k&lt;/sup&gt;</td>
</tr>
<tr>
<td>Inpatient behavioral health stay, including residential treatment and partial hospitalization</td>
<td>80%</td>
<td>60%&lt;sup&gt;g,k&lt;/sup&gt;</td>
</tr>
<tr>
<td>Doctor hospital visits</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Lab and X-ray</td>
<td>80%</td>
<td>60%&lt;sup&gt;g&lt;/sup&gt;</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>80%</td>
<td>60%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Alternatives to inpatient hospital care&lt;sup&gt;e&lt;/sup&gt;</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled nursing facility (up to 60 days/plan year)&lt;sup&gt;l&lt;/sup&gt;</td>
<td>80%</td>
<td>60%&lt;sup&gt;g,k&lt;/sup&gt;</td>
</tr>
<tr>
<td>Home health care (limited to 120 visits/plan year)&lt;sup&gt;l&lt;/sup&gt;</td>
<td>80%</td>
<td>60%&lt;sup&gt;k&lt;/sup&gt;</td>
</tr>
<tr>
<td>Hospice care</td>
<td>80%</td>
<td>60%&lt;sup&gt;g,k&lt;/sup&gt;</td>
</tr>
<tr>
<td>Outpatient private duty nursing (up to 70 shifts/plan year)&lt;sup&gt;l&lt;/sup&gt;</td>
<td>80%</td>
<td>60%&lt;sup&gt;k&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other covered services&lt;sup&gt;e&lt;/sup&gt;</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic care (including lab/X-ray provided by a chiropractor); up to 20 visits/plan year&lt;sup&gt;l&lt;/sup&gt;</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Contraceptive administration (includes coverage for all contraceptive devices including the associated office visit)</td>
<td>100%, no deductible</td>
<td>60%</td>
</tr>
<tr>
<td>Durable medical equipment, orthotics, consumable medical supplies&lt;sup&gt;m&lt;/sup&gt;</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Prosthetic appliances (including external breast prostheses, wigs)</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Breast pumps and supplies (electronic breast pump limited to one per 36 months)</td>
<td>100%, no deductible</td>
<td>60%</td>
</tr>
<tr>
<td>Lactation consultation</td>
<td>100%, no deductible/copay for first 6 visits; then deductible and primary care/specialist copay applies (deductible and coinsurance apply if not part of office visit)</td>
<td>60%</td>
</tr>
<tr>
<td>Infertility treatment (limited to diagnostic testing and corrective surgery)</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Sterilization (female tubal ligation)</td>
<td>100% covered, no deductible/copay; includes ancillary services</td>
<td>60%</td>
</tr>
<tr>
<td>Sterilization (male vasectomy)</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Outpatient rehabilitation (physical/speech/occupational therapy) and cardiac rehabilitation (A combined maximum of 60 visits per plan year applies to physical, speech and occupational therapy, with no medical review required. Additional visits are not covered.)&lt;sup&gt;o&lt;/sup&gt;</td>
<td>80%</td>
<td>60%</td>
</tr>
</tbody>
</table>
Benefits are subject to recognized charge limits.
You may need to pay the full amount and submit a claim for reimbursement to Aetna.
Covered network expenses do not apply to the plan year out-of-network deductible or out-of-pocket maximum, and covered out-of-network expenses do not apply to the plan year network deductible or out-of-pocket maximum.
Precertification penalties and amounts above recognized charges do not apply to the plan year deductible or out-of-pocket maximum. Office visit copays and emergency room/urgent care facility copays do not apply to the plan year deductible; however, they do apply to the out-of-pocket maximum. Prescription drug expenses apply to the plan year deductible and out-of-pocket maximum.
Unless otherwise noted, benefits paid at 80% or 60% are paid after the plan year deductible has been met.
The office visit copay covers lab and X-ray charges performed in a doctor’s office and billed as part of the visit. When these services are not performed at the time of the office visit, performed at another network facility or performed by a network entity other than the doctor’s office, you must first meet your deductible and then the expense, if covered, would be paid at 80%.
For facility charges and non-emergency admissions, reimbursement is limited to 60%, with a maximum allowed amount of 1.5 times the Medicare Fee Schedule for that area.
Except for routine physicals, which are covered annually, preventive care benefits are subject to age restrictions/limitations as determined under guidelines established by Aetna. For additional information about covered preventive care benefits, contact Aetna Member Services at 1-866-436-2606.
Includes all tests (e.g., lab work, X-rays) associated with the visit and all office-based procedures.
Non-facility charges for emergency services incurred in the emergency room are paid at applicable network levels.
Precertification required; benefits may be reduced or denied if precertification not obtained.
The visit/plan year limit applies to total of both network and out-of-network visits.
Deductible waived for diabetic insulin pumps and tubing.
The following in-network services require precertification: cardiac imaging (including non-urgent outpatient diagnostic heart catheterizations and echo stress tests); cardiac rhythm implantable devices; sleep studies; high-tech radiology (e.g., MRI/MRA, CT scans, PET scans and nuclear imaging); radiation oncology therapy.
Speech therapy is subject to medical review if one of the following circumstances exist: developmentally delayed due to an injury or sickness (other than a functional nervous disorder); diagnosis of chronic otitis media; or a congenital defect for which corrective surgery has been performed.

Publication date: April 2019
How the PPO Options work

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

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

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

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

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

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

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

**Primary doctors**

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

Primary doctors are:

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

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

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

Keep in mind that network providers occasionally change, so you will want to make sure the provider you choose is still in the network and at the location you would like to visit before you make an appointment. For the most up-to-date information, including whether a provider is accepting new patients, call the provider. If Aetna determines in a particular case that there is no viable Aetna Choice POS II network provider option available, Aetna may treat a non-network provider as if it were an in-network provider until a viable Choice POS II network provider becomes available. In order for this special treatment to apply, the alleged provider deficiency must be raised with Aetna Member Services in advance of treatment and Aetna must agree with the special treatment.

If your dependents live away from home

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

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

Transition care benefits

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

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

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

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

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

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

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

Who can contribute to an HSA

You are eligible for an HSA if you are:

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

How to enroll

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

To access your account information, log on to the Aetna website at www.aetna.com using your Aetna login information. Your HSA Information will be accessible through the website. See the HSA Quick Reference Guide for tips on how to manage your account online.

You can start, stop and change your contribution amount at any time, as long as you don’t exceed the annual maximum.

Note that if you dis-enroll from the Health+Savings Option during a calendar year, this could have a retroactive effect on the tax-free nature of some of your HSA contributions. You should consult a tax advisor for any tax issues related to the HSA. Also, if you are eligible for the BP Retiree Reimbursement Account (RRA), you will automatically be placed into the limited RRA reimbursement option, otherwise you would not be able to contribute to an HSA.
Your contributions to your HSA

To contribute to your HSA, you can mail a deposit coupon and payment directly to PayFlex, our HSA administrator. Use the HSA Contribution Coupon to deposit new funds via check.

For the 2019 calendar year, the IRS allows up to $3,500 to be contributed for retiree-only coverage and up to $7,000 for family coverage.

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

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

You claim your contributions to your HSA on your tax return at the end of the year to get your tax savings.

Investment of your HSA

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

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

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

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

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

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

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

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

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

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

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

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

**Eligible expenses**

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

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

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

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

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

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

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

The money in your HSA account is always yours. You can transfer it to another HSA account or keep it with PayFlex, paying any required administrative fees.

Publication date: April 2019
What the PPO Options pay

Network providers

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

- Covered office visit expenses are covered at:
  - 100% after you pay a copay, with no deductible, by the HealthPlus PPO Option.
  - 80% after the deductible by the Standard PPO Option.
  - 100% after you pay a copay, and after you meet the deductible, by the Health+Savings PPO Option.
- Under all PPO Options, in-network preventive care is covered at 100% with no copay and no deductible.
- Emergency room facility charges are paid at:
  - 80% after a copay, with no deductible, by the HealthPlus and Standard PPO Options.
  - 80% after a copay, and after you meet the deductible, by the Health+Savings PPO Option.
- Most other covered in-network services are paid at 80% of the contracted rate for other covered expenses after you meet the individual or family plan year deductible, and you pay the remaining portion of the charges (the coinsurance).
- Once you meet the plan year network out-of-pocket maximum, the PPO Options pay 100% of the contracted rate for covered expenses for the rest of the plan year.

See the applicable summary chart (HealthPlus and Standard PPOs or Health+Savings PPO) for more information.

Out-of-network providers

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

Once you meet the plan year out-of-network out-of-pocket maximum, each PPO Option pays 100% of recognized charges for most covered expenses for the rest of the plan year.

If you use a network hospital or doctor in Aetna’s NAP for a covered expense, you may receive the advantage of contracted rates, however, if those providers are not in the Aetna Choice POS II Network, the charges will be considered out-of-network. (See National Advantage Program (NAP).)

Publication date: April 2019
Deductibles

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

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

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

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

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

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

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

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

Expenses excluded from the deductibles

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

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

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, 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 Medicare HMO, or to the BP Medicare Advantage PPO ESA.
Copays/coinsurance

Network providers

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

<table>
<thead>
<tr>
<th>Office visits for non-preventive care under the HealthPlus and Health+Savings PPO Options</th>
<th>Note: Under the Health+Savings PPO Option only, you must satisfy the applicable individual or family deductible first before the office visit copay will apply for these services. (The individual deductible applies if you have Personal coverage. The family deductible applies if you have Personal + dependents coverage.)</th>
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<tr>
<td></td>
<td>The office visit copay includes:</td>
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<td>The office visit copay does not apply to:</td>
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</table>

| Emergency room facility charges | Under the HealthPlus and Standard PPO Options, both network and out-of-network emergency room facility charges are covered at 80% after a copay, with no deductible. |
| Urgent care facility charges under the HealthPlus and Health+Savings PPO Options | Under the HealthPlus PPO Option, network urgent care facility charges are covered at 100% after a copay, with no deductible. |
|   | Under the Health+Savings PPO Option, network urgent care facility charges are covered at 100% after a copay, and after the deductible is met. |

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

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

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

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

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

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

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

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

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

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

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

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, 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.

Publication date: April 2019
The HealthPlus, Standard and Health+Savings Options include special plan provisions. These important features include preventive care, recognized charge limits, precertification requirements and more. More information about each of these features is outlined in this section.

- Preventive care
- Emergency care
- Recognized charge limits
- Aetna's National Advantage Program (NAP)
- Transplant services
- Precertification requirements
- Coverage while traveling
- Alternatives to physician office visits
- Teladoc
- Enhanced Aetna Concierge

Publication date: April 2019
Preventive care

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

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

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

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

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

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

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

Emergency medical condition

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

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

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

Emergency services

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

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

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

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

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

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

Recognized charge limits do not apply to:

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

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

- What the provider bills or submits for that service or supply; and
- The charge the claims administrator determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made, billed or coded.
  * For non-facility charges:
    - PPO Options: The 85th percentile of the Prevailing Charge Rate, for the Geographic Area where the service is furnished.
    - OOA Options: Twice the 95th percentile of the Prevailing Charge Rate, for the Geographic Area where the service is furnished.
  * For facility charges:
    - PPO Options: 150% of the Medicare Fee Schedule for the Geographic Area where the service is furnished.
    - OOA Options: Aetna uses the charge Aetna determines to be the usual charge level made for it in the Geographic Area where it was furnished.

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

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

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

Publication date: April 2019
The National Advantage Program (NAP) offers you access to Aetna-contracted rates for many hospital and doctor expenses that would otherwise be billed at the provider's normal rate. These include:

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

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

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

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

NAP ancillary providers include:

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

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

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

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

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

For the PPO Options:

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

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

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

Out-of-country care

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

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

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

If you are in a PPO Option and you use a network provider for covered medical care, the provider will take care of precertification for you.

If you use a NAP provider, confirm that the provider is obtaining precertification on your behalf; otherwise contact Aetna directly for precertification. (The NAP Program is a discount program and does not guarantee precertification.)

In all other instances, you are responsible for obtaining any required precertification.

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

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

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

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

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

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

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

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

- **Partial hospitalization or a day program.** Outpatient care focused on psychiatric, eating disorder care and/or substance abuse care that is generally four or more hours per day and includes individual, group and family therapies must be precertified in advance by calling the claims administrator at the toll-free precertification number shown on your medical option ID card.
Electroconvulsive therapy treatment (ECT). ECT is systematic use of electric shocks to produce convulsions. Care must be precertified in advance by calling the claims administrator at the toll-free precertification number shown on your medical option ID card.

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

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

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

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

Precertification penalties

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

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

2. **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.

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

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

Publication date: April 2019
Coverage while traveling

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

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

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

Publication date: April 2019
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.
Teladoc provides you with 24/7 telephonic access to a national network of U.S. board-certified doctors when enrolled in an Aetna medical plan. There is no additional cost to you for this service. You can call a physician from anywhere — home, work or on the road. Teladoc doctors diagnose non-emergency medical problems, recommend treatment, and can even call in any necessary prescription(s) to your pharmacy.

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

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

**How to use Teladoc**

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

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

Publication date: April 2019
Enhanced Aetna Concierge

How the Enhanced Aetna Concierge program works

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

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

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

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

How to reach Enhanced Aetna Concierge

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

Publication date: April 2019
Prescription drug coverage

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

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

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

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

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

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

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

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

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

The ESI formulary excludes certain drugs from coverage. However, ESI provides preferred alternatives to all non-covered drugs that achieve similar results.

Excluded products are not covered by the plan. An exception process exists for participants, but you will need a qualified medical necessity, which must be evidenced in writing from your doctor. If you believe you are in need of this exception following a denial, you will be provided a form to appeal this decision along with the denial. If you have any questions about this process, please contact Express Scripts at the number listed later in this document or the BP HR & Benefits Center.

The Prescription Drug Program includes a Generic Preferred Program, which is designed to encourage use of generic medications to lower prescription drug costs.

If a generic equivalent drug is available and you choose the brand name medication rather than the generic option, you will pay the brand name copay/coinsurance plus the difference between the cost of the brand name medication and the equivalent generic medication. The additional cost applies regardless of whether your doctor prescribes a brand name drug. Note: For the Health+Savings Option, you will still be required to satisfy the medical deductible first before you pay your applicable prescription drug copay.
If a prescription drug does not have a generic equivalent available, you will be charged the brand name copay (preferred or non-preferred, depending on the drug). Please note that the information on the formulary drug list is not BP-specific, and not all of the preferred drugs covered may be listed nor does BP cover all the drugs that may be listed. If you do not see your drug listed, contact Express Scripts for coverage information.

