BP spending accounts

IMS#65525

Table of Contents

Spending accounts

Spending accounts are tax-savings opportunities for eligible employees

Spending accounts are a smart and convenient way for you to stretch your paycheck and receive real tax savings. They accomplish those goals by allowing you to set aside money on a before-tax basis to pay for certain eligible health care and dependent care expenses. After you pay for an eligible expense and file a claim you will be reimbursed from your spending account contributions.

bp offers two types of spending accounts, both administered by PayFlex (now part of Aetna):

- The Health Care Flexible Spending Account (HCFSA).
- The Dependent Care Spending Account (DCSA).

Depending on your needs, you may choose to enroll in either the HCFSA or the DCSA, or both. When you enroll in a spending account, you decide how much you want to contribute on a before-tax basis up to certain limits.

While spending accounts offer tax advantages, there are some rules you will need to follow. With a little planning, you will find that spending accounts offer you significant savings for your efforts.

You may enroll whether or not you have bp medical, dental or vision plan coverage. However, you may NOT enroll in the HCFSA if you are enrolled in bp's Health+Savings Option, regardless of whether you choose to contribute to a Health Savings Account. Also, if you are enrolled in a high deductible health plan with a health savings account through your spouse's employer, your enrollment in the HCFSA would negatively affect the benefits of your other plan.

The Aetna Commuter Benefit is another way to lower your taxes. This benefit allows you to pay for certain work-related transportation expenses via convenient pre-tax payroll deductions.

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.

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Eligibility and participation

Learn about the eligibility rules governing the accounts

Who is eligible

You are eligible to participate in a spending account if you are classified as a full-time or part-time employee of a participating employer.

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

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

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

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

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Who is not eligible

Regardless of your employee classification, you are not eligible to participate in the spending accounts if you are:

- An occasional employee.
- A temporary employee.
- A member of a collective bargaining unit (union), unless your collective bargaining agreement provides that you are eligible to participate.
- Not classified as an employee on a participating employer's payroll, even if reclassified as a common-law employee by any third party.
- An Inpat (foreign resident working in the U.S.).
- An employee on an unpaid leave of absence not approved by bp.

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

Temporary employee: An employee assigned to a position that:

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

Interns and co-ops are considered occasional employees.

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

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How to enroll

To enroll in spending accounts, contact the bp Benefits Center. There are two ways to access the bp Benefits Center:

Online	By phone
The bp Benefits Center online: • http://www.bp.com/lifebenefits You can: • Change or reset your bp Benefits Center password. • View your coverage details. • Enroll in bp health and protection benefits*. • Review and/or request a change in your current coverage based on certain qualifying status changes*.	Through the bp Benefits Center: • Within the U.S.: 1-800-890-4100 • Outside the U.S.: +1-312-843-5290 You can speak to a Participant Services Representative (available Monday – Friday, 7:00 A.M. – 7:00 P.M., Central time) to: • Get answers to your questions about bp's benefits. • Make changes to your current coverage based on qualifying status changes or relocation.

You can enroll in one or both of the spending accounts:

- **When you first become eligible.** If you do not enroll within 30 days of your initial eligibility date (generally your date of hire or the date you change or transfer into an eligible position), you will not participate in a spending account until you enroll during a future enrollment opportunity (i.e., annual enrollment or a qualifying status change).
- **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).
- **If you have a qualifying status change**. If you experience a qualifying event, such as marriage or the birth of a child, you may make changes to your benefits that are consistent with the event. You must make changes within 30 days of the qualifying status change. If you do not enroll within 30 days of a qualifying event, you may not enroll again until the next annual enrollment. For more information on qualifying status changes, review the "Life Events" tab on the LifeBenefits website or contact the bp Benefits Center.**

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.

To continue participating in a spending account, you must enroll each year during annual enrollment. Your election will not carry over from one plan year to the next.

Participation is based on the truthfulness of statements made by you. Coverage may be terminated, including retroactively, if such statements are found to be false, and intentional falsehoods will be considered a violation of the bp Code of Conduct, subjecting you to disciplinary actions, up to and including termination of employment.

* If you are enrolling during the last three months of the existing plan year, online enrollment is not available. You must contact the bp Benefits Center by phone to make your enrollment elections if you choose to participate.

** If you have been enrolled in the Health+Savings medical option during any portion of the bp plan year, you may not enroll in the Health Care Flexible Spending Account during the remainder of that plan year. This applies even if you did not contribute to the Health Savings Account while you were enrolled and have a zero HSA balance.

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When participation begins

The date your coverage begins depends on when you enroll.

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

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Your contributions

By enrolling in a spending account, you authorize bp to take before-tax payroll deductions for the amount you wish to set aside to reimburse yourself for eligible health care or dependent care expenses. Deductions will begin as soon as administratively possible. Deductions are taken retroactively to the effective date of your participation as long as you timely enroll. If your pay is not sufficient to take deductions for contributions (for example, if you are on an unpaid leave of absence), you will be billed directly by the bp Benefits Center, which you must pay within 30 days of receipt.

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

There are limits to the amount of before-tax dollars you can contribute to the HCFSA and the DCSA each plan year. See Spending accounts at-a-glance for details.

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When you can change participation

COVID-19 Extension for HIPAA Special Enrollment Rights

Due to the COVID-19 Pandemic and Declaration of National Emergency, the US Departments of Labor (DOL) and Treasury/IRS have provided revised guidance that extends deadlines related to HIPAA special enrollment rights. The guidance states that every affected individual gets an extension to take actions based on when their HIPAA special enrollment event occurred. This extension applies to the following actions discussed in this section.

- The 30-day time period allowed to make enrollment changes due to loss of non-bp coverage or acquisition of a new dependent.
- The 60-day time period allowed to make enrollment changes due to adding or losing Medicare or state children's health insurance program.