**Drug utilization management**

The Prescription Drug program also includes a Drug Utilization Management Program, designed to help you make more cost-effective drug choices. The program has three components: prior authorization, step therapy and drug quantity management:

**Prior authorization**

Prior authorization is a program that monitors certain prescription drugs and their costs to get you the medication you require while reducing costs. If you're prescribed a certain medication, that drug may need a “prior authorization.” This program helps to make sure you’re getting a prescription that is covered by your pharmacy benefit.

Your own medical professionals are consulted, since your plan will cover it only when your doctor prescribes it to treat a medical condition that will promote your health and wellness. When your pharmacist tells you that your prescription needs a prior authorization, it simply means that more information is needed to see if your plan covers the drug. Only your physician can provide this information and request a prior authorization.

**Step therapy**

Step therapy is designed for people who regularly take prescription drugs to treat ongoing medical conditions, such as arthritis, asthma or high blood pressure. **How does step therapy work?** Prescription medications are grouped into categories:

- **Step 1 medications** are generic drugs that have been approved by the U.S. Food & Drug Administration (FDA). This program will look to see if these medications are prescribed first, since many generics can provide the same health benefits as more-expensive medications but at a lower cost.
- **Step 2 medications** are brand-name drugs such as those you see advertised on TV. They're approved for coverage only if a Step 1 medication doesn't work for you. Step 2 medications almost always cost more.

**What if your doctor prescribes a Step 2 medication?** Ask if a generic (Step 1) medication may be right for you. Please share your formulary – the list of prescription drugs covered by your plan – with your doctor. The pharmacy will not automatically change your prescription; your doctor must write a new prescription for you to change from a Step 2 medication to a Step 1 medication, or indicate that a generic can be substituted for the brand name drug, as many providers already do. If a Step 1 medication is not a good choice for you, your doctor can request prior authorization from Express Scripts to determine if a Step 2 medication will be covered by your plan.

**Drug quantity management**

Certain drugs will have quantity limits in order to help promote economical use. The program follows guidelines developed by the U.S. Food and Drug Administration (FDA).

Here is how the program works at the pharmacy:

- When your pharmacist attempts to fill your prescription, the pharmacist will get a message about any applicable quantity limitations for the quantity prescribed. This could mean:
  - You are getting your refill too soon; that is, you should still have medicine left from your last supply. In this case, ask your pharmacist when it will be time to get a refill; or
  - Your physician wrote you a prescription for a quantity larger than the plan covers.

- If the quantity on your prescription is more than the plan allows, you can:
  - Have your pharmacist fill your prescription as written, for the amount the plan covers and pay the appropriate copayment or coinsurance amount. If you would like the additional quantity prescribed, you have the option to pay the full price.
  - Ask your pharmacist to call your physician. They can discuss changing your prescription to a higher strength or different quantity, if available.
  - Ask your pharmacist to contact your physician about getting a “prior authorization.” That is, your physician can call Express Scripts to request that you receive the original quantity and strength he/she prescribed. Express Scripts' prior authorization is available to your physician, 24 hours a day, seven days a week, so a determination can be made right away.
For home delivery, the Express Scripts Home Delivery Pharmacy will try to contact your physician to discuss the prior authorization review process. If the Express Scripts Home Delivery Pharmacy does not hear back from your physician within two days, they will fill your prescription for the quantity covered by the plan. If a higher strength is not available, or the plan does not provide a prior authorization for a higher quantity, the Home Delivery Pharmacy can fill your prescription for the quantity that the plan covers. For more information about quantity limits under the plan, visit www.express-scripts.com or call Express Scripts.

You should review the medications prescribed to you with your doctor and discuss whether a generic medication may be right for you. Should your doctor determine a generic medication is not right for you, an exception process exists when you have a qualified medical necessity and at the request of your doctor. The program procedures typically take place with your doctor before you fill your prescription. You should inform your doctor of any required steps at the time he or she recommends any prescriptions to you.

### Prescription drug summary chart

<table>
<thead>
<tr>
<th>Prescription Drug</th>
<th>HealthPlus Option</th>
<th>Standard Option</th>
<th>Health+Savings Option</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Retail&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Home Delivery</td>
<td>Retail&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Rx Deductible</td>
<td>No separate Rx deductible</td>
<td>$75/person; $225/family</td>
<td>No separate Rx deductible; Rx subject to medical plan deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Copay&lt;sup&gt;b&lt;/sup&gt;/Coinsurance</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>$5 copay</td>
<td>$12 copay</td>
<td>$5 copay</td>
</tr>
<tr>
<td></td>
<td>$25 copay</td>
<td>$65 copay</td>
<td>20%; $25 minimum; $50 maximum</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Deductible, then 100% after $5 copay, except for certain generic preventive covered at 100% with no copay or deductible</td>
</tr>
<tr>
<td>Brand name (preferred)</td>
<td>$25 copay</td>
<td>$65 copay</td>
<td>20%; $25 minimum; $50 maximum</td>
</tr>
<tr>
<td>Brand name (non-preferred)</td>
<td>$45 copay</td>
<td>$125 copay</td>
<td>40%; $45 minimum; $100 maximum</td>
</tr>
<tr>
<td>Brand name (when generic is available)&lt;sup&gt;c&lt;/sup&gt;</td>
<td>Brand name copay plus the difference in cost between the brand name and the equivalent generic</td>
<td>Brand name coinsurance plus the difference in cost between the brand name and the equivalent generic</td>
<td>Deductible, then brand name copay plus the difference in cost between the brand name and the equivalent generic</td>
</tr>
</tbody>
</table>

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

<sup>b</sup> You always pay the lesser of the actual cost of your prescription or the copay.

<sup>c</sup> When paying the brand name copay/coinsurance plus the difference in cost between the brand name and equivalent generic, your cost will not exceed the negotiated cost of the brand name medication.

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

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

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

**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, 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.

**Inpatient care and your prescription benefit (Out-of-network facilities)**

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

**Prescriptions covered without deductibles or copays**

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

- FDA-approved women’s contraception.
- Certain generic preventive prescriptions (applies to the Health+Savings Options only).
- Generic and over-the-counter medications that are prescribed for use in cleansing the bowel as a preparation for screening colonoscopy.
Retail pharmacy network

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

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

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

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

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

If you are enrolled in the Health+Savings Option, you may use your PayFlex Card® (your HSA debit card) to pay for eligible prescription drug expenses at a participating retail pharmacy.

Publication date: April 2019
Home delivery program

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

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

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

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

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

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

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

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

If you are enrolled in the Health+Savings Option, you may use your PayFlex Card® (your HSA debit card) to pay for eligible prescription drug expenses you incur through the home delivery program.
**Specialty pharmacy**

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

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

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.

**Copays for specialty medications**

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

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

The Prescription Drug Program does not pay benefits for:

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

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

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

See Expenses not covered under the BP NonMedicare-Eligible Option (NMEO) for all other limitations and exclusions.

Publication date: April 2019
A note about Medicare and prescription drug coverage

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

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

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

Publication date: April 2019
The OOA Options are available only if you live in an area where the Aetna Choice POS II network is not available. In addition to the options described below, you may want to consider the Health+Savings OOA Option.

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

### HealthPlus OOA Option

<table>
<thead>
<tr>
<th>Plan Year</th>
<th>$300/person; $900/family maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Year out-of-pocket maximum</td>
<td>$3,000/person; $6,000/family maximum</td>
</tr>
<tr>
<td>Lifetime maximum benefit</td>
<td>None</td>
</tr>
</tbody>
</table>

### Standard OOA Option

<table>
<thead>
<tr>
<th>Plan Year</th>
<th>$600/person; $1,800/family maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Year out-of-pocket maximum</td>
<td>$5,000/person; $12,500/family maximum</td>
</tr>
<tr>
<td>Lifetime maximum benefit</td>
<td>None</td>
</tr>
</tbody>
</table>

### General information

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

<table>
<thead>
<tr>
<th></th>
<th>HealthPlus OOA Option&lt;sup&gt;a,b&lt;/sup&gt; 2019/2020 Plan Year</th>
<th>Standard OOA Option&lt;sup&gt;a,b&lt;/sup&gt; 2019/2020 Plan Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription drug plan year deductible&lt;sup&gt;c&lt;/sup&gt;</td>
<td>No separate deductible</td>
<td>$75/person; $225/family</td>
</tr>
<tr>
<td>FDA-approved women’s contraception and generic and OTC bowel prep medications for colonoscopy</td>
<td>100%; no deductible or copay</td>
<td>100%; no deductible or copay</td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th></th>
<th>HealthPlus OOA Option&lt;sup&gt;a,b&lt;/sup&gt; 2019/2020 Plan Year</th>
<th>Standard OOA Option&lt;sup&gt;a,b&lt;/sup&gt; 2019/2020 Plan Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>100% after $5 copay</td>
<td>100% after $5 copay</td>
</tr>
<tr>
<td>Brand name (preferred)</td>
<td>100% after $25 copay</td>
<td>80% covered; you pay 20% ($25 minimum; $50 maximum)</td>
</tr>
<tr>
<td>Brand name (non-preferred)</td>
<td>100% after $45 copay</td>
<td>60% covered; you pay 40% ($45 minimum; $100 maximum)</td>
</tr>
<tr>
<td>Brand name (when generic is available)</td>
<td>Brand name copay plus the difference in cost between the brand name and the equivalent generic</td>
<td>Brand name coinsurance plus the difference in cost between the brand name and the equivalent generic</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>HealthPlus OOA Option&lt;sup&gt;a,b&lt;/sup&gt; 2019/2020 Plan Year</th>
<th>Standard OOA Option&lt;sup&gt;a,b&lt;/sup&gt; 2019/2020 Plan Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>100% after $12 copay</td>
<td>100% after $12 copay</td>
</tr>
<tr>
<td>Brand name (preferred)</td>
<td>100% after $65 copay</td>
<td>80% covered; you pay 20% ($65 minimum; $130 maximum)</td>
</tr>
<tr>
<td>Brand name (non-preferred)</td>
<td>100% after $125 copay</td>
<td>60% covered; you pay 40% ($125 minimum; $250 maximum)</td>
</tr>
<tr>
<td>Brand name (when generic is available)</td>
<td>Brand name copay plus the difference in cost between the brand name and the equivalent generic</td>
<td>Brand name coinsurance plus the difference in cost between the brand name and the equivalent generic</td>
</tr>
</tbody>
</table>

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

### Doctor visits (other than preventive care)<sup>d</sup>

The most up-to-date information is available online at [http://hr.bpglobal.com/lifebenefits/RetireeNonMedicare](http://hr.bpglobal.com/lifebenefits/RetireeNonMedicare).
<table>
<thead>
<tr>
<th>Service Type</th>
<th>COA/COPayment Details</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care office visit</td>
<td>100% after $20 copay, no deductible&lt;sup&gt;e&lt;/sup&gt; Note: surgery is covered at 80% after deductible</td>
<td>80%</td>
</tr>
<tr>
<td>Specialist office visit</td>
<td>100% after $30 copay, no deductible&lt;sup&gt;e&lt;/sup&gt; Note: surgery is covered at 80% after deductible</td>
<td>80%</td>
</tr>
<tr>
<td>Behavioral health office visit</td>
<td>100% after $20 copay, no deductible&lt;sup&gt;e&lt;/sup&gt;</td>
<td>80%</td>
</tr>
<tr>
<td>Maternity services</td>
<td>100%, no deductible/copay (prenatal); 80% after deductible (post-natal)</td>
<td>80%</td>
</tr>
<tr>
<td>Lab and X-ray</td>
<td>80%&lt;sup&gt;e&lt;/sup&gt;</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Preventive care</strong>&lt;sup&gt;d,f&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine physicals&lt;sup&gt;g&lt;/sup&gt;</td>
<td>100%, no copay, no deductible</td>
<td>100%, no copay, no deductible</td>
</tr>
<tr>
<td>Annual well-woman exam&lt;sup&gt;g&lt;/sup&gt;</td>
<td>100%, no copay, no deductible</td>
<td>100%, no copay, no deductible</td>
</tr>
<tr>
<td>Mammograms (routine)</td>
<td>100%, no copay, no deductible</td>
<td>100%, no copay, no deductible</td>
</tr>
<tr>
<td>Gestational diabetes screening</td>
<td>100%, no copay, no deductible</td>
<td>100%, no copay, no deductible</td>
</tr>
<tr>
<td>Prostate Specific Antigen (PSA) tests (routine)</td>
<td>100%, no copay, no deductible</td>
<td>100%, no copay, no deductible</td>
</tr>
<tr>
<td>Colorectal screenings (routine)</td>
<td>100%, no copay, no deductible</td>
<td>100%, no copay, no deductible</td>
</tr>
<tr>
<td>Well-child care (routine)&lt;sup&gt;g&lt;/sup&gt;</td>
<td>100%, no copay, no deductible</td>
<td>100%, no copay, no deductible</td>
</tr>
<tr>
<td><strong>Emergency services</strong>&lt;sup&gt;d&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency room (applies to facility charges only)</td>
<td>80% after $150 copay, no deductible</td>
<td>80% after $150 copay, no deductible</td>
</tr>
<tr>
<td>Ambulance</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Urgent care facility (applies to facility charges only)</td>
<td>100% after $30 copay, no deductible</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Outpatient services</strong>&lt;sup&gt;d&lt;/sup&gt;</td>
<td>(services provided other than in a doctor’s office)</td>
<td></td>
</tr>
<tr>
<td>Outpatient surgery facility</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Hospital outpatient services</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Doctor/surgeon and related professional fees</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Behavioral health outpatient treatment (other than office visit)&lt;sup&gt;h&lt;/sup&gt;</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Lab and X-ray</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Radiation therapy/chemotherapy</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Inpatient hospital services</strong>&lt;sup&gt;d&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Room and board (semi-private room)&lt;sup&gt;h&lt;/sup&gt;</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Inpatient behavioral health stay, including residential treatment and partial hospitalization&lt;sup&gt;h&lt;/sup&gt;</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Doctor hospital visits</td>
<td>80%</td>
<td>80%</td>
</tr>
</tbody>
</table>
### Alternatives to inpatient hospital care

<table>
<thead>
<tr>
<th>Service</th>
<th>Inpatient</th>
<th>Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled nursing facility (up to 60 days/plan year)</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Home health care (limited to 120 visits/plan year)</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Hospice care</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Outpatient private duty nursing (up to 70 shifts/plan year)</td>
<td>80%</td>
<td>80%</td>
</tr>
</tbody>
</table>

### Other covered services

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

---

**Notes:**

- **a** Benefits are subject to recognized charge limits.
- **b** You may need to pay the full amount and submit a claim for reimbursement to Aetna.
- **c** Precertification penalties and amounts above recognized charges do not apply to the plan year deductible or out-of-pocket maximum. Office visit copays, urgent care facility copays and prescription drug expenses do not apply to the plan year deductible; however, they do apply to the plan year out-of-pocket maximum.
- **d** Unless otherwise noted, benefits paid at 80% or 60% are paid after the plan year deductible has been met.
- **e** The office visit copay covers lab and X-ray charges performed in a doctor's office and billed as part of the visit. When these services are not performed at the time of the office visit, performed at another facility or performed by an entity other than the doctor's office, you must first meet your deductible and then the expense, if covered, would be paid at 80%.
- **f** Except for routine physicals, which are covered annually, preventive care benefits are subject to age restrictions/limitations as determined under guidelines established by Aetna. For additional information about covered preventive care benefits, contact Aetna Member Services at 1-866-436-2606.
Includes all tests (e.g., lab work, X-rays) associated with the visit and all office-based procedures.

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

Deductible waived for diabetic insulin pumps and tubing.

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

The OOA Options are only available if you live in an area where the network used in the PPO Options is not available. BP offers three OOA Options: HealthPlus, Standard and Health+Savings.

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

The Health+Savings Option comes with a Health Savings Account (HSA), a tax-preferred account that you will own and which will help you save for future health expenses. See Health Savings Account (HSA) for more details about how HSAs work.

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

Each OOA Option covers a broad range of medical services and supplies once you meet your deductible, as well as preventive care services that don't require you to meet your deductible. If you enroll in an OOA Option, you can choose any licensed doctor, nurse, therapist, hospital, lab or other health care facility you wish whenever you need medical care.

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

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

Each OOA Option also includes the Prescription Drug Program, administered by Express Scripts, Inc. (ESI). In the Health+Savings OOA Option, you must meet your medical plan deductible before you receive plan coverage for all formulary brand preventive prescriptions and all non-preventive prescriptions.

Primary doctors

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

Primary doctors are:

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

You are not required to designate a primary doctor or have your primary doctor’s referral to see a specialist.

Publication date: April 2019
What the OOA Option pays

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

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

Covered office visit expenses are covered at:

- 100% after you pay a copay, with no deductible, by the HealthPlus OOA Option.
- 80% after the deductible by the Standard OOA Option.
- 100% after you pay a copay, after the deductible, by the Health+Savings OOA Option.

Emergency room facility charges are paid at:

- 80% after a copay, with no deductible, by the HealthPlus and Standard OOA Options.
- 80% after a copay, after the deductible, by the Health+Savings OOA Option.

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

Once you meet the plan year out-of-pocket maximum, each OOA Option pays 100% of recognized charges for most covered expenses for the rest of the plan year.

See the applicable summary chart (HealthPlus and Standard OOAs or Health+Savings OOA) for more information.

Publication date: April 2019
Deductibles

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

The Health+Savings OOA Option has two separate deductibles. Under the Health+Savings OOA Option, the lower deductible applies only if you have Personal coverage. The higher deductible applies if you have Personal + dependents coverage, even if only one family member incurs medical expenses during the year. Under the Health+Savings OOA Option, the lower Personal deductibles would not apply to any covered individual in your family if you have Personal + dependents coverage.

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

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

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

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

Expenses excluded from the deductibles

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

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

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 dependents’ 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, 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 Medicare HMO, or to the BP Medicare Advantage PPO ESA.

Publication date: April 2019
## Copays/coinsurance

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

<table>
<thead>
<tr>
<th>Office visits for non-preventive care under the HealthPlus and Health+Savings OOA Options</th>
<th>Note: Under the Health+Savings OOA Option only, you must pay the deductible first before the office visit copay applies for these services. (The individual deductible applies if you have Personal coverage. The family deductible applies if you have Personal + dependents coverage.)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The office visit copay includes:</td>
</tr>
<tr>
<td>1</td>
<td>The doctor office visit.</td>
</tr>
<tr>
<td>1</td>
<td>Diagnostic laboratory tests or X-rays performed in a doctor's office and billed as part of the visit.</td>
</tr>
<tr>
<td>1</td>
<td>Injections administered in a doctor's office as part of the visit (including allergy injections).</td>
</tr>
<tr>
<td>The office visit copay does not apply to:</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Office visits if a surgical procedure as defined by Aetna is performed as part of the visit (for example, if a mole is removed or a broken bone is set during the office visit).</td>
</tr>
<tr>
<td>1</td>
<td>Prenatal maternity-related office visits (except for the first office visit to confirm the pregnancy). These visits are included in the delivery charge. However, post-natal maternity services are covered at 80% after the deductible.</td>
</tr>
<tr>
<td>1</td>
<td>Routine and diagnostic laboratory tests or X-rays performed:</td>
</tr>
<tr>
<td></td>
<td>° In a doctor's office, but not at the time of the visit.</td>
</tr>
<tr>
<td></td>
<td>° In a facility other than the doctor's office.</td>
</tr>
<tr>
<td></td>
<td>° By an entity other than the doctor's office.</td>
</tr>
<tr>
<td>(Ask your doctor whether the lab facilities he/she uses are in the network.)</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Chiropractic visits.</td>
</tr>
</tbody>
</table>

| Emergency room facility charges under the HealthPlus, Standard and Health+Savings OOA Options | Under the HealthPlus and Standard OOA Options, emergency room facility charges are covered at 80% after a copay, with no deductible. |
| Under the Health+Savings OOA Option, emergency room facility charges are covered at 80% after a copay, after the deductible. |

| Urgent care facility charges under the HealthPlus and Health+Savings OOA Options | Under the HealthPlus OOA Option, urgent care facility charges are covered at 100% after a copay, with no deductible. |
| Under the Health+Savings OOA Option, urgent care facility charges are covered at 100% after a copay, after the deductible. |

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

Under all OOA Options:

1. Eligible preventive care expenses are covered at 100% of recognized charges with no copay and no deductible. See Preventive care for details.
2. Most other covered services are paid at 80% of recognized charges after you meet the individual or family plan year deductible, and you pay the remaining 20% (the coinsurance) and any amounts over the recognized charge limit.
Out-of-pocket maximums

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

In addition, the Health+Savings OOA Option has two separate out-of-pocket maximum amounts. Under the Health+Savings OOA Option, the lower out-of-pocket maximum amount applies only if you have Personal coverage. The higher out-of-pocket maximum amount applies if you have Personal + dependents coverage, even if only one family member incurs medical expenses during the year. Under the Health+Savings OOA Option, the lower Personal out-of-pocket maximum amount would not apply to any covered individual in your family if you have Personal + dependents coverage.

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

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

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

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, 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.

Publication date: April 2019
The HealthPlus, Standard and Health+Savings Options include special plan provisions. These important features include preventive care, recognized charge limits, precertification requirements and more. More information about each of these features is outlined in this section.

- Preventive care
- Emergency care
- Recognized charge limits
- Aetna's National Advantage Program (NAP)
- Transplant services
- Precertification requirements
- Coverage while traveling
- Alternatives to physician office visits
- Teladoc
- Enhanced Aetna Concierge

Publication date: April 2019
Preventive care

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

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

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

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

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

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

Publication date: April 2019
Emergency care

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

Emergency medical condition

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

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

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

Emergency services

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

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

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

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

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

Publication date: April 2019
Recognized charge limits

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

Recognized charge limits do not apply to:

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

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

- What the provider bills or submits for that service or supply; and
- The charge the claims administrator determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made, billed or coded.
  - For non-facility charges:
    - PPO Options: The 85th percentile of the Prevailing Charge Rate, for the Geographic Area where the service is furnished.
    - OOA Options: Twice the 95th percentile of the Prevailing Charge Rate, for the Geographic Area where the service is furnished.
  - For facility charges:
    - PPO Options: 150% of the Medicare Fee Schedule for the Geographic Area where the service is furnished.
    - OOA Options: Aetna uses the charge Aetna determines to be the usual charge level made for it in the Geographic Area where it was furnished.

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

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

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

Publication date: April 2019
The National Advantage Program (NAP) offers you access to Aetna-contracted rates for many hospital and doctor expenses that would otherwise be billed at the provider's normal rate. These include:

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

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

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

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

NAP ancillary providers include:

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

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

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

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

Publication date: April 2019
Transplant services

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

For the PPO Options:

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

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

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

Out-of-country care

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

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

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

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

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

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

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

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

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

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

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

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

- **Partial hospitalization or a day program.** Outpatient care focused on psychiatric, eating disorder care and/or substance abuse care that is generally four or more hours per day and includes individual, group and family therapies must be precertified in advance by calling the claims administrator at the toll-free precertification number shown on your medical option ID card.
Electroconvulsive therapy treatment (ECT). ECT is systematic use of electric shocks to produce convulsions. Care must be precertified in advance by calling the claims administrator at the toll-free precertification number shown on your medical option ID card.

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

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

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

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

Precertification penalties

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

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

2. **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.

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

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

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

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

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

Walk-in clinic visits

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

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

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

- In a group setting for screening and counseling services.

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

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

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

**How to use Teladoc**

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

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

Publication date: April 2019
Enhanced Aetna Concierge

How the Enhanced Aetna Concierge program works

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

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

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

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

How to reach Enhanced Aetna Concierge

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

Publication date: April 2019
Prescription drug coverage

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

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

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

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

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

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

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

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

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

The ESI formulary excludes certain drugs from coverage. However, ESI provides preferred alternatives to all non-covered drugs that achieve similar results.

Excluded products are not covered by the plan. An exception process exists for participants, but you will need a qualified medical necessity, which must be evidenced in writing from your doctor. If you believe you are in need of this exception following a denial, you will be provided a form to appeal this decision along with the denial. If you have any questions about this process, please contact Express Scripts at the number listed later in this document or the BP HR & Benefits Center.

The Prescription Drug Program includes a Generic Preferred Program, which is designed to encourage use of generic medications to lower prescription drug costs.

If a generic equivalent drug is available and you choose the brand name medication rather than the generic option, you will pay the brand name copay/coinsurance plus the difference between the cost of the brand name medication and the equivalent generic medication. The additional cost applies regardless of whether your doctor prescribes a brand name drug. Note: For the Health+Savings Option, you will still be required to satisfy the medical deductible first before you pay your applicable prescription drug copay.

The most up-to-date information is available online at http://hr.bpglobal.com/lifebenefits/RetireeNonMedicare.
If a prescription drug does not have a generic equivalent available, you will be charged the brand name copay (preferred or non-preferred, depending on the drug). Please note that the information on the formulary drug list is not BP-specific, and not all of the preferred drugs covered may be listed nor does BP cover all the drugs that may be listed. If you do not see your drug listed, contact Express Scripts for coverage information.

Drug utilization management

The Prescription Drug program also includes a Drug Utilization Management Program, designed to help you make more cost-effective drug choices. The program has three components: prior authorization, step therapy and drug quantity management:

Prior authorization

Prior authorization is a program that monitors certain prescription drugs and their costs to get you the medication you require while reducing costs. If you’re prescribed a certain medication, that drug may need a “prior authorization.” This program helps to make sure you’re getting a prescription that is covered by your pharmacy benefit.

Your own medical professionals are consulted, since your plan will cover it only when your doctor prescribes it to treat a medical condition that will promote your health and wellness. When your pharmacist tells you that your prescription needs a prior authorization, it simply means that more information is needed to see if your plan covers the drug. Only your physician can provide this information and request a prior authorization.

Step therapy

Step therapy is designed for people who regularly take prescription drugs to treat ongoing medical conditions, such as arthritis, asthma or high blood pressure.

How does step therapy work? Prescription medications are grouped into categories:

- **Step 1 medications** are generic drugs that have been approved by the U.S. Food & Drug Administration (FDA). This program will look to see if these medications are prescribed first, since many generics can provide the same health benefits as more-expensive medications but at a lower cost.
- **Step 2 medications** are brand-name drugs such as those you see advertised on TV. They’re approved for coverage only if a Step 1 medication doesn’t work for you. Step 2 medications almost always cost more.

What if your doctor prescribes a Step 2 medication? Ask if a generic (Step 1) medication may be right for you. Please share your formulary – the list of prescription drugs covered by your plan – with your doctor. The pharmacy will not automatically change your prescription; your doctor must write a new prescription for you to change from a Step 2 medication to a Step 1 medication, or indicate that a generic can be substituted for the brand name drug, as many providers already do. If a Step 1 medication is not a good choice for you, your doctor can request prior authorization from Express Scripts to determine if a Step 2 medication will be covered by your plan.

Drug quantity management

Certain drugs will have quantity limits in order to help promote economical use. The program follows guidelines developed by the U.S. Food and Drug Administration (FDA).

Here is how the program works at the pharmacy:

- When your pharmacist attempts to fill your prescription, the pharmacist will get a message about any applicable quantity limitations for the quantity prescribed. This could mean:
  - You are getting your refill too soon; that is, you should still have medicine left from your last supply. In this case, ask your pharmacist when it will be time to get a refill; or
  - Your physician wrote you a prescription for a quantity larger than the plan covers.
- If the quantity on your prescription is more than the plan allows, you can:
  - Have your pharmacist fill your prescription as written, for the amount the plan covers and pay the appropriate copayment or coinsurance amount. If you would like the additional quantity prescribed, you have the option to pay the full price.
  - Ask your pharmacist to call your physician. They can discuss changing your prescription to a higher strength or different quantity, if available.
  - Ask your pharmacist to contact your physician about getting a “prior authorization.” That is, your physician can call Express Scripts to request that you receive the original quantity and strength he/she prescribed. Express Scripts’ prior authorization is available to your physician, 24 hours a day, seven days a week, so a determination can be made right away.
For home delivery, the Express Scripts Home Delivery Pharmacy will try to contact your physician to discuss the prior authorization review process. If the Express Scripts Home Delivery Pharmacy does not hear back from your physician within two days, they will fill your prescription for the quantity covered by the plan. If a higher strength is not available, or the plan does not provide a prior authorization for a higher quantity, the Home Delivery Pharmacy can fill your prescription for the quantity that the plan covers. For more information about quantity limits under the plan, visit www.express-scripts.com or call Express Scripts.