The extension pauses the deadline to take the above actions until the "Outbreak Period" for that individual and event is over. For *each* HIPAA special enrollment event, the Outbreak Period ends on the *earlier* of:

- One year after the period starts for that event; or
- 60 days after the Declaration of National Emergency ends. (The Declaration was recently extended and is still ongoing.)

Essentially, the HIPAA special enrollment deadlines listed above are extended (delayed) until the earlier of one year after the Outbreak Period starts for that event, or 60 days after the emergency declaration ends. The normal deadlines then apply.

The rules for these extensions are complex and subject to change. Please contact the bp benefits center for assistance.

Normally the choices you make during enrollment for participation in a spending account stay in effect for the entire plan year (April 1 – March 31). However, if you experience a qualifying status change during the plan year, that event may allow you to begin or stop participating or increase your contribution level, but does not allow you to decrease your contribution level mid-year.

You can make changes to your benefits within 30 days of the qualifying status event. Any changes you make must be consistent with your qualifying status change. If you do not make your change within 30 days of the event, you must wait until the next annual enrollment period to make any changes.

To make your changes, log on to the bp benefits center 0nline or call the bp benefits center and speak with a representative.

Effective April 1, 2018, some changes to participation in the Dependent Care Spending Account (DCSA) are allowed mid-year without the changes needing to be a qualifying status change. Additional circumstances allowing a change in participation include:

• A change in the cost of day care, as long as the provider is not a relative. (Example: Your day care center raises its rates.)
• A change in day care providers. (Example: You change day care centers or individual day care providers.)
• A dependent gains or loses dependent status under DCSA rules. (Example: Your dependent reaches age 13.)

This exception to the requirement for a qualifying status change does not apply to the Health Care Flexible Spending Account (HCFSA).

Qualifying status changes

In general, you can begin participating, increase your election or drop FSA coverage mid-year if you experience a qualifying status change. See below for special rules that may apply.

HCFSA	DCSA
l If you enroll yourself or a new dependent in bp medical, dental or vision coverage due to a qualifying status change, you can:* ¡ Start participating in the HCFSA (this applies only if you are not already enrolled). ¡ Increase your contribution for the remainder of the plan year (if you are already a participant). ¡ You cannot stop your participation. l If you disenroll yourself or a dependent from bp medical, dental or vision coverage or if you change bp medical options, you can:* ¡ Start participating in the HCFSA (this applies only if you are not already enrolled). ¡ Increase or decrease your contribution for the remainder of the plan year (if you are already a participant). ¡ Stop participation. l Special rules apply to domestic partnerships, as follows: ¡ If you establish a domestic partnership, you cannot make any changes because domestic partnerships are not recognized for Federal tax purposes. ¡ If your domestic partnership ends or your domestic partner dies, you can stop your participation ONLY if your domestic partner qualified as your tax dependent. ¡ If you lose medical, dental or vision coverage under your domestic partner's employer's plan, you can start participating or increase your contribution for the remainder of the plan year. l If you move during the plan year, you can:* ¡ Start participating in the HCFSA (this applies only if you are not already enrolled). ¡ Increase or decrease your contribution for the remainder of the plan year (if you are already a participant). ¡ Stop participation.	l If your dependent is no longer an eligible dependent per plan rules, you can stop your participation in the plan. l If you gain an eligible dependent who qualifies under the DCSA or if your dependent care expenses increase due to marriage, legal separation, divorce, death of a spouse, change in child custody, your move or your spouse's change in employment, you can: ¡ Start participating in the DCSA (this applies only if you are not already enrolled). ¡ Increase your contribution. Please note: if you start participation or increase your contribution due to marriage, your new spouse must be employed, disabled or a full-time student. If your new spouse does not meet any of these conditions, the DCSA election may be terminated. l If you move during the plan year, you can: ¡ Start participating in the DCSA (this applies only if you are not already enrolled). ¡ Increase or decrease your contribution for the remainder of the plan year (if you are already a participant). ¡ Stop participation.

If you start participation or increase your contribution during the middle of a plan year, keep in mind that the plan year maximum elections will not be prorated for the remainder of the year. Further, you may only be reimbursed for eligible expenses incurred during your period of coverage – meaning the date the election takes effect through the remainder of the plan year (unless coverage ends earlier). You will not be reimbursed for any expenses that would otherwise be eligible but were incurred before you enrolled.

* If you have been enrolled in the Health+Savings medical option during any portion of the bp plan year, you may not enroll in the Health Care Flexible Spending Account during the remainder of that plan year. This applies even if you did not contribute to the Health Savings Account while you were enrolled and have a zero HSA balance.

When coverage changes take effect after a qualifying status change

Changes in spending account participation due to a qualifying status change take effect as follows, if you make the change within 30 days of the qualifying event:

If you ...	The change in coverage takes effect on ...
Enroll in a spending account or increase the coverage amount.	The date the qualifying status change occurs.
Stop spending account participation.	The last day of the month in which the qualifying status change occurs.

HIPAA special enrollment rights

Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, as long as you request enrollment within 30 days. (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.) So, if you are eligible for coverage in another plan (such as a spouse's plan), you should request enrollment as soon as possible after your current coverage ends.

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When participation ends

Your participation in the HCFSA and/or the DCSA ends on the earliest of the following dates:

- The last day of the month in which you are no longer an eligible employee.
- The last day of the month in which your employment ends for any reason.
- The last day of the month in which you drop coverage due to a qualifying status change.
- The last day of the month for which your last contribution was made within the required time period.
- On March 31, unless during annual enrollment you elect to participate in the HCFSA and/or the DCSA for the following plan year.
- The last day of the month in which you die.
- The date bp terminates the HCFSA and/or the DCSA.
- The date you begin an unpaid leave of absence not approved by bp.

If you become ineligible to participate in a spending account, continuation of HCFSA participation on an after-tax basis may be available through COBRA under certain circumstances, when participation would otherwise end (see Leaving bp). There is no continued participation in the DCSA.

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How the bp spending accounts work

Important information about how the accounts work

bp offers two types of spending accounts, both administered by PayFlex (which is part of Aetna):

- The Health Care Flexible Spending Account (HCFSA) — allows you to pay yourself back for eligible health care expenses for you and your eligible dependents that are not paid by any medical, dental and/or vision plan.
- The Dependent Care Spending Account (DCSA) — allows you to pay yourself back for eligible dependent day care expenses so you (and your spouse, if married) can work or attend school on a full-time basis. This does not include expenses incurred for health care services.

The HCFSA and the DCSA are completely separate. This means you cannot transfer contributions between the two accounts. In addition, you cannot use contributions in the HCFSA to pay for dependent care expenses or contributions in the DCSA to pay for health care expenses. Also, please note that only the HCFSA is subject to ERISA rules and regulations — the DCSA is not subject to ERISA.

Spending accounts at-a-glance

Option	Eligible dependents are defined as shown below	Contribution limits
Health Care Flexible Spending Account (HCFSA)	l An individual whom you can claim as your dependent for federal income tax purposes. l A child for whom you are required to provide health benefits under a court order.	l Contribute from $120 to the maximum amount allowed by the IRS at the start of the particular plan year in which you participate before-tax each plan year.

Dependent Care Spending Account (DCSA)	l Any child under age 13 whom you can claim as a dependent for federal income tax purposes. If you are divorced or legally separated and have primary custody of the child, you do not need to be able to claim the child as a dependent for federal income tax purposes.
	l Your spouse or other dependent (including a parent), regardless of age:
	  l Who is physically or mentally incapable of caring for himself/herself.
	  l Who lives in your home for at least one-half of the tax year.
	  l Who earns no more than the annual legal limit ($3,950 in 2014).
	  l Whom you can claim as a dependent for federal income tax purposes.
		l Contribute from $120 to $5,000 before-tax each plan year, subject to the following legal limits:
		  l Regardless of your income tax filing status, your maximum annual contribution cannot be more than what you or your spouse earns (or is expected to earn), whichever is less. If your spouse does not have any earned income but is disabled or a full-time student, your spouse will be considered to earn $3,000 a year if you have one eligible dependent or $6,000 a year if you have two or more eligible dependents.
		  l The $5,000 maximum applies to all contributions you and your spouse make to any dependent care spending account during the ***calendar*** year, whether at bp or through another employer.
		  l If you and your spouse file a joint income tax return, you may contribute up to $5,000 for the year, regardless of the number of eligible dependents you have.
		  l If you and your working spouse file separate income tax returns, the maximum annual contribution you can make is $2,500.

Note: When you enroll in the HCFSA and/or the DCSA during the plan year rather than during annual enrollment, your contribution elections will be allocated over the remaining months of the plan year for which you are enrolling.

Before you decide on the amount to contribute to the HCFSA and/or the DCSA, you need to consider:

- Any anticipated eligible health care expenses not covered by a health plan (if you are thinking of enrolling in the HCFSA).
- Any anticipated eligible dependent care needs (if you are thinking of enrolling in the DCSA).
- Any tax considerations that could affect your decision.
- Whether or not you currently contribute to a Health Savings Account, or expect to in the very near future. **Note:** You may not contribute to both an HSA and an HCFSA in the same bp plan year.

Keep in mind that once you are participating in the HCFSA and/or DCSA, you cannot decrease your contribution amount during the plan year. However, you may be able to increase your contribution amount or stop participating in the HCFSA or DCSA if you have a qualifying status change for which such a change would be consistent.

Also keep in mind that you cannot transfer money between the accounts, this means you cannot use the HCFSA to pay for dependent care expenses and you cannot use the DCSA to pay for health care expenses.

Contribution limits and highly compensated employees

If the HCFSA and/or DCSA do not satisfy non-discrimination tests, elected plan year contributions may be adjusted for highly compensated employees. If this applies, you will be notified.

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Use it or lose it rule

If you participate in the HCFSA and/or DCSA and do not incur reimbursable expenses sufficient to deplete the balance of your account(s) by the end of your coverage period — generally March 31 (the plan year end) — by law, any portion remaining in your HCFSA or DCSA is generally forfeited. This is known as the “use it or lose it” rule.

It is therefore critical to not elect contribution levels in excess of what you reasonably believe you will incur during the period of coverage. Forfeited contributions are used to pay plan benefits and expenses.

Limited $500 Health Care FSA carry-over exception

Employees may "carry over" up to $500 of their Health Care FSA (HCFSA) balance from one plan year to the next plan year. This applies to the current plan year and allows up to $500 of your HCFSA balance to be carried over to the next plan year.

- Claims incurred during the new plan year can be applied to the carried-over amount from the previous plan year.
- The amount carried over (up to $500) will be added to your new plan year election, not to exceed the allowed legal maximum plus $500 carried over.
- The carry-over is automatic, employees do not need to take any action. However, please note that if you are choosing an HSA for the first time in the new plan year, due to Federal regulations your carry-over funds will be rolled over to a Limited Purpose Health Care FSA, which can only be used for dental and vision expenses.
- Any HCFSA balance amounts exceeding $500 at the end of the plan year, will be lost (forfeited) due to Federal regulations.

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Estimating your expenses

Before deciding on the amount you want to contribute to the HCFSA, you will also want to look carefully at any anticipated eligible health care expenses that are not covered by the BP Medical Program, Dental Program and/or Vision Plan, or any other health plan under which you have coverage. The same holds true for the DCSA: Before deciding on the amount you want to contribute, assess any anticipated eligible child care and/or elder care needs.

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Tax considerations

When you contribute to the HCFSA and/or the DCSA, you lower the amount of Social Security tax, Medicare tax, federal income tax and, in some areas, state and local income tax withheld from your paycheck. Claiming tax deductions for your unreimbursed health care expenses or taking the Dependent Care Tax Credit, on the other hand, reduces the amount of tax you pay when you file your annual income tax return.