You should review the medications prescribed to you with your doctor and discuss whether a generic medication may be right for you. Should your doctor determine a generic medication is not right for you, an exception process exists when you have a qualified medical necessity and at the request of your doctor. The program procedures typically take place with your doctor before you fill your prescription. You should inform your doctor of any required steps at the time he or she recommends any prescriptions to you.

### Prescription drug summary chart

<table>
<thead>
<tr>
<th>Prescription Drug</th>
<th>HealthPlus Option</th>
<th>Standard Option</th>
<th>Health+Savings Option</th>
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<tbody>
<tr>
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<td>Retaila Home Delivery</td>
<td>Retaila Home Delivery</td>
<td>Retaila Home Delivery</td>
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<tr>
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<td>$75/person; $225/family</td>
<td>No separate Rx deductible; Rx subject to medical plan deductible</td>
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<tr>
<td>Copayb/Coinsurance</td>
<td>Generic</td>
<td>Brand name (preferred)</td>
<td>Brand name (non-preferred)</td>
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<td>$125 copay</td>
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<td>$5 copay</td>
<td>20%; $25 minimum; $50 maximum</td>
<td>40%; $45 minimum; $100 maximum</td>
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<tr>
<td></td>
<td>$12 copay</td>
<td>20%; $65 minimum; $130 maximum</td>
<td>40%; $125 minimum; $250 maximum</td>
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<td>Deductible, then 100% after $5 copay, except for certain generic preventive covered at 100% with no copay or deductible</td>
<td>Deductible, then 100% after $25 copay</td>
<td>Deductible, then 100% after $45 copay</td>
</tr>
<tr>
<td></td>
<td>Deductible, then 100% after $12 copay, except for certain generic preventive covered at 100% with no copay or deductible</td>
<td>Deductible, then 100% after $65 copay</td>
<td>Deductible, then 100% after $125 copay</td>
</tr>
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### 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

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*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 copay.*

*c When paying the brand name copay/coinsurance plus the difference in cost between the brand name and equivalent generic, your cost will not exceed the negotiated cost of the brand name medication.*
Are not experimental in nature.

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

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

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

**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, 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.

**Inpatient care and your prescription benefit (Out-of-network facilities)**

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

**Prescriptions covered without deductibles or copays**

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

- FDA-approved women’s contraception.
- Certain generic preventive prescriptions (applies to the Health+Savings Options only).
- Generic and over-the-counter medications that are prescribed for use in cleansing the bowel as a preparation for screening colonoscopy.

Publication date: April 2019
Retail pharmacy network

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

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

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

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

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

If you are enrolled in the Health+Savings Option, you may use your PayFlex Card® (your HSA debit card) to pay for eligible prescription drug expenses at a participating retail pharmacy.

Publication date: April 2019
Home delivery program

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

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

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

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

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

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

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

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

If you are enrolled in the Health+Savings Option, you may use your PayFlex Card® (your HSA debit card) to pay for eligible prescription drug expenses you incur through the home delivery program.
Specialty pharmacy

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

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

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.

Copays for specialty medications

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

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

Publication date: April 2019
Drugs not covered

The Prescription Drug Program does not pay benefits for:

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

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

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

See Expenses not covered under the BP NonMedicare-Eligible Option (NMEO) for all other limitations and exclusions.

Publication date: April 2019
A note about Medicare and prescription drug coverage

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

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

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

Publication date: April 2019
The Health+Savings OOA Option is available only if you live in an area where the Aetna Choice POS II network is not available. In addition to the option described below, you may want to consider the HealthPlus and Standard OOA Options.

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

<table>
<thead>
<tr>
<th>General information</th>
<th>Health+Savings OOA Option&lt;sup&gt;a,b&lt;/sup&gt; 2019/2020 Plan Year</th>
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<td>Plan year deductible&lt;sup&gt;c&lt;/sup&gt;</td>
<td>$1,500 if you have Personal coverage; $3,000 if you have Personal + dependents coverage</td>
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<td>See Deductibles for more information</td>
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<tr>
<td>Plan year out-of-pocket maximum&lt;sup&gt;c&lt;/sup&gt;</td>
<td>$3,000 if you have Personal coverage; $6,000 if you have Personal + dependents coverage</td>
</tr>
<tr>
<td>See Out-of-pocket maximums for more information</td>
<td></td>
</tr>
<tr>
<td>Lifetime maximum benefit</td>
<td>None</td>
</tr>
</tbody>
</table>

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

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

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

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

<table>
<thead>
<tr>
<th>Medication Type</th>
<th>Coverage Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>After medical deductible is met, 100% after $5 copay, except for generic preventive covered at 100% with no copay or deductible</td>
</tr>
<tr>
<td>Brand name (preferred)</td>
<td>After medical deductible is met, 100% after $25 copay</td>
</tr>
<tr>
<td>Brand name (non-preferred)</td>
<td>After medical deductible is met, 100% after $45 copay</td>
</tr>
<tr>
<td>Brand name (when generic is available)</td>
<td>After medical deductible is met, brand name copay plus the difference in cost between the brand name and the equivalent generic</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Medication Type</th>
<th>Coverage Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>After medical deductible is met, 100% after $12 copay, except for generic preventive covered at 100% with no copay or deductible</td>
</tr>
<tr>
<td>Brand name (preferred)</td>
<td>After medical deductible is met, 100% after $65 copay</td>
</tr>
<tr>
<td>Brand name (non-preferred)</td>
<td>After medical deductible is met, 100% after $125 copay</td>
</tr>
<tr>
<td>Brand name (when generic is available)</td>
<td>After medical deductible is met, brand</td>
</tr>
</tbody>
</table>
For the following covered treatments and services, the Health+Savings OOA Option pays

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

The most up-to-date information is available online at http://hr.bpglobal.com/lifebenefits/RetireeNonMedicare.
Benefits are subject to recognized charge limits.

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

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

Prescription drug expenses apply to the plan year deductible and out-of-pocket maximum.

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

Except for routine physicals, which are covered annually, preventive care benefits are subject to age restrictions/limitations as determined under guidelines established by Aetna. For additional information about covered preventive care benefits, contact Aetna Member Services at 1-866-436-2606.

Benefits are subject to recognized charge limits.

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

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

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

Except for routine physicals, which are covered annually, preventive care benefits are subject to age restrictions/limitations as determined under guidelines established by Aetna. For additional information about covered preventive care benefits, contact Aetna Member Services at 1-866-436-2606.

Benefits are subject to recognized charge limits.

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

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

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

Except for routine physicals, which are covered annually, preventive care benefits are subject to age restrictions/limitations as determined under guidelines established by Aetna. For additional information about covered preventive care benefits, contact Aetna Member Services at 1-866-436-2606.
(other than a functional nervous disorder); diagnosis of chronic otitis media; or a congenital defect for which corrective surgery has been performed.
How an Out-of-Area Option works

The OOA Options are only available if you live in an area where the network used in the PPO Options is not available. BP offers three OOA Options: HealthPlus, Standard and Health+Savings.

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

The Health+Savings Option comes with a Health Savings Account (HSA), a tax-preferred account that you will own and which will help you save for future health expenses. See Health Savings Account (HSA) for more details about how HSAs work.

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

Each OOA Option covers a broad range of medical services and supplies once you meet your deductible, as well as preventive care services that don’t require you to meet your deductible. If you enroll in an OOA Option, you can choose any licensed doctor, nurse, therapist, hospital, lab or other health care facility you wish whenever you need medical care.

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

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

Each OOA Option also includes the Prescription Drug Program, administered by Express Scripts, Inc. (ESI). In the Health+Savings OOA Option, you must meet your medical plan deductible before you receive plan coverage for all formulary brand preventive prescriptions and all non-preventive prescriptions.

Primary doctors

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

Primary doctors are:

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

You are not required to designate a primary doctor or have your primary doctor’s referral to see a specialist.

Publication date: April 2019
Health Savings Account (HSA)

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

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

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

Who can contribute to an HSA

You are eligible for an HSA if you are:

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

How to enroll

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

To access your account information, log on to the Aetna website at www.aetna.com using your Aetna login information. Your HSA Information will be accessible through the website. See the HSA Quick Reference Guide for tips on how to manage your account online.

You can start, stop and change your contribution amount at any time, as long as you don’t exceed the annual maximum.

Note that if you dis-enroll from the Health+Savings Option during a calendar year, this could have a retroactive effect on the tax-free nature of some of your HSA contributions. You should consult a tax advisor for any tax issues related to the HSA. Also, if you are eligible for the BP Retiree Reimbursement Account (RRA), you will automatically be placed into the limited RRA reimbursement option, otherwise you would not be able to contribute to an HSA.
Your contributions to your HSA

To contribute to your HSA, you can mail a deposit coupon and payment directly to PayFlex, our HSA administrator. Use the HSA Contribution Coupon to deposit new funds via check.

For the 2019 calendar year, the IRS allows up to $3,500 to be contributed for retiree-only coverage and up to $7,000 for family coverage.

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

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

You claim your contributions to your HSA on your tax return at the end of the year to get your tax savings.

Investment of your HSA

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

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

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

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

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

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

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

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

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

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

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

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

Eligible expenses

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

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

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

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

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

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

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

The money in your HSA account is always yours. You can transfer it to another HSA account or keep it with PayFlex, paying any required administrative fees.
What the OOA Option pays

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

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

Covered office visit expenses are covered at:

- 100% after you pay a copay, with no deductible, by the HealthPlus OOA Option.
- 80% after the deductible by the Standard OOA Option.
- 100% after you pay a copay, after the deductible, by the Health+Savings OOA Option.

Emergency room facility charges are paid at:

- 80% after a copay, with no deductible, by the HealthPlus and Standard OOA Options.
- 80% after a copay, after the deductible, by the Health+Savings OOA Option.

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

Once you meet the plan year out-of-pocket maximum, each OOA Option pays 100% of recognized charges for most covered expenses for the rest of the plan year.

See the applicable summary chart (HealthPlus and Standard OOAs or Health+Savings OOA) for more information.
Deductibles

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

The Health+Savings OOA Option has two separate deductibles. Under the Health+Savings OOA Option, the lower deductible applies only if you have Personal coverage. The higher deductible applies if you have Personal + dependents coverage, even if only one family member incurs medical expenses during the year. Under the Health+Savings OOA Option, the lower Personal deductibles would not apply to any covered individual in your family if you have Personal + dependents coverage.

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

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

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

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

Expenses excluded from the deductibles

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

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

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, 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 Medicare HMO, or to the BP Medicare Advantage PPO ESA.

Publication date: April 2019
A “copay” is a fixed dollar amount you pay in lieu of a deductible and coinsurance at the time you receive medical services. They apply to certain expenses under the HealthPlus, Standard and Health+Savings OOA Options as follows:

<table>
<thead>
<tr>
<th>Office visits for non-preventive care under the HealthPlus and Health+Savings OOA Options</th>
<th>Note: Under the Health+Savings OOA Option only, you must pay the deductible first before the office visit copay applies for these services. (The individual deductible applies if you have Personal coverage. The family deductible applies if you have Personal + dependents coverage.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The office visit copay includes:</td>
<td>The office visit copay does not apply to:</td>
</tr>
<tr>
<td>Ⅰ The doctor office visit.</td>
<td>Ⅰ Office visits if a surgical procedure as defined by Aetna is performed as part of the visit (for example, if a mole is removed or a broken bone is set during the office visit).</td>
</tr>
<tr>
<td>Ⅰ Diagnostic laboratory tests or X-rays performed in a doctor’s office and billed as part of the visit.</td>
<td>Ⅰ Prenatal maternity-related office visits (except for the first office visit to confirm the pregnancy). These visits are included in the delivery charge. However, post-natal maternity services are covered at 80% after the deductible.</td>
</tr>
<tr>
<td>Ⅰ Injections administered in a doctor’s office as part of the visit (including allergy injections).</td>
<td>Ⅰ Routine and diagnostic laboratory tests or X-rays performed:</td>
</tr>
<tr>
<td></td>
<td>Ⅰ In a doctor’s office, but not at the time of the visit.</td>
</tr>
<tr>
<td></td>
<td>Ⅰ In a facility other than the doctor’s office.</td>
</tr>
<tr>
<td></td>
<td>Ⅰ By an entity other than the doctor’s office.</td>
</tr>
<tr>
<td></td>
<td>(Ask your doctor whether the lab facilities he/she uses are in the network.)</td>
</tr>
<tr>
<td></td>
<td>Ⅰ Chiropractic visits.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency room facility charges under the HealthPlus, Standard and Health+Savings OOA Options</th>
<th>Under the HealthPlus and Standard OOA Options, emergency room facility charges are covered at 80% after a copay, with no deductible.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under the Health+ Savings OOA Option, emergency room facility charges are covered at 80% after a copay, after the deductible.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Urgent care facility charges under the HealthPlus and Health+Savings OOA Options</th>
<th>Under the HealthPlus OOA Option, urgent care facility charges are covered at 100% after a copay, with no deductible.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under the Health+Savings OOA Option, urgent care facility charges are covered at 100% after a copay, after the deductible.</td>
<td></td>
</tr>
</tbody>
</table>

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

Under all OOA Options:

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

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

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

In addition, the Health+Savings OOA Option has two separate out-of-pocket maximum amounts. Under the Health+Savings OOA Option, the lower out-of-pocket maximum amount applies only if you have Personal coverage. The higher out-of-pocket maximum amount applies if you have Personal + dependents coverage, even if only one family member incurs medical expenses during the year. Under the Health+Savings OOA Option, the lower Personal out-of-pocket maximum amount would not apply to any covered individual in your family if you have Personal + dependents coverage.

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

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

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

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, 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.