Depending on your personal situation, you may save more in taxes using the tax deduction and/or tax credit than by participating in a spending account. (You cannot, however, claim a tax deduction or take a tax credit on your federal income tax return for the same expenses that are reimbursed through a spending account. You may want to consult a tax advisor to determine which alternative offers you the greater tax advantage.

HCFSA tax considerations

Federal tax law allows you to claim a deduction on your federal income tax return for out-of-pocket health care expenses you incurred during the year. To claim these deductions, your total unreimbursed expenses for the calendar year must be more than 10% of your adjusted gross income.

DCSA tax considerations

Depending on your adjusted gross income, you may be able to take the Dependent Care Tax Credit on your federal income tax return. This tax credit can range from 20% to 35% of your eligible dependent care expenses. For this calculation, eligible expenses are limited to $3,000 a year for one dependent and $6,000 a year for two or more dependents.

In general, when your total family income is more than $40,000, your tax savings will generally be greater if you participate in the DCSA than if you claim the tax credit.

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Eligible/ineligible expenses

Find out more about what expenses are covered and what are not

Only eligible expenses can be reimbursed through the HCFSA and/or the DCSA.

- In the case of the HCFSA, eligible expenses are for medically necessary health care expenses not covered by your medical, dental or vision plan and incurred by you and/or your eligible dependents for federal income tax purposes.
- In the case of the DCSA, eligible expenses are for necessary dependent care costs you pay for your eligible dependents while you work. If you are married, your spouse must be gainfully employed, disabled or a full-time student for these dependent care expenses to be reimbursable. This account is for dependent day care expenses only and not for dependent health care expenses.

Expenses must be incurred during your period of coverage to be considered eligible. For purposes of the HCFSA and DCSA, your period of coverage is the plan year or, if you began participating in coverage mid-plan year or ended it early due to a qualifying status change, the shorter period during which you had elected coverage.

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HCFSA expenses

Expenses reimbursed under the HCFSA

Eligible health care expenses include, but are not limited to, the following (keep in mind that some expenses may require a doctor's certification).

- Abdominal supports.
- Acupuncture.
- Automobile equipment to help any physically disabled eligible dependent.
- Back supports.
- Birth control-related expenses.
- Bone marrow transplants.
- Braille books and magazines.
- Certain schooling for any disabled eligible dependent.
- Charges in excess of recognized charge/reasonable and customary/prevailing rate limits under the Medical Program and/or Dental Program, or any other health plan under which you have coverage.
- Childbirth preparation classes.
- Chiropractic care.
- Cost of a note-taker for a hearing-impaired child while in school.
- Cost of a special diet when medically necessary and only to the extent that cost exceeds that of a normal diet.
- Crutches.
- Deductibles/coinsurance/copays under the Medical Program, Dental Program and/or Vision Plan, or any other health plan under which you have coverage.
- Dental cleanings and fillings.
- Detoxification or drug abuse centers.
- Diabetic supplies.
- Diathermy.
- Elevators (in home) for any disabled eligible dependent. (**Note:** The eligible amount of this expense would depend on how much the item permanently improves the property.)
- Expenses for services connected with donating an organ.
- Eye exams, eyeglasses, contact lenses and supplies.
- Fees to use a swimming pool for exercises prescribed by a doctor to alleviate a specific medical condition.
- Guide or guide dog for any eligible dependent who is visually or hearing-impaired.
- Hearing aids.
- Home pregnancy tests.
- Household visual-alert systems for any hearing-impaired eligible dependent.
- Infertility treatment.
- Lactation supplies (the purchase of breast pumps and related supplies).
- Medically necessary mattresses and boards.
- Orthodontia (participants will generally be eligible for reimbursement for the component of expenses related to the orthodontia services paid during the participant's current plan year; see **How orthodontia is handled** for more information).
- Orthopedic shoes.
- Over-the-counter medications and supplies used to treat a medical condition or injury, and feminine hygiene products. **Note:** Effective retroactively to January 1, 2020, over-the-counter medications do not need to be prescribed by a physician.
- Physical therapy.
- Prescription drugs.
- Psychotherapy.
- Radial keratotomy or LASIK surgery.
- Radiation treatments.
- Respirators.
- Routine physical exams.
- Smoking-cessation programs and products.
- Special devices, such as tape recorders and computers, for any eligible dependent who is visually impaired.
- Specialized equipment for any disabled eligible dependent.
- Speech therapy.
- Sterilization and reverse-sterilization surgery.
- Surgical stockings.
- Well-baby and well-child care.
- Wheelchairs.

- Wigs for hair loss due to disease.
- X-rays.

How orthodontia is handled

For reimbursement of orthodontia services, you must submit a signed FSA Health Care Reimbursement claim and proof of payment.

Note: If you participate in the BP Dental Program and have not opted out of the *Streamline* Program, claims will automatically be forwarded to PayFlex.

When requesting reimbursement for additional paid service dates, you must submit:

- A signed FSA Health Reimbursement claim form (or you may submit this online through PayFlex).
- A written statement from an independent third-party (i.e., orthodontia coupon book or itemized statement) stating that the expense has been paid and the amount of such expense. A canceled check is not proper documentation in absence of third-party documentation.

For information on how payment plans are handled, please contact the claims administrator.

Expenses not reimbursed under the HCFSA

While certain expenses are eligible, others are not. Ineligible health care expenses include, but are not limited to:

- Expenses for which you receive reimbursement under the Medical Program, Dental Program and/or Vision Plan, or any other health plan under which you have coverage.
- Cosmetic surgery that is not medically necessary.
- Cosmetics.
- Custodial care.
- Expenses claimed on your income tax return.
- Expenses not eligible to be claimed as an income tax deduction.
- Expenses reimbursed by other sources, such as insurance companies.
- Fees for athletic clubs, health clubs or spas where there is no specific medical reason for membership.
- Hair transplants.
- Illegal treatments, operations or drugs.
- Insurance premiums or contributions for coverage.
- Maternity clothes.
- Nursing services for care of healthy infants.
- Over-the-counter medications not used to treat a medical condition or injury, and supplies used for general health (such as toothpaste or mouthwash) or for cosmetic purposes.
- Vitamins (except for prenatal purposes or when prescribed by a doctor for a specific medical diagnosis).
- Weight-loss programs for general well-being.