Publication date: April 2019
Important plan provisions

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

- Preventive care
- Emergency care
- Recognized charge limits
- Aetna's National Advantage Program (NAP)
- Transplant services
- Precertification requirements
- Coverage while traveling
- Alternatives to physician office visits
- Teladoc
- Enhanced Aetna Concierge

Publication date: April 2019
Preventive care

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

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

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

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

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

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

Publication date: April 2019
Emergency care

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

Emergency medical condition

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

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

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

Emergency services

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

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

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

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

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

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

Recognized charge limits do not apply to:

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

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

- What the provider bills or submits for that service or supply; and
- The charge the claims administrator determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made, billed or coded.
  * For non-facility charges:
    - PPO Options: The 85th percentile of the Prevailing Charge Rate, for the Geographic Area where the service is furnished.
    - OOA Options: Twice the 95th percentile of the Prevailing Charge Rate, for the Geographic Area where the service is furnished.
  * For facility charges:
    - PPO Options: 150% of the Medicare Fee Schedule for the Geographic Area where the service is furnished.
    - OOA Options: Aetna uses the charge Aetna determines to be the usual charge level made for it in the Geographic Area where it was furnished.

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

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

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

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

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

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

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

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

NAP ancillary providers include:

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

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

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

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

Publication date: April 2019
Transplant services

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

For the PPO Options:

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

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

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

Out-of-country care

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

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

Publication date: April 2019
Precertification requirements

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

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

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

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

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

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

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

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

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

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

- **Partial hospitalization or a day program.** Outpatient care focused on psychiatric, eating disorder care and/or substance abuse care that is generally four or more hours per day and includes individual, group and family therapies must be precertified in advance by calling the claims administrator at the toll-free precertification number shown on your medical option ID card.
Electroconvulsive therapy treatment (ECT). ECT is systematic use of electric shocks to produce convulsions. Care must be precertified in advance by calling the claims administrator at the toll-free precertification number shown on your medical option ID card.

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

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

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

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

Precertification penalties

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

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

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

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

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

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

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

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

Publication date: April 2019
Alternatives to physician office visits

Walk-in clinic visits

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

1. Unscheduled, non-emergency illnesses and injuries;
2. The administration of certain immunizations administered within the scope of the clinic’s license; and
3. 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:

1. In a group setting for screening and counseling services.

Important Note:

1. 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.
2. 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:

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

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

Neither:

1. An emergency room; nor
2. The outpatient department of a hospital;

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

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

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

How to use Teladoc

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

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

Publication date: April 2019
Enhanced Aetna Concierge

How the Enhanced Aetna Concierge program works

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

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

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

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

How to reach Enhanced Aetna Concierge

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

Publication date: April 2019
Prescription drug coverage

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

In general, the program offers prescription drug benefits 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 must use the home delivery service.

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

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

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

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

1. **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.
2. **Brand name drugs** are drugs patented by the FDA and subject to an exclusivity agreement, which allows the company to be the sole manufacturer of the drug for a certain number of years. Brand name drugs include preferred drugs and non-preferred drugs.
   - Preferred drugs are drugs that Express Scripts considers preferred choices, based on their effectiveness and cost, and are on ESI's formulary drug list.
   - Non-preferred drugs are those that are not on ESI's formulary drug list.

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

The ESI formulary excludes certain drugs from coverage. However, ESI provides preferred alternatives to all non-covered drugs that achieve similar results.

Excluded products are not covered by the plan. An exception process exists for participants, but you will need a qualified medical necessity, which must be evidenced in writing from your doctor. If you believe you are in need of this exception following a denial, you will be provided a form to appeal this decision along with the denial. If you have any questions about this process, please contact Express Scripts at the number listed later in this document or the BP HR & Benefits Center.

The Prescription Drug Program includes a Generic Preferred Program, which is designed to encourage use of generic medications to lower prescription drug costs.

If a generic equivalent drug is available and you choose the brand name medication rather than the generic option, you will pay the brand name copay/coinsurance plus the difference between the cost of the brand name medication and the equivalent generic medication. The additional cost applies regardless of whether your doctor prescribes a brand name drug. Note: For the Health+Savings Option, you will still be required to satisfy the medical deductible first before you pay your applicable prescription drug copay.
If a prescription drug does not have a generic equivalent available, you will be charged the brand name copay (preferred or non-preferred, depending on the drug). Please note that the information on the formulary drug list is not BP-specific, and not all of the preferred drugs covered may be listed nor does BP cover all the drugs that may be listed. If you do not see your drug listed, contact Express Scripts for coverage information.

**Drug utilization management**

The Prescription Drug program also includes a Drug Utilization Management Program, designed to help you make more cost-effective drug choices. The program has three components: prior authorization, step therapy and drug quantity management:

**Prior authorization**

Prior authorization is a program that monitors certain prescription drugs and their costs to get you the medication you require while reducing costs. If you’re prescribed a certain medication, that drug may need a “prior authorization.” This program helps to make sure you’re getting a prescription that is covered by your pharmacy benefit.

Your own medical professionals are consulted, since your plan will cover it only when your doctor prescribes it to treat a medical condition that will promote your health and wellness. When your pharmacist tells you that your prescription needs a prior authorization, it simply means that more information is needed to see if your plan covers the drug. Only your physician can provide this information and request a prior authorization.

**Step therapy**

Step therapy is designed for people who regularly take prescription drugs to treat ongoing medical conditions, such as arthritis, asthma or high blood pressure.

**How does step therapy work?** Prescription medications are grouped into categories:

- **Step 1 medications** are generic drugs that have been approved by the U.S. Food & Drug Administration (FDA). This program will look to see if these medications are prescribed first, since many generics can provide the same health benefits as more-expensive medications but at a lower cost.

- **Step 2 medications** are brand-name drugs such as those you see advertised on TV. They’re approved for coverage only if a Step 1 medication doesn’t work for you. Step 2 medications almost always cost more.

**What if your doctor prescribes a Step 2 medication?** Ask if a generic (Step 1) medication may be right for you. Please share your formulary – the list of prescription drugs covered by your plan – with your doctor. The pharmacy will not automatically change your prescription; your doctor must write a new prescription for you to change from a Step 2 medication to a Step 1 medication, or indicate that a generic can be substituted for the brand name drug, as many providers already do. If a Step 1 medication is not a good choice for you, your doctor can request prior authorization from Express Scripts to determine if a Step 2 medication will be covered by your plan.

**Drug quantity management**

Certain drugs will have quantity limits in order to help promote economical use. The program follows guidelines developed by the U.S. Food and Drug Administration (FDA).

Here is how the program works at the pharmacy:

- When your pharmacist attempts to fill your prescription, the pharmacist will get a message about any applicable quantity limitations for the quantity prescribed. This could mean:
  - You are getting your refill too soon; that is, you should still have medicine left from your last supply. In this case, ask your pharmacist when it will be time to get a refill; or
  - Your physician wrote you a prescription for a quantity larger than the plan covers.

- If the quantity on your prescription is more than the plan allows, you can:
  - Have your pharmacist fill your prescription as written, for the amount the plan covers and pay the appropriate copayment or coinsurance amount. If you would like the additional quantity prescribed, you have the option to pay the full price.
  - Ask your pharmacist to call your physician. They can discuss changing your prescription to a higher strength or different quantity, if available.
  - Ask your pharmacist to contact your physician about getting a “prior authorization.” That is, your physician can call Express Scripts to request that you receive the original quantity and strength he/she prescribed. Express Scripts’ prior authorization is available to your physician, 24 hours a day, seven days a week, so a determination can be made right away.
For home delivery, the Express Scripts Home Delivery Pharmacy will try to contact your physician to discuss the prior authorization review process. If the Express Scripts Home Delivery Pharmacy does not hear back from your physician within two days, they will fill your prescription for the quantity covered by the plan. If a higher strength is not available, or the plan does not provide a prior authorization for a higher quantity, the Home Delivery Pharmacy can fill your prescription for the quantity that the plan covers. For more information about quantity limits under the plan, visit www.express-scripts.com or call Express Scripts.

You should review the medications prescribed to you with your doctor and discuss whether a generic medication may be right for you. Should your doctor determine a generic medication is not right for you, an exception process exists when you have a qualified medical necessity and at the request of your doctor. The program procedures typically take place with your doctor before you fill your prescription. You should inform your doctor of any required steps at the time he or she recommends any prescriptions to you.

**Prescription drug summary chart**

<table>
<thead>
<tr>
<th>Prescription Drug</th>
<th>HealthPlus Option</th>
<th>Standard Option</th>
<th>Health+Savings Option</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Retail&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Home Delivery</td>
<td>Retail&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Rx Deductible</td>
<td>No separate Rx deductible</td>
<td>$75/person; $225/family</td>
<td>No separate Rx deductible; Rx subject to medical plan deductible</td>
</tr>
</tbody>
</table>

**Copay<sup>b</sup>/Coinsurance**

| Generic           | $5 copay | $12 copay | $5 copay | $12 copay | Deductible, then 100% after $5 copay, except for certain generic preventive covered at 100% with no copay or deductible | Deductible, then 100% after $12 copay, except for certain generic preventive covered at 100% with no copay or deductible |
| Brand name (preferred) | $25 copay | $65 copay | 20%; $25 minimum; $50 maximum | 20%; $65 minimum; $130 maximum | Deductible, then 100% after $25 copay | Deductible, then 100% after $65 copay |
| Brand name (non-preferred) | $45 copay | $125 copay | 40%; $45 minimum; $100 maximum | 40%; $125 minimum; $250 maximum | Deductible, then 100% after $45 copay | Deductible, then 100% after $125 copay |
| Brand name (when generic is available)<sup>c</sup> | Brand name copay plus the difference in cost between the brand name and the equivalent generic | Brand name coinsurance plus the difference in cost between the brand name and the equivalent generic | Deductible, then brand name copay plus the difference in cost between the brand name and the equivalent generic |

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

<sup>b</sup> You always pay the lesser of the actual cost of your prescription or the copay.

<sup>c</sup> When paying the brand name copay/coinsurance plus the difference in cost between the brand name and equivalent generic, your cost will not exceed the negotiated cost of the brand name medication.

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

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

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

### 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, 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.

### Inpatient care and your prescription benefit (Out-of-network facilities)

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

### Prescriptions covered without deductibles or copays

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

- FDA-approved women's contraception.
- Certain generic preventive prescriptions (applies to the Health+Savings Options only).
- Generic and over-the-counter medications that are prescribed for use in cleansing the bowel as a preparation for screening colonoscopy.
Retail pharmacy network

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

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

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

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

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

If you are enrolled in the Health+Savings Option, you may use your PayFlex Card® (your HSA debit card) to pay for eligible prescription drug expenses at a participating retail pharmacy.

Publication date: April 2019
If you live in the United States you can order up to a 90-day supply of maintenance medication for chronic conditions, such as asthma or high blood pressure, through ESI’s home delivery program. The home delivery program is not available if you live outside the United States.

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

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

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

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

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

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

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

If you are enrolled in the Health+Savings Option, you may use your PayFlex Card® (your HSA debit card) to pay for eligible prescription drug expenses you incur through the home delivery program.

Publication date: April 2019
Specialty pharmacy

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

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

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.

Copays for specialty medications

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

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

The Prescription Drug Program does not pay benefits for:

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

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

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

See Expenses not covered under the BP NonMedicare-Eligible Option (NMEO) for all other limitations and exclusions.

Publication date: April 2019
A note about Medicare and prescription drug coverage

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

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

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

Publication date: April 2019
How HMOs work

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

An HMO, or Health Maintenance Organization, takes a different approach to health care relative to the BP NonMedicare-Eligible Option (NMEO) options. If you participate in an HMO, all of your health care must be provided by the HMO’s network of providers to receive benefits. You must select a primary care physician (PCP) from the HMO’s network for yourself and for each family member you cover. Your PCP will direct your care, including providing referrals to see a specialist. If you want to change to a different PCP, you need to contact your HMO.

You have the right to designate any PCP who participates in the HMO’s network and who is available to accept you or your family members. For children, you may designate a pediatrician as the PCP. Women do not need to obtain authorization from their HMO or PCP to obtain access to obstetrical or gynecological care from HMO network providers who specialize in obstetrics or gynecology.

Some HMOs do not provide coverage for domestic partners. If you want to cover a domestic partner, be sure to call the HMO’s member services department for information before you enroll in the plan. Contact information for the available HMOs is available through the LifeBenefits site.

If you see a health care provider who is not affiliated with the HMO or receive medical care without the proper referrals, no benefits will be paid.

If you are enrolled in an HMO and have benefit questions, contact your HMO’s member services department for answers at the phone number listed on your HMO ID card.

You may also request a booklet describing your HMO’s general rules and services. Be aware that covered services and treatments may vary from HMO to HMO and may be different from those provided by the BP NMEO.

HMOs are subject to the same rules regarding health care claims that apply to the BP NMEO. Therefore, the HMO’s rules and procedures must be no less beneficial to HMO participants than the rules that apply to claimants under the BP NMEO. Because HMOs are generally insured, they may be subject to claims and appeals rules and procedures under applicable state laws that provide participants even greater potential procedural protections. Contact your HMO for its rules and procedures regarding health care claims.

What else you should know about HMOs

HMOs are independent business entities. The HMO — and not BP — is fully responsible for providing benefits and coverage once the HMO premium has been paid. As a result, neither BP nor the plan administrator can interfere in medical or administrative decisions made by an HMO or direct the HMO in any way regarding benefits or coverage. Therefore, if you and an HMO medical provider do not agree on a course of treatment, you must personally pursue the matter through the HMO’s appeals process. Similarly, if an HMO fails to pay its network provider for service you receive, you may be individually liable to pay for such services. Additional financial assistance from BP will not be provided.

Publication date: April 2019
BP Wellness Program for Retirees

BP has partnered with a third-party wellness organization, StayWell, to offer a variety of wellness programs to support the health needs and interests of plan participants. These wellness programs are only available to covered BP employees and their covered spouse/domestic partner.

Participation in these programs also determines your eligibility to enroll in the HealthPlus or Health+Savings Options. You (and your covered spouse/domestic partner if electing You + spouse/domestic partner or You + family coverage) must each earn a minimum of 1,000 points annually by participating in these programs.

To learn more about the available activities in the BP Wellness Program and their associated points, visit the StayWell website, which you can log onto via the BP HR & Benefits Center. Also, as with all other plan benefits, you are not eligible to participate in the Wellness Program unless you are a participant in this plan.

Wellness for all of you

Whether it's exercising regularly, utilizing preventive care or educating yourself on wellness, be sure to take advantage of these programs and activities designed to help you throughout the year. Every gain in one area leads to healthier habits for mind, for body and for life — it's all connected.

Here is a snapshot of your 2019 wellness program and points.

Set your baseline
Well-being assessment — Health questionnaire (125 points)

Your annual health baseline is an excellent entry point for your optimal wellness journey. It helps you assess the true current condition of your health and take proactive steps to ensure a longer, healthier life.

At the beginning of the year, take 10 minutes to complete the Health Questionnaire on the StayWell portal and earn 125 wellness points. The results will give you a roadmap to go for your personal best while also earning points.

Annual physical/well-woman exam (500 points)

Then schedule an annual physical and/or a well-woman exam to earn an additional 500 wellness points. The BP Medical Plan covers one in-network annual physical and one well-woman exam per calendar year at 100%.* Try to schedule your exam(s) early in the year so you can identify any lifestyle changes needed to become a healthier you.

Note for women: While your annual well-woman exam qualifies for the 500 points, we highly encourage you to also complete an annual physical exam with your primary physician.

If you are enrolled in the HealthPlus, Health+Savings or Standard medical option, Aetna and/or BCBS-IL will automatically notify StayWell when a claim is processed for a routine annual physical/annual well-woman exam. This process can take up to eight weeks from your office visit before StayWell is notified and your points are awarded.

Alternative self-report option

In order to help expedite this process, you may also self-report your annual physical/well-woman exam by accessing the StayWell portal, and clicking on the Annual Physical Self-Report option in My Points.

Simply certify that you have already completed your annual physical/well-woman exam during the 2019 calendar year and your 500 points will be immediately loaded to your My Points.

* The in-network requirement does not apply if you are enrolled in an Out-of-Area (OOA) medical option.

Move your body

Excess sitting is now linked with 35 diseases and conditions, including obesity, hypertension and depression. Move your body with the BP Million Step Challenge.
BP Million Step Challenge (250-1,000 points)

From January 1 – December 31, 2019, earn 250 points for each one million steps, up to four million steps, for 1,000 points and a special prize.

Also, watch for additional activities to keep you moving:

- MSC bonus challenges worth up to 50 points each.
- Two mini-challenges — one in the spring and one during the holiday season — worth 125 points each.
- Lots of local activities to keep you moving, worth 75-125 points each, up to 500 points total. Visit the Local Activity section on the StayWell portal to see what your site is offering in 2019.

You will need an activity tracker to track your steps, which you can purchase through StayWell or elsewhere.

How it works

StayWell's technology platform includes broad device connection capabilities, including Fitbit, Apple Watch and Garmin. If you already have a compatible device (including BP-provided Fitbits), you are encouraged to use your existing device to track your steps. If you need to obtain a new one, you can order one through StayWell or purchase one elsewhere.

To get started, log on to the StayWell portal via LifeBenefits to connect your existing or new tracking device to the MSC activity tracker and start turning your steps into points. Devices maintain steps for three to six months and must be connected to the MSC activity tracker to record data.

If you are using the same device as in 2018 and you haven't disconnected, you are already in the MSC and no further action is required. Just wear your tracker and sync to your account.

You must complete your steps and connect your device by December 31, 2019, to earn your points.

The BP Million Step Challenge runs from January 1, 2019, through December 31, 2019. All steps tracked on your device once you're enrolled will be counted toward your total step count. The amount of step data that syncs to the BP Million Step Challenge varies by device provider, ranging from one month to one year from date of connection, as far back as January 1, 2019.

Once you enroll, you'll have access to tools to help you track your progress along the way, including the StayWell portal, StayWell mobile option, connect with friends and more.

* Only compatible device-tracked steps will count toward the BP Million Step Challenge. Self-reported or manually tracked steps will not be applied, nor will steps tracked on non-compatible products (Jawbone, Vivofit, etc.). A maximum of 35,000 steps are allowed per day.

Feed your mind

As important as it is to feed your body, it’s just as important to feed your mind. Choose from a wide variety of wellness education, both live and online, including:

Quartely workshops (125-375 points)

Complete four new workshops (one per quarter) on a range of topics to increase your health aptitude and your points. Earn 125 points each, up to a maximum of 375 points.

The quarterly workshops will also be available in the digital learning series format.

Digital workshops (25-125 points)

Choose from a variety of topics for an interactive learning experience, which includes an article, video and quiz. Digital workshops take about 15 minutes to complete and will earn you 25 points per workshop, up to a maximum of 125 points.
Daily Dash (25-250 points)
Choose from a daily selection of four mini challenges — physical, nutrition, stress and sleep — to help keep your eye on the wellness prize. Ten completed dashes earn 25 points, up to 250 points total. Log on to the StayWell portal via LifeBenefits to get started.

The best possible you (75 points)
This mindfulness digital workshop series will help you enhance your emotional and physical well-being. Complete three workshops and earn 75 wellness points.

The 21-day meditation experience (14 videos, 125 points upon completion)
Learn a variety of meditation techniques through a series of 14 videos with guided meditation exercises.

Know your number$ — make progress toward your financial objectives
BP offers you a variety of ways to start developing sound money management habits and build toward a more secure and healthier financial future.

PwC financial wellness programs (up to 750 points)
You and your spouse/partner can now earn up to 750 points through financial wellness programs offered by PwC.

Go to the financial wellness page to find out more about financial wellness opportunities.

Live better — manage your health
Take charge of your chronic health condition and improve your quality of life with one of BP’s condition management programs.

Care management (250 points)
Care management includes condition management and complex case management, and is coordinated through various providers.

You can work with a condition management coach by telephone or onsite to manage your chronic condition, such as asthma (both pediatric and adult), diabetes, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF) and coronary artery disease (CAD). To be eligible, participants must be moderate to high-risk and complete at least three calls or onsite sessions with a coach to earn 250 points. To determine your eligibility for the condition management program, call the StayWell HelpLine at 1-888-343-9862.

Complex case management is for participants with an acute condition such as a severe stroke, transplant, severe injury or cancer that requires extensive treatment. The program allows you to receive support with navigating healthcare, creating a care plan and optimizing your health benefits. Complete a plan and complete at least one call with a Case Management nurse to earn 250 points. This program is available to eligible participants who are identified for case management by Aetna or BCBS-IL.

Livongo diabetes management program (250 points)
Livongo is a comprehensive diabetes management program that includes free test strips on demand, a complimentary blood glucose meter with real-time updates, and certified diabetes educators to advise on nutrition, lifestyle and diabetes management. Eligible participants must complete at least three calls with a Livongo coach to earn 250 points. To see if you qualify, call 1-800-945-4355.
Lifestyle management (250 points)

The lifestyle management program places a professional, personal health coach at your disposal via telephone to assist you with reaching your individual health goals.

The coach will call you monthly at convenient prearranged times to help you set goals, deal effectively with barriers, evaluate helpful resources and keep you on track for success!

Note: You must start this program by September 30, 2019, in order to have time to complete it by December 31, 2019. You must complete at least three calls with a StayWell health coach to earn your 250 points. Points are awarded in the program year that the third call with a StayWell health coach is completed. It may take up to 24-48 hours for the new points to be added to your My Points.

Online self-directed coaching (125-500 points)

This online coaching system helps you set health goals, and identify and overcome the challenges you face as you work toward your goals. Pick from several programs and advance at your own pace through proven tips, tools, content, suggestions, quizzes, encouragement and more. Your program is customized based on your current risk status and health profile. You can earn 125 points per topic completed, up to 500 points.

Notice regarding wellness program

BP's wellness program is a voluntary wellness program available to all participants in the BP Medical Plan. The program is administered according to federal rules governing wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program, you will have the opportunity to complete the Health Questionnaire. The Health Questionnaire is a voluntary health risk assessment that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease).

This opportunity is voluntary to you, as is participation in the wellness program overall. However, participants who choose to participate in the wellness program earn points towards your eligibility for the HealthPlus and Health+Savings Plans.

Additional points-earning opportunities are available throughout the BP wellness program, some of which are health-related. Please refer to the wellness guide for a complete description of each opportunity. If you are unable due to a medical condition to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, a reasonable accommodation or an alternative standard is available. You may request a reasonable accommodation or an alternative standard by contacting the BP HR & Benefits Center at 1-800-890-4100.

The information from the Health Questionnaire will be used to provide you with information to help you understand your current health and potential risks, and may also be used in partnership with a StayWell health advisor to design wellness activities that suit you specifically. You also are encouraged to share your results or concerns with your own doctor.
Protections from disclosure of medical information

As further described in the Plan's summary plan description, the BP Medical Plan is required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program coordinator and BP's Benefits team may use aggregate information it collects to design a program based on identified health risks, the BP Medical Plan will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information from the BP wellness program are Alight, StayWell, Livongo, approved members of the BP Benefits department and Aetna, and all done in order to provide you with services under the wellness program.

In addition, all personally identifiable medical information obtained by BP Benefits through the wellness program will be maintained wholly separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you in accordance with applicable law.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.
Eligible/ineligible expenses

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

The BP NonMedicare-Eligible Option (NMEO) 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 NonMedicare-Eligible Option (NMEO)
- Expenses not covered under the BP NonMedicare-Eligible Option (NMEO)

Publication date: April 2019
Expenses covered under the BP NonMedicare-Eligible Option (NMEO)

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

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

- Acupuncture in lieu of anesthesia.
- Autism spectrum disorder:
  - Covered expenses include charges made by a physician or behavioral health provider for the services and supplies for the diagnosis and treatment (including routine behavioral health services such as office visits or therapy and Applied Behavioral Analysis) of Autism Spectrum Disorder when ordered by a physician, licensed psychologist or licensed clinical social worker, as part of a treatment plan; and the covered child is diagnosed with Autism Spectrum Disorder.
  - Applied Behavioral Analysis is an educational service that is the process of applying interventions:
    - That systematically change behavior; and
    - That are responsible for the observable improvement in behavior.
  - Autism Spectrum Disorder is defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.
- Behavioral health (mental health and substance abuse), including:
  - Inpatient hospital care.
  - Residential treatment facility care.
  - Outpatient physician and facility care.
  - Partial hospitalization. This includes day care and night care treatment.
- Behavioral health care includes treatment of:
  - Anorexia/Bulimia Nervosa (including nutritional counseling).
  - Bipolar disorder.
  - Major depressive disorder.
  - Obsessive compulsive disorder.
  - Panic disorder.
  - Psychotic disorders/Delusional disorder.
  - Schizo-affective disorder.
  - Schizophrenia.
  - Substance abuse.
- Biofeedback.
- Chiropractic care (up to 20 visits/plan year combined maximum for network and out-of-network care).
- Contraceptive drugs (administered in a physician’s office) and contraceptive devices prescribed by a physician provided they have been approved by the Federal Drug Administration, as well as associated office visits, procedures, and other medical services and supplies.
- Durable medical equipment, orthotics and consumable medical supplies, including diabetic insulin pumps and tubing.
- Emergency services, including:
  - Ambulance services (ground, air or water).
  - Hospital emergency room/urgent care center.
- Home health care expenses (up to 120 visits/plan year combined maximum for network and out-of-network care) 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.

- Hospice care, including:
  - Charges made by a hospital, hospice or skilled nursing facility for:
    - Room and board (semi-private room) and other services and supplies furnished during a stay for pain control and other acute and chronic symptom management; and
    - Services and supplies furnished on an outpatient basis.
  - Charges made on an outpatient basis by a Hospice Care Agency for:
    - Part-time or intermittent nursing care by an R.N. or L.P.N. for up to eight hours a day;
    - Part-time or intermittent home health aide services for up to eight hours a day;
Medical social services under the direction of a physician. These include but are not limited to:
- Assessment of your social, emotional and medical needs, and your home and family situation;
- Identification of available community resources; and
- Assistance provided to you to obtain resources to meet your assessed needs;
- Physical and occupational therapy;
- Consultation or case management services by a physician;
- Medical supplies and prescription drugs;
- Dietary counseling; and
- Psychological counseling.

Charges made by the providers below if they are not an employee of a Hospice Care Agency; and such Agency retains responsibility for your care:
- A physician for a consultation or case management;
- A physical or occupational therapist;
- A home health care agency for:
  - Physical and occupational therapy;
  - Part-time or intermittent home health aide services for up to eight hours a day;
  - Medical supplies and prescription drugs;
  - Psychological counseling; and
  - Dietary counseling.

Infertility treatment (limited to diagnostic testing, corrective surgery and drug therapy for the underlying medical cause of infertility).

Inpatient hospital services, including:
- Room and board (semi-private room), other facility services and supplies.
- Doctor hospital visits, surgery and related professional fees.
- Maternity and newborn care.
- Lab, X-ray and anesthesia.

Metabolic formulas for a covered person diagnosed with phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homosystinuria.

Outpatient rehabilitation (physical/speech/occupational therapy) and cardiac rehabilitation. A combined maximum of 60 visits per plan year applies to physical, speech and occupational therapy, with no medical review required. Additional visits are not covered.

Outpatient services (i.e., services provided other than in a doctor’s office), including:
- Outpatient surgery facility.
- Doctor, surgeon and related professional fees.
- Lab and X-ray and complex imaging, including:
  - C.A.T. scans;
  - Magnetic Resonance Imaging (MRI); and
  - Positron Emission Tomography (PET) scans.
- Radiation therapy/chemotherapy/infusion therapy.

Preventive care in accordance with the claims administrator’s standards and pursuant to that which is identified by the United States Preventive Services Task Force as a requirement for coverage, including:
- Routine physicals (once per calendar year).
- Well-child care (routine).
- Annual well-woman exams.
- Routine mammograms.
- Routine PSA tests.
- Colorectal screenings (routine).

Primary care/specialist office visits, including:
- Lab and X-ray.
- Maternity services.

Private duty nursing by an R.N. or L.P.N., if the person’s condition requires skilled nursing care and visiting nursing care is not adequate, for up to 70 8-hour shifts per plan year.

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

Skilled nursing facility (up to 60 days/plan year combined maximum for network and out-of-network care).

Sterilization (tubal ligation or vasectomy).

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

Transgender reassignment surgery, when deemed medically necessary and subject to satisfying specific criteria established by the claims administrator, depending on the type of reassignment. Contact the medical claims administrator at the number on your ID card for further details about medical necessity and coverage criteria.