Because the eligibility of any health care expense is subject to legal restrictions, there is no guarantee that a specific health care expense will be eligible for reimbursement under the HCFSA. For more information, call PayFlex.

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DCSA expenses

Expenses reimbursed under the DCSA

Dependent care must be provided by:

- A care provider in your home, including an au pair.
- A care provider outside your home.
- A dependent care center — for example, a day care center that provides preschool care or before- or after-school care — that complies with applicable state and local licensing laws or that is exempt from such laws.

You are required to provide the IRS with the name, address and taxpayer identification or Social Security number of your dependent care provider. If this is not possible, you may not want to participate in the DCSA.

If you have custody of a dependent for part of the year, you may claim dependent expenses only for the part of the year that your dependent is living with you.

Eligible dependent care expenses include, but are not limited to:

- Before-school and after-school care.
- Day camp.
- Day care center.
- Elder care.
- Nursery school/preschool tuition.
- Services by housekeepers, au pairs or nannies whose primary responsibility is to care for the dependent.

Because the eligibility of any dependent care expense is subject to legal restrictions, there is no guarantee that a specific dependent care expense will be eligible for reimbursement under the DCSA. For more information, call PayFlex.

Expenses not reimbursed under the DCSA

You will not be reimbursed for dependent care provided by:

- Your spouse.
- Your own children under age 19.
- Anyone you could legally claim as a dependent on your federal income tax return.

Ineligible dependent care expenses include, but are not limited to:

- Clothing.
- Overnight camp.
- Overnight care in a convalescent nursing home.
- Private school for a school-age child.
- Transportation to and from the dependent care site.
- Au pair programming or agency fees.

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How to file a claim

Claims for eligible expenses should be filed with the claims administrator

COVID-19 Extension for Filing Claims and Appeals

Due to the COVID-19 Pandemic and Declaration of National Emergency, the US Departments of Labor (DOL) and Treasury/IRS have provided revised guidance that extends deadlines related to filing claims and appeals under ERISA plans. The guidance states that every affected individual gets an extension to take actions based on when their claims event occurred. This extension applies to the following deadlines discussed in this claims section:

- Filing a claim;
- Appealing a claim denial;
- Requesting an external review; and
- Filing information needed to complete/perfect an external review request.

The extension pauses the deadline to take the above actions until the "Outbreak Period" for that individual is over. For *each* claims event, the Outbreak Period ends on the *earlier* of:

- One year after the period starts for that event; or
- 60 days after the Declaration of National Emergency ends. (The Declaration was recently extended and is still ongoing.)

Essentially, the claims and appeals deadlines for the actions listed above are extended (delayed) until the earlier of one year after the Outbreak Period starts for that event, or 60 days after the emergency declaration ends. The normal deadlines then apply. Here is an example:

Assume the National Emergency does not end until November 30, 2022. Kendrick submits a claim on August 1, 2021. The claim is denied on August 5, 2021. Under the plan, Kendrick would normally have 180 days to appeal the claim. However, Kendrick's Outbreak Period for his appeal does not start until he receives his claims denial. Kendrick's Outbreak Period will end on August 4, 2022. He will have 180 days after that to submit his appeal.

The rules for these extensions are complex and subject to change. Please contact the bp Benefits Center for assistance. However, since the end of the extension period is currently unknown, please do not delay submitting your claim or appeal in a timely manner.

After you incur an eligible expense, you can file a claim for reimbursement from the HCFSA and/or the DCSA anytime during the plan year in which you incur the expense.

An expense is incurred on the date the service is provided, not the date you are billed or you make payment. If you enroll midyear, you may be reimbursed only for expenses incurred after the date you begin participating.

Deadline for filing claims

You have up to 90 days after the end of the plan year to submit completed claim forms and attachments to PayFlex for reimbursement. This can be by fax or by mail (see Administrative information for the phone number and address).

Be sure to keep a copy of the claim form and any attachments for your personal records. Your claim form must be faxed or postmarked by June 30, or you will forfeit any remaining contributions in the HCFSA and/or DCSA due to the “use it or lose it” rule.

Effective April 1, 2021, any remaining funds in the Health Care Flexible Spending Account and/or the Dependent Care Spending Account from the 04/01/20–03/31/21 plan year will be carried over to the 04/01/21–03/31/22 plan year after the runout period for submitting 2020 plan year claims has expired (06/30/21).

Here's how this will work:

- Employees have until 06/30/21 to submit claims incurred between 04/01/20–03/31/21.
- After 06/30/21 any remaining funds will be carried over to the 04/01/21–03/31/22 plan year.
- Those funds that were carried over can be used for claims incurred fromn 04/01/21–03/31/22.

Reimbursement process

There are several ways in which you can submit your claim for reimbursement or have providers reimbursed directly from PayFlex:

- **Online.** To file your claim online, upload your documentation (receipts, Explanation of Benefits) in the form of PDFs through the PayFlex site, *My Dashboard*, at www.aetna.com. You can use your Aetna login information to access the features on this site. You can choose to be reimbursed directly ("Pay Me") or have your provider be reimbursed directly ("Pay Them") through this feature.

- **By mail or fax.** You can also complete a paper claim form (available through the PayFlex site at www.aetna.com) and fax your claim and documentation to 1-888-238-3539 or 1-888-AET-FLEX, or mail them to the following address:

  Aetna Inc.
  P.O. Box 14879
  Lexington, KY 40512-4879

You can receive your reimbursement in one of the following ways from PayFlex:

- **By direct deposit.** Direct deposit allows you to have payments for claims submitted online or by mail deposited directly into your checking or savings account. Go to the PayFlex site, *My Dashboard*, at www.aetna.com to sign up for direct deposit.