Treatment for morbid obesity as follows:
- Charges made by a physician, licensed or certified dietician, nutritionist or hospital for non-surgical treatment of obesity for the following outpatient weight management services: initial medical history and physical exam, diagnostic tests given or ordered during the first exam, and prescription drugs.
- Charges for one morbid obesity surgical procedure, unless a multi-stage procedure is planned.
- Morbid obesity means a body mass index (calculated by dividing the weight in kilograms by the height in meters squared) that is greater than 40 kilograms per meter squared, or equal to greater than 35 kilograms per meter squared with a comorbid
medical condition, including hypertension, a cardiopulmonary condition, sleep apnea or diabetes.

- Urgent care services.
- Wigs, if hair loss is due to certain medical conditions.

**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 NMEO provides medical and surgical benefits for mastectomies, it must also provide coverage for:

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction on the other breast to produce a symmetrical appearance.
- Coverage for prostheses (such as a breast implant).
- Treatment for physical complications at all stages of the mastectomy, including lymphedema.

The same deductibles and coinsurance limitations apply to these procedures as apply to any other illness.

**The Newborns’ and Mothers’ Health Protection Act of 1996 (NMHPA)** requires coverage for 48 hours of hospitalization for mothers and their newborn children following a normal vaginal delivery and 96 hours following an uncomplicated Caesarean section. Shorter or longer lengths of stay may be approved by the claims administrator at the request of the attending doctor.

**The Patient Protection and Affordable Care Act (PPACA)** requires coverage for women’s preventive health care services, including breast pumps (manual or electric) and lactation consultants. The BP NMEO will cover these services both in-network and out-of-network. They are subject to the same deductibles and coinsurance limitations as other services.

Publication date: April 2019
Expenses not covered under the BP NonMedicare-Eligible Option (NMEO)

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

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

I 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.
I Any biomechanical external prosthetic device or replacement of external prosthetics due to loss, theft or destruction.
I 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.
I Care provided by Christian Science Sanitariums and Practitioners.
I Charges for services not ordered by a covered provider.
I 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.
I Drugs that do not require a prescription, even if prescribed by a doctor.
I 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.
I 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.
I Expenses that are in excess of recognized charge/maximum reimbursable charge limits, as determined by the claims administrator.
I Injury due to a military action, unless the injury results from being an innocent bystander in the situation.
I Injury or illness covered by Workers’ Compensation or other federal, state or local laws.
I Inpatient personal services such as television rental and guest meals.
I 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).
   ° 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 (unless for prescription drugs for participants and eligible dependents who are enrolled in a HealthPlus Option and participating in a smoking cessation program sponsored by StayWell).
- 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 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, or when related to preventive care identified by the United States Preventive Services Task Force as a requirement for coverage.
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 dietitian, foods required for special diets or nutritional supplements that do not require a prescription (except as an inpatient hospital expense or prior to surgical treatment of morbid obesity, or metabolic formulas for a covered person diagnosed with phenylketonuria (PKU), branch-chain ketonuria, galactosemia, homocystinuria or autism).
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 (unless for prescription drugs for participants and eligible dependents who are enrolled in a HealthPlus Option and participating in a smoking cessation program sponsored by StayWell).
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.

1. TMJ-related dental services and orthodontic appliances.
2. Transportation services other than ambulance service to the nearest hospital where the needed medical care and treatment can be provided.
3. 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.
4. 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.
5. 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 NonMedicare-Eligible Option (NMEO).
6. 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 NonMedicare-Eligible Option (NMEO), coverage under the BP NMEO 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:

- A plan that does not coordinate benefits is the primary plan and determines its benefits first.
- If you have continuation coverage under the BP NMEO and other group health coverage, the BP NMEO will not be the primary plan.
- 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.
- If your children are covered by the BP NMEO 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.
- If you are separated or divorced and your children are covered by more than one group health plan:
  - The plan of the natural parent with custody is the primary plan.
  - The plan of the spouse/domestic partner of the natural parent with custody is the secondary plan.
  - The plan of the other natural parent is the tertiary plan.

If the natural parent without custody has legal financial responsibility for the child’s medical care, the plan of that parent becomes the primary plan.

- 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 NMEO is secondary.
- If an employee or dependent of an active employee has Medicare coverage, the BP NMEO 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.
- If a person has Medicare coverage and coverage under the BP NMEO 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 NMEO is the secondary plan, as long as no tertiary plan is involved. When the BP NMEO is the secondary plan, the benefits paid by Medicare are subtracted from the benefits that would normally be paid by the BP NMEO. The reduction of Medicare benefits is called a Medicare offset and will be applied only if they have Medicare coverage. If a person permanently lives in the United States but is traveling temporarily outside the country, the BP NMEO will consider full plan benefits without applying the Medicare offset if Medicare does not provide coverage during that travel.

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

Employees who receive Long-Term Disability (LTD) benefits from the BP Long-Term Disability Plan are typically considered active employees during the first 24 months of LTD. After 24 months, a person is no longer eligible for coverage as an active employee in the BP Retiree Medical Plan, regardless of the person’s status on BP’s payroll system. If you are receiving LTD benefits from the BP Long-Term Disability Plan, and are in the initial 24-month period, this plan will be the primary plan and Medicare will be secondary as long as you are considered an active employee by BP. After the earlier to occur of the end of this 24-month period or the termination of your active employment, Medicare will be the primary plan and the BP Retiree Medical plan will be secondary.
If you are enrolled in an HMO

If you are enrolled in an HMO, contact the HMO to learn how that plan coordinates benefits.

Publication date: April 2019
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 NonMedicare-Eligible Option (NMEO), 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 HR & Benefits Center. Keep in mind that your issue may not necessarily be resolved in your favor, as the terms of the plan will apply in all situations.

Responsibility for filing claims

The following can help you determine when providers will file claims on your behalf and when you must file claims directly with the appropriate claims administrator.

<table>
<thead>
<tr>
<th></th>
<th>PPO Options, including Health+Savings PPO</th>
<th>Out-of-Area Options, including Health+Savings OOA</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-network</td>
<td>Provider files medical claims.</td>
<td>You may have to pay for services at the time you receive them and file a claim with Aetna for reimbursement.</td>
</tr>
<tr>
<td>Out-of-network</td>
<td>You pay for services and file a claim with Aetna.</td>
<td>You pay for services and file a claim with Aetna.</td>
</tr>
</tbody>
</table>

**Prescription drugs**

<table>
<thead>
<tr>
<th></th>
<th>PPO Options, including Health+Savings PPO</th>
<th>Out-of-Area Options, including Health+Savings OOA</th>
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<tbody>
<tr>
<td>In-network</td>
<td>Provider files claims.</td>
<td>Provider files claims.</td>
</tr>
<tr>
<td>Out-of-network</td>
<td>You pay for services and file a claim with ESI.</td>
<td>You pay for services and file a claim with ESI.</td>
</tr>
</tbody>
</table>

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

1. A completed claim form.
2. All itemized bills indicating the date of service, description of service provided, diagnosis, name of the provider and charges incurred.

You can request claim forms from the claims administrator or download them from the claims administrator’s Internet site. A list of claims administrators is available under Administrative Information.

If you have other medical coverage

Periodically, a claims administrator will ask you to provide information about other medical coverage you and/or your eligible dependents may have. This request may occur in connection with a claim you have submitted. In that case, you will be advised that the other medical coverage information, including an Explanation of Benefits (EOB) from the other coverage’s administrator, is required before your claim can
Your claim will not be processed until you comply with the claims administrator’s request.

**Health Savings Account (HSA) Debit Card**

Your share of the cost for eligible medical expenses you incur may be paid to the provider through your PayFlex Card® (your HSA debit card), if you contribute to the HSA and have an available balance in your account. **Note:** You cannot use the HSA debit card outside the U.S.
## Submitting claims for expenses incurred with out-of-network providers

To submit claims for expenses incurred with out-of-network providers, or if you have questions about how to file a claim, here is what you need to do:

### Medical claims

<table>
<thead>
<tr>
<th>Medical claims</th>
<th>Submit claims for expenses incurred with out-of-network providers to…</th>
<th>If you have questions about how to file a claim, call…</th>
</tr>
</thead>
</table>
| The HealthPlus Options (including behavioral health care) | Aetna  
P.O. Box 14586  
Lexington, KY 40512-4586                                                   | Aetna  
1-866-436-2606                                                   |
| The Standard Options (including behavioral health care) |                                                                        |                                                        |
| The Health+Savings Options (including behavioral health care) |                                                                        |                                                        |

### Prescription drug claims

<table>
<thead>
<tr>
<th>Prescription drug claims</th>
<th>Submit claims for expenses incurred with out-of-network providers to…</th>
<th>If you have questions about how to file a claim, call…</th>
</tr>
</thead>
</table>
| The HealthPlus, Standard and Health+Savings Options | Express Scripts  
P.O. Box 2872  
Clinton, IA 52733                                                  | Express Scripts  
Within the U.S.  
1-800-451-6245 (claims)  
1-800-216-6506 (customer service)                                               |

If you file a claim, an Explanation of Benefits (EOB) will be generated. The Aetna and Express Scripts websites allow you to print this information, which you can keep for your records or use to file a claim for reimbursement from your Health Savings Account (HSA).

### What else you should know about claims administrators under the BP NonMedicare-Eligible Option (NMEO)

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

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Publication date: April 2019
Under the BP Medical Plan, you may file claims for benefits and appeal Adverse Benefit Determinations. Any reference to “you” in this section includes a covered person and his/her authorized representative. An “Authorized Representative” is a person you authorize, in writing, to act on your behalf using the plan’s designation of authority form for appeals. The Medical Plan will also recognize a court order giving a person authority to submit claims on your behalf. In the case of an urgent care claim, a health care professional with knowledge of your condition may always act as your “Authorized Representative.”

If your claim is denied in whole or in part, you will receive a written notice of the denial from the respective claims administrator. The notice will explain the reason for the denial and the appeal procedures available under the Medical Plan.

If you are enrolled in an Aetna-administered PPO Option, Health+Savings Option or Out-of-Area Option, you can choose to submit an appeal or complaint electronically through Aetna’s website at www.aetna.com. On that site, choose the “Contact Us” link, select “A complaint or appeal” from the drop-down menu of message topics, and provide the necessary information prior to submitting.

**Note:** This feature is not available to participants who are:

- Enrolled in any other medical option; or
- Eligible for Medicare

**Urgent care claims**

An “Urgent Care Claim” is legally defined as “any claim for medical care or treatment for which the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.”

If the Medical Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if the claims administrator or your physician determines that it is an Urgent Care Claim, you will be notified of the decision, whether adverse or not, as soon as possible but not later than 24 hours after the claim is received.

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

**Other claims (pre-service and post-service)**

If the Medical Plan requires you to obtain advance approval of a non-urgent service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim.

For other claims (post-service claims), you will be notified of the decision not later than 30 days after receipt of the claim.

For either a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside the claims administrator’s control. In that case, you will be notified of the extension before the end of the initial 15- or 30-day period. For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of the claims administrator’s claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

For pre-service claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to a claims administrator representative responsible for handling benefit matters, but which otherwise fail to follow the Medical Plan’s procedures for filing pre-service claims, you will be notified of the failure within 5 days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.
Ongoing course of treatment

If you have received pre-authorization for an ongoing course of treatment, you will be notified in advance if the previously authorized course of treatment is intended to be terminated or reduced so that you will have an opportunity to appeal any decision to the claims administrator and receive a decision on that appeal before the termination or reduction takes effect. If the course of treatment involves urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

Health claims — standard appeals

As an individual enrolled in the Medical Plan, you have the right to file an appeal from an Adverse Benefit Determination relating to service(s) you have received or could have received from your health care provider under the Medical Plan.

An “Adverse Benefit Determination” is defined as a denial, reduction, termination of, or failure to provide or make payment (in whole or in part) for a service, supply or benefit. Such Adverse Benefit Determination may be based on:

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

A “Final Internal Adverse Benefit Determination” is defined as an Adverse Benefit Determination that has been upheld by the appropriate claims administrator, which is a named fiduciary of the Medical Plan, at the completion of the internal appeals process, or an Adverse Benefit Determination for which the internal appeals process has been exhausted.

Exhaustion of internal appeals process

You are required to complete all appeal processes of the Medical Plan before being able to obtain External Review or bring an action in litigation. However, if the claims administrator, or the Medical Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under applicable federal law, you are considered to have exhausted the Medical Plan's appeal requirements (“Deemed Exhaustion”) and may proceed with External Review or may pursue any available remedies under §502(a) of ERISA or under state law, as applicable, as long as such an action is (a) filed within one (1) year of a final denial decision, and (b) any such litigation is filed in a federal court in Harris County, Texas.
Full and fair review of claim determinations and appeals

The claims administrator will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the claims administrator (or at the direction of the claims administrator), or any new or additional rationale as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is provided, to give you a reasonable opportunity to respond prior to that date.

You may file an appeal in writing or via the Aetna website to the claims administrator at the address provided in this summary, or, if your appeal is of an urgent nature, you may call the claims administrator’s Member Services Unit at the toll-free phone number on the back of your ID card (also listed at the end of this summary). Your request should include the name of your employer, your name, member ID, or other identifying information shown on the front of the Explanation of Benefits form, and any other comments, documents, records and other information you would like to have considered, whether or not submitted in connection with the initial claim.

A claims administrator representative may call you or your health care provider to obtain medical records and/or other pertinent information in order to respond to your appeal.

You will have 180 days following receipt of an Adverse Benefit Determination to appeal the determination to the claims administrator. You will be notified of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim. A copy of the specific rule, guideline or protocol relied upon in the Adverse Benefit Determination will be provided free of charge upon request by you or your authorized representative. You may also request that the claims administrator provide you, free of charge, copies of all documents, records and other information relevant to the claim.

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to the phone number included in your denial, or to the claims administrator’s Member Services, which number is on your Identification Card. You or your authorized representative may appeal urgent care claim denials either orally, in writing or via the Aetna website. All necessary information, including the appeal decision, will be communicated between you or your authorized representative and the claims administrator by telephone, facsimile, or other similar method. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with the appeal decision on an urgent care claim, you may file a second level appeal with the claims administrator. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with a pre-service or post-service appeal decision, you may file a second level appeal with the claims administrator within 60 days of receipt of the level one appeal decision. The claims administrator will notify you of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received.