- **By check to you.** Generally, within two weeks after receiving your online reimbursement request or claim form, PayFlex will send a reimbursement check directly to your address of record if you have not set up direct deposit.

- **By payment directly to your provider.** If you applied for reimbursement online and selected the "Pay Them" option on the PayFlex site (*My Dashboard* at www.aetna.com) using the process described above, your spending account reimbursement will be sent directly to your provider.

HCFSA claims

To be reimbursed from your HCFSA, if the expense is covered under your medical, dental or vision plan, you must first file a claim with the relevant plan. Once you receive an explanation of benefits (EOB) from your medical, dental or vision plan indicating the portion of the expense not covered by the plan, complete an HCFSA claim form or file for reimbursement online.

When you file for reimbursement online, via fax or via mail, you will need to include the Explanation of Benefits (EOB) or the original receipt, which must include:

- The name of the person or organization providing the service or product.
- The type of service or product provided.
- The date the service was performed and the expense was incurred.
- The name of the covered person for whom the service or product was provided.

When you file a claim for an eligible health care expense, you will be reimbursed for the full amount of the claim whether or not you have accumulated enough contributions in the HCFSA to cover that expense as of that date, as long as your total claims submitted do not exceed the annual amount you elected to contribute to the HCFSA.

Streamline HCFSA reimbursement

Streamline reimbursement is not available for reimbursements from HMOs, the BP Vision Plan or from the Dental Health Maintenance Organization (DHMO). It's also not available if you are covering a domestic partner or a domestic partner's child in your BP Medical Plan or BP Dental Plan coverage.

If you enroll in the HCFSA and you participate in the HealthPlus or Standard Option — or if you are enrolled in the BP Dental Plan — you are automatically enrolled in Aetna's *Streamline* reimbursement program if you elect to participate in a spending account during annual enrollment. (If you're a new hire and elect to participate within 30 days of your date of hire, you'll need to contact Aetna to add this feature.) Under this program, Aetna processes your HCFSA claims automatically.

Here is how the program works for your claims processed by Aetna/PayFlex as claims administrator under the BP Medical Plan:

1. Aetna/PayFlex receives a claim — either from the provider directly or from you.
2. Aetna/PayFlex determines the benefits payable under the BP Medical Plan and the amount for which you are responsible (your out-of-pocket expenses such as copays, deductibles and/or coinsurance).
3. Based on your out-of-pocket expenses, Aetna/PayFlex determines the amount eligible to be reimbursed from your HCFSA.
4. Aetna/PayFlex automatically reimburses you for your out-of-pocket expenses.

To facilitate automated reimbursement of your expenses under the BP Medical Plan's Prescription Drug Program administered by Express Scripts and expenses under the BP Dental Plan administered by MetLife, Aetna has established electronic feeds of the prescription and dental expense claims incurred by you or your covered dependents under the BP Medical Plan or BP Dental Plan. Aetna/PayFlex then determines the amount eligible to be reimbursed from your HCFSA, and processes these amounts just like your eligible medical expenses.

You may not want to select the *Streamline* feature if:

- You and/or your dependent also have coverage under another health plan and coordination of benefits applies.
- You're covering a domestic partner, who isn't your dependent for federal income tax purposes, under your health care plan.
- You have access to a spending account through your spouse's plan.

If these circumstances apply to you, or if you prefer to submit your HCFSA claims yourself, you should cancel your *Streamline* participation by logging on to the Aetna website. Once *Streamline* is cancelled, you will need to manually submit online, mail or fax claims for reimbursement of your eligible health care expenses.

Remember, the *Streamline* reimbursement option stays in effect for the entire plan year.

DCSA claims

To be reimbursed from the DCSA, you must complete a DCSA claim form online or via mail or fax. You can file a claim through the PayFlex site, *My Dashboard*, at www.aetna.com.

The IRS requires that the claim form indicate:

- The type of service provided.
- The date the service was provided and the expense was incurred.
- The name of the eligible dependent for whom the service was provided.
- The name, address and taxpayer identification or Social Security number of your dependent care provider.

When you file a claim for an eligible dependent care expense, you will be reimbursed only up to the amount you have accumulated in the DCSA as of the date the claim is processed.

Account information

You may access your personal benefits information online anytime through the PayFlex site, My Dashboard, at www.aetna.com. Through this site, you can:

- Retrieve complete account information, such as your current balance, claim history and dates of payment.
- Verify payment information or check the status of your claims.

Publication date: April 2021

Process for formal benefit claims

When a claimant files a claim, the claims administrator will notify the claimant of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond the claims administrator's control, the claims administrator will notify the claimant within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed. The claimant must provide the specified information to the claims administrator within 45 days after receiving the notice. The determination period will be suspended on the date the claims administrator sends such a notice of missing information, and the determination period will resume on the date the claimant responds to the notice.

If you do not agree with the decision, you may choose to file a formal appeal. See below for more information on the appeals process.

Publication date: April 2021

If your claim is denied

Notice of adverse benefit determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination:

- The specific reason or reasons for the adverse benefit determination;
- Reference to the specific plan provisions on which the determination is based;
- A description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
- A description of the plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal; and
- Upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding the claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit.

Process for formal appeals relating to claim denials

A claimant will have 180 days following receipt of an adverse benefit determination to appeal the decision to the same claims administrator. The claimant will be notified of the decision not later than 60 days after the appeal is received by the claims administrator. A claimant may submit written comments, documents, records and other information relating to the claim, whether or not the materials or information was submitted in connection with the initial claim. The claimant may also request that the claims administrator provide, free of charge, copies of all documents, records and relevant information relating to the claim.

An appeal will be reviewed and the decision made by a reviewer not involved in the initial decision — the initial claims determination will not be taken into consideration. Appeals involving medical necessity will be considered by an approved health care professional.

Notice of benefit determination on appeal

Every notice of determination on appeal will be provided in writing or electronically and, if an adverse benefit determination, will include:

- The specific reason or reasons for the adverse benefit determination;
- Reference to the specific plan provisions on which the determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other relevant information;
- A statement describing any voluntary appeal procedures offered by the plan and any claimant's right to bring an action under ERISA section 502(a);
- Upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit; and
- A statement that you or your plan may have other voluntary alternative dispute resolution options such as mediation and that one way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency.

The applicable claims administrator’s decision on your appeal is final, conclusive and not subject to further review (unless the claims administrator provides an additional level of voluntary review or voluntary alternative dispute resolution options and the claimant exercises that right). The applicable claims administrator has full and exclusive authority and discretion to grant and deny claims under the plan, including the power to interpret the plan, and to make any related findings of fact.

If following exhaustion of the plan's appeal procedure, if you still believe that you are entitled to participate in the plan or are entitled to benefits 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.

Publication date: April 2021

Process for formal claims relating to eligibility to participate

You may make a verbal inquiry to the bp Benefits Center if you have a claim related to such issues as:

- Eligibility to enroll in the plan;
- Enrollment elections; or
- Qualifying status changes.

In many cases, the inquiry will resolve your issue.

If you believe that the response to your inquiry was based on inaccurate information or that additional information may clarify the issue, you may submit a written request for reconsideration to:

Claims and Appeals Management – bp
P.O. Box 1407
Lincolnshire, IL 60069-1407

You should receive a decision on your request for reconsideration within 30 days.

If you are not satisfied with the reconsideration decision, you may file a formal claim with the claims administrator by submitting a claim to the claims administrator in care of:

ERISA Claims and Appeals
P.O. Box 941644
Houston, TX 77094-8644

A formal claim related to eligibility cannot be filed with the claims administrator in care of ERISA Claims and Appeals until an inquiry and a request for reconsideration have been completed.

If you file a formal claim with ERISA Claims and Appeals on behalf of the claims administrator, it will be reviewed subject to the same timeframes applicable to formal claims for benefits. The review will be subject to the same procedures, protocols and standards.

If your claim is denied in whole or in part, you may appeal the adverse benefits determination by submitting an appeal to the claims administrator for appeals in care of ERISA Claims and Appeals. It will be reviewed subject to the same timeframes applicable to formal appeals for benefits. The review will be subject to the same procedures, protocols and standards.

If following exhaustion of the plan's appeal procedure, you still believe that you are entitled to either participate in the plan or to a benefit under the plan, you may file a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). You may not file a civil action unless you have exhausted the plan’s claims and appeals procedure. However, any such suit must be filed with a federal court of proper jurisdiction located in Harris County, Texas, no later than one (1) year following a final denial pursuant to the plan's appeal procedure.

Publication date: April 2021

Commuter benefit

The PayFlex Commuter Benefit allows you to pay for certain work-related transportation expenses via convenient pre-tax payroll deductions.

You can also find out more about the PayFlex Commuter Benefit by calling 1-800-284-4885.

You may elect to contribute to one or both of the following options:

Parking benefit	**Transit benefit**

You can contribute up to $270 per month on a pre-tax basis to be used for:
- Qualified parking expenses at or near your work site.
- Qualified parking expenses at a facility from which you commute to work, either by mass transit, qualifying commuter highway vehicles or carpools. It does not include parking at or near your home.
	You can contribute up to $270 per month on a pre-tax basis to be used for:
	- Purchase passes or vouchers on a tax-free basis to cover the cost of traveling to and from work via mass transit including subway, train or bus.
	- Vanpool costs, if all of the following apply:
	  - The vehicle seats at least six passengers in addition to the driver.
	  - At least 80% of the vehicle's mileage is used to transport employees to/from work.
	  - At least half of the vehicle's seating capacity is occupied by employees.

Unlike the HCFSA and DCSA, the Commuter Benefit is a **pre-paid** benefit. Here's how to participate:

- Visit www.payflex.com to register (see below) and then to place your order for eligible transit and/or parking passes/vouchers. Orders must be entered by the 10th of each month for the following benefit period. For example, to receive an order for use in January, you must place your order before December 10th. Changes must be made online before the cut-off date of the 10th of the month for the following benefit month.
- There is a recurring set-up option that will allow your order to be sent automatically to you each month.
- The cost is deducted from your paycheck before taxes are calculated and withheld. The amounts due will be deducted from your paycheck in the month prior to an order. For example, the February payroll deduction will allow you to get Commuter Checks for the following March. You cannot receive cash back for the difference when redeeming Commuter Checks or other vouchers. Commuter Checks are good for thirteen months and will not be refunded, replaced or exchanged when lost, stolen, damaged or expired.
- Your transit and/or parking passes/vouchers are sent to you in the mail. You should receive your order no later than the 25th of the month.
- PayFlex Commuter Benefit will only refund one order per year in the event your order is not received in the mail. To apply for a refund, complete the claim form, which may be accessed at www.payflex.com, and submit a receipt for a transit pass or fare media product of equal or greater value than your order in the same benefit month.
- Transit pass items must be ordered separately. For example, if you choose to order a transit pass (such as Muni, or BART) and a Commuter Check for the balance of your order, each of these products must be ordered separately.

How to register and place orders

1. Go to www.payflex.com. To register, log into the site and click *Sign in*, located at the top right corner. Then select *CREATE YOUR PROFILE* and fill out the required fields. If you're an Aetna member and have other PayFlex products, you can also get to the PayFlex member website through aetna.com.
2. Once in the PayFlex member website, go to *Online Commuter*. Then click *Manage my commuter account* to access the commuter benefit ordering platform. From the Commuter Benefits dashboard, you can place an order, view your current orders and any recurring orders, and edit or delete any current orders.

Publication date: April 2021

Leaving bp

What happens to benefits if you leave bp

COVID-19 Extension for COBRA elections, premium payments and notifications

Due to the COVID-19 Pandemic and Declaration of National Emergency, the US Departments of Labor (DOL) and Treasury/IRS have provided revised guidance that extends deadlines related to COBRA actions. The guidance states that every affected individual gets an extension to take actions based on when their COBRA event occurred. This extension applies to the following actions discussed in this COBRA section:

- The 60-day COBRA election.
- The 45-day period to submit the initial COBRA premium, once COBRA is elected.
- The 30-day grace period for a beneficiary to make ongoing monthly premium payments.
- The date for individuals to notify the plan of COBRA qualifying events such as divorce or disability.

The extension pauses the deadline to take the above actions until the “Outbreak Period” for that individual and event is over. For *each* COBRA event, the Outbreak Period ends on the *earlier* of:

- One year after the period starts for that event; or
- 60 days after the Declaration of National Emergency ends. (The Declaration was recently extended and is still ongoing.)

Essentially, the COBRA deadlines listed above are extended (delayed) until the earlier of one year after the Outbreak Period starts for that event, or 60 days after the emergency declaration ends. The normal deadlines then apply.

The rules for these extensions are complex and subject to change. Please contact the bp benefits center for assistance.

COBRA Coverage

When you leave bp, you may be eligible to continue participating in the HCFSA under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA allows you to elect a temporary continuation of HCFSA participation, under certain circumstances, when coverage would otherwise end, as long as you have a positive balance at that time. There is no continued participation in the DCSA.

Qualifying events

You may elect COBRA coverage if your HCFSA participation would otherwise end because you leave bp.

Maximum period of COBRA coverage

HCFSA participation through COBRA can continue until the end of the plan year only.

Electing COBRA coverage

On your termination of employment, the bp benefits center will automatically mail COBRA enrollment materials to you. You must contact the bp benefits center to elect COBRA within 60 days of your termination date or the date the COBRA notice is sent by the bp benefits center, whichever is later. Notify the bp benefits center if the COBRA materials are not received in a timely manner.

Even if you do not continue participating in the HCFSA, eligible health care expenses you incur through the last month you were participating will be reimbursed, as long as you file a claim form for these expenses with PayFlex, and the claim form is faxed or postmarked by June 30 of the following plan year.

Paying for COBRA coverage

If you wish to continue participating in the HCFSA through COBRA, COBRA premiums are due monthly and must be paid on an after-tax basis. If you elect COBRA coverage, the bp benefits center will send a monthly bill to you. You 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

Your HCFSA participation through COBRA will end before the end of the plan year on the earlier of:

- The last day of the month in which your last contribution was made within the required time period.
- The date bp stops providing group health benefits.

Publication date: April 2021

Administrative information

Detailed information about plan administration and your rights

The Dependent Care Spending Account portion of the plan is not subject to ERISA. Only the Health Care Flexible Spending Account portion of the plan is subject to ERISA.

Name of plan	Health Care Flexible Spending Account, Dependent Care Spending Account and Commuter Benefits, which are component benefit programs of the BP Corporation North America Inc. Cafeteria Plan, which is itself a component program of the BP Corporation North America Inc. Consolidated Welfare Benefit Plan
Type of plan	Welfare benefit plan including: - Health Care Flexible Spending Account (HCFSA) — self-insured. - Dependent Care Spending Account (DCSA) — self-insured.* - Commuter Benefit — self-insured. * The DCSA is a dependent care assistance program under section 129 of the IRC and is not subject to ERISA, HIPAA or COBRA.
Plan number	504
Plan year	April 1 – March 31
Plan sponsor and identification number	BP Corporation North America Inc. 501 Westlake Park Blvd. Houston, TX 77079 Employer ID#: 36-1812780
Plan administrator	Director, Health & Welfare BP Corporation North America Inc. 501 Westlake Park Blvd. Houston, TX 77079 1-800-890-4100
Sources of contributions	The BP Corporation North America Inc. Consolidated Welfare Benefit Plan is funded by participants' and participating employers' contributions and by investment earnings. Participant contributions are set by bp and may be adjusted from time to time. If participant contributions and investment earnings are insufficient to pay plan costs or expenses, the balance of the cost of the plan (if any) is paid by bp. Benefits may be paid through the BP Welfare Benefits Trust-III ("VEBA").
VEBA trustee	JPMorgan Chase Bank Worldwide Securities Services 4 New York Plaza New York, NY 10005
Claims administrator	PayFlex P.O. Box 4000 Richmond, KY 40476-4000 http://www.aetna.com 1-888-238-6226 Fax: 1-888-238-3539
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 2021

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 Corporation North America Inc. Consolidated Welfare Benefit Plan.
- Terminate a covered person's participation in the plan if he/she has engaged in improper conduct.

Once it has been determined that an individual has engaged in improper conduct, the plan administrator has the authority to take any actions he deems appropriate to remedy such violations, including pursuing legal or equitable remedies to recoup any payments made by the BP Corporation North America Inc. Consolidated Welfare Benefit Plan to any party, regardless of when such improper conduct was taken or discovered. Such action will not preclude the company from taking other appropriate action.

If any individual loses any rights or coverage under the BP Corporation North America Inc. Consolidated Welfare Benefit Plan as a result of the plan administrator's determination of improper conduct, coverage will be retroactively terminated as of the date of the improper conduct, and such individual will not be entitled to elect COBRA continuation coverage as may otherwise be available.

Publication date: April 2021

HIPAA privacy practices

The Health Care Flexible Spending Account (HCFSA) portion of the 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. **Note:** This law applies only to the HCFSA, and not to the Dependent Care Spending Account (DCSA) or the Commuter Benefits portion of this summary plan description.

To obtain a copy of the HIPAA Notice, please click here or contact the bp benefits