If you do not agree with the Final Internal Adverse Benefit Determination on review, you have the right to bring a civil action under Section 502 (a) of ERISA, if applicable. However, you may not file a civil action unless you have exhausted the Medical Plan’s claims and appeals procedures. Any such suit must be filed with a federal court located in Harris County, Texas, and may not be filed any later than one (1) year following a final denial pursuant to the Medical Plan’s claims and appeals procedures.

Publication date: April 2019
Process for formal claims relating to eligibility to participate

You may make a verbal inquiry to the BP HR & 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 HR & 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 HR & 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 have HMO coverage, state law may provide for an additional period of coverage beyond the COBRA Continuation periods. Contact the HMO directly for more information.

ELECTING COBRA COVERAGE

The COBRA election process is a three-step process:

1. You or your covered dependent must experience a qualifying event that triggers COBRA eligibility.
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.

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

### Detailed information about plan administration and your rights

<table>
<thead>
<tr>
<th>Name of plan</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>Type of plan</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>- Health Maintenance Organization (HMOs) — insured.</td>
</tr>
<tr>
<td>Plan number</td>
<td>851</td>
</tr>
<tr>
<td>Plan year</td>
<td>January 1 – December 31</td>
</tr>
</tbody>
</table>
| Plan sponsor and identification number | BP Corporation North America Inc.  
|                                  | 501 Westlake Park Blvd.  
|                                  | Houston, TX 77079  
|                                  | Employer ID#: 36-1812780                                                                         |
| Plan administrator               | Director, Health & Welfare  
|                                  | BP Corporation North America Inc.  
|                                  | 501 Westlake Park Blvd  
|                                  | Houston, TX 77079  
|                                  | 1-800-890-4100                                                                                   |
| Sources of contributions         | The BP Corporation North America Inc. 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 ("VEBA"). |
| VEBA trustee                     | JPMorgan Chase Bank  
|                                  | Worldwide Securities Services  
|                                  | 4 New York Plaza  
|                                  | New York, NY 10005                                                                               |
| Claims administrators            | See Claims administrators.                                                                        |
| Agent for service of legal process | For disputes arising from the plans, legal process may be served on:  
|                                  | BP Legal  
|                                  | BP Corporation North America Inc.  
|                                  | P.O. Box 940669  
|                                  | Houston, TX 77094-7669                                                                           |
|                                  | Legal process may be made upon the plan administrator.                                             |

Publication date: April 2019
Claims administrators

All of the coverage options include behavioral health services and prescription drug coverage.

- The HealthPlus, Standard and Health+Savings Options, including behavioral health care, are all administered by Aetna.
- The Prescription Drug Program is administered by Express Scripts, Inc. (ESI). Specialty drug coverage is administered by Accredo. MCMC is the final claims fiduciary for prescription drug appeals.
- The claims administrator for an HMO option is the HMO.
- The medical coverage claims administrator (Aetna) determines incapacity for a dependent child to continue as an eligible dependent child beyond otherwise applicable age limits.

<table>
<thead>
<tr>
<th>Administrator</th>
<th>Online</th>
<th>By phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP NonMedicare-Eligible Program: Aetna</td>
<td>Aetna&lt;br&gt;www.aetna.com&lt;br&gt;BP's custom DocFind website&lt;br&gt;www.aetna.com/dsepublic/#/contentPage?page=providerSearchLanding&amp;site_id=bp</td>
<td><strong>Note:</strong> The phone numbers below include the Enhanced Aetna Concierge program&lt;br&gt;<strong>Within the U.S.:</strong> 1-866-436-2606&lt;br&gt;<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>
</tbody>
</table>

| HMOs | For questions or to submit claims to a BP-offered HMO, contact your HMO directly. The phone number is on your HMO medical option ID card or available by contacting the BP HR & Benefits Center. |

| Prescription Drug Program for the PPO or OOA Options, including the Health+Savings PPO and OOA Options: Express Scripts, Inc. (ESI) | www.express-scripts.com | **Note:** MCMC is the final claims fiduciary for prescription drug appeals. | 1-800-216-6506 |

Publication date: April 2019
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 2019
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 HR & Benefits Center.

Complaints

If you believe the plan has violated your privacy rights, you may file a complaint with the plan, the plan's Privacy Officer or with the Secretary of Health and Human Services. Complaints to the plan or to the Privacy Officer should be filed in writing with:

BP HIPAA Privacy Compliance Monitor
BP Corporation North America Inc.
P.O. Box 941614
Houston, Texas 77094-8644
713-366-2000

You will not be penalized in any way for filing such a complaint.
Certificate of Group Health Coverage

If you and/or your covered dependent lose medical coverage, the BP HR & 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.
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 HR & 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 HR & 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 2019
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 HR & 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 HR & 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 HR & Benefits Center will not process a transaction if there is a reason to believe that the person making the transaction is not the plan participant, the participant's agent under a POA or court-appointed conservator or guardian.

Anti-assignment

The rights or benefits under this plan may not be assigned by a participant or beneficiary. Any attempted assignment to a medical provider will be treated as a direction to pay benefits to such provider rather than as an assignment of rights.
Governing plan documents

In the preparation of this plan summary, effort was made to provide a clear, concise description of your benefits and to avoid contract and legal terms wherever possible. The aim has been to present a simplified overview of essential information about your benefits in words that are not obscure or likely to be misunderstood. As highlighted earlier in this summary, in the event of an inconsistency between this summary and the plan document (including insurance policies as applicable), the plan document will govern.

Publication date: April 2019
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 2019
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.
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, 2019. You should contact your State for further information on eligibility.

<table>
<thead>
<tr>
<th>State</th>
<th>Program</th>
<th>Website</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALABAMA</td>
<td>Medicaid</td>
<td><a href="http://www.myalhipp.com">http://www.myalhipp.com</a></td>
<td>1-855-692-5447</td>
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<tr>
<td>ALASKA</td>
<td>The AK Health Insurance Premium Payment Program</td>
<td><a href="http://myakhipp.com/">http://myakhipp.com/</a></td>
<td>1-866-251-4861</td>
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<td><a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a></td>
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<td><a href="https://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx">https://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</a></td>
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<tr>
<td>ARKANSAS</td>
<td>Medicaid</td>
<td><a href="http://myarhipp.com/">http://myarhipp.com/</a></td>
<td>1-855-MyARHIPP (855-692-7447)</td>
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<td>FLORIDA</td>
<td>Medicaid</td>
<td><a href="http://www.flmedicaidtplrecovery.com/hipp">http://www.flmedicaidtplrecovery.com/hipp</a></td>
<td>1-877-357-3268</td>
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<td>GEORGIA</td>
<td>Medicaid</td>
<td><a href="http://www.medicaid.georgia.gov">http://www.medicaid.georgia.gov</a></td>
<td>1-404-656-4507</td>
</tr>
<tr>
<td>INDIANA</td>
<td>Healthy Indiana Plan for low-income adults 19-64</td>
<td></td>
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</tbody>
</table>

The most up-to-date information is available online at http://hr.bpglobal.com/lifebenefits/RetireeNonMedicarePage 202 of 209
<table>
<thead>
<tr>
<th>State</th>
<th>Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iowa</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Website: <a href="http://www.dhs.iowa.gov/hawk-i">http://www.dhs.iowa.gov/hawk-i</a></td>
<td></td>
</tr>
<tr>
<td>Phone: 1-800-257-8563</td>
<td></td>
</tr>
<tr>
<td>Kansas</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Website: <a href="http://www.kdheks.gov/hcf/">http://www.kdheks.gov/hcf/</a></td>
<td></td>
</tr>
<tr>
<td>Phone: 1-785-296-3512</td>
<td></td>
</tr>
<tr>
<td>Kentucky</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Website: <a href="http://chfs.ky.gov/">http://chfs.ky.gov/</a></td>
<td></td>
</tr>
<tr>
<td>Phone: 1-800-635-2570</td>
<td></td>
</tr>
<tr>
<td>Louisiana</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Website: <a href="http://dhh.louisiana.gov/index.cfm/subhome/1/n/331">http://dhh.louisiana.gov/index.cfm/subhome/1/n/331</a></td>
<td></td>
</tr>
<tr>
<td>Phone: 1-888-695-2447</td>
<td></td>
</tr>
<tr>
<td>Maine</td>
<td>Medicaid</td>
</tr>
<tr>
<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>
<td></td>
</tr>
<tr>
<td>Phone: 1-800-442-6003</td>
<td></td>
</tr>
<tr>
<td>Phone (TTY): Maine relay 711</td>
<td></td>
</tr>
<tr>
<td>Massachusetts</td>
<td>Medicaid and CHIP</td>
</tr>
<tr>
<td>Website: <a href="http://www.mass.gov/eohhs/gov/departments/masshealth/">http://www.mass.gov/eohhs/gov/departments/masshealth/</a></td>
<td></td>
</tr>
<tr>
<td>Phone: 1-800-862-4840</td>
<td></td>
</tr>
<tr>
<td>Minnesota</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Website: <a href="http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp">http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp</a></td>
<td></td>
</tr>
<tr>
<td>Phone: 1-800-657-3739 or 651-431-2670</td>
<td></td>
</tr>
<tr>
<td>Missouri</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Website: <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a></td>
<td></td>
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<tr>
<td>Phone: 573-751-2005</td>
<td></td>
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<tr>
<td>Montana</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Website: <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a></td>
<td></td>
</tr>
<tr>
<td>Phone: 1-800-694-3084</td>
<td></td>
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<tr>
<td>Nebraska</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Website: <a href="http://www.ACCESSNebraska.ne.gov">http://www.ACCESSNebraska.ne.gov</a></td>
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</tbody>
</table>

The most up-to-date information is available online at [http://hr.bpglobal.com/lifebenefits/RetireeNonMedicare](http://hr.bpglobal.com/lifebenefits/RetireeNonMedicare).
<table>
<thead>
<tr>
<th>State</th>
<th>Program(s)</th>
<th>Website</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>NEVADA</td>
<td>Medicaid</td>
<td><a href="http://dhcfp.nv.gov">dhcfp.nv.gov</a></td>
<td>1-800-992-0900</td>
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<tr>
<td>NEW HAMPSHIRE</td>
<td>Medicaid</td>
<td><a href="https://www.dhhs.nh.gov/oii/hipp.htm">https://www.dhhs.nh.gov/oii/hipp.htm</a></td>
<td>603-271-5218 or 1-800-852-3345 ext. 5218</td>
</tr>
<tr>
<td>NEW JERSEY</td>
<td>Medicaid and CHIP</td>
<td><a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a></td>
<td>609-631-2392</td>
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<tr>
<td>NEW YORK</td>
<td>Medicaid</td>
<td><a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a></td>
<td>1-800-541-2831</td>
</tr>
<tr>
<td>NORTH CAROLINA</td>
<td>Medicaid</td>
<td><a href="https://dma.ncdhhs.gov/">https://dma.ncdhhs.gov/</a></td>
<td>919-855-4100</td>
</tr>
<tr>
<td>OKLAHOMA</td>
<td>Medicaid and CHIP</td>
<td><a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a></td>
<td>1-888-365-3742</td>
</tr>
<tr>
<td>OREGON</td>
<td>Medicaid and CHIP</td>
<td>(English): <a href="http://healthcare.oregon.gov/Pages/index.aspx">http://healthcare.oregon.gov/Pages/index.aspx</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Spanish): <a href="http://oregonhealthcare.gov/index-es.html">http://oregonhealthcare.gov/index-es.html</a></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Phone: 1-800-699-9075</td>
<td></td>
</tr>
<tr>
<td>PENNSYLVANIA</td>
<td>Medicaid</td>
<td><a href="http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm">http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm</a></td>
<td>1-800-692-7462</td>
</tr>
<tr>
<td>RHODE ISLAND</td>
<td>Medicaid</td>
<td><a href="http://www.eohhs.ri.gov">http://www.eohhs.ri.gov</a></td>
<td>855-697-4347</td>
</tr>
<tr>
<td>SOUTH CAROLINA</td>
<td>Medicaid</td>
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</tbody>
</table>
To see if any more States have added a premium assistance program since January 31, 2019, or for more information on special enrollment rights, you can contact either:

<table>
<thead>
<tr>
<th>State</th>
<th>Program</th>
<th>Website</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOUTH DAKOTA</td>
<td>Medicaid</td>
<td>website: <a href="https://www.scdhhs.gov">https://www.scdhhs.gov</a></td>
<td>Phone: 1-888-549-0820</td>
</tr>
<tr>
<td>TEXAS</td>
<td>Medicaid</td>
<td>website: <a href="http://www.gethipptexas.com/">http://www.gethipptexas.com/</a></td>
<td>Phone: 1-800-440-0493</td>
</tr>
<tr>
<td>UTAH</td>
<td>Medicaid and CHIP</td>
<td>Medicaid Website: <a href="https://medicaid.utah.gov/">https://medicaid.utah.gov/</a></td>
<td>CHIP Website: <a href="http://health.utah.gov/chip">http://health.utah.gov/chip</a></td>
</tr>
<tr>
<td>VERMONT</td>
<td>Medicaid</td>
<td>website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a></td>
<td>Phone: 1-800-250-8427</td>
</tr>
<tr>
<td>VIRGINIA</td>
<td>Medicaid and CHIP</td>
<td>Medicaid Website: <a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a></td>
<td>CHIP Website: <a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a></td>
</tr>
<tr>
<td>WASHINGTON</td>
<td>Medicaid</td>
<td>website: <a href="http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program">http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program</a></td>
<td>Phone: 1-800-562-3022 ext. 15473</td>
</tr>
<tr>
<td>WISCONSIN</td>
<td>Medicaid and CHIP</td>
<td>Website: <a href="https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf">https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf</a></td>
<td>Phone: 1-800-362-3002</td>
</tr>
<tr>
<td>WYOMING</td>
<td>Medicaid</td>
<td>website: <a href="https://health.wyo.gov/healthcarefin/medicaid/">https://health.wyo.gov/healthcarefin/medicaid/</a></td>
<td>Phone: 307-777-7531</td>
</tr>
</tbody>
</table>

The most up-to-date information is available online at http://hr.bpglobal.com/lifebenefits/RetireeNonMedicare.
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 HR & Benefits Center, copies of governing plan documents. A reasonable fee for copying may be assessed. The address used to request plan documents is:

   BP HR & 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 HR & 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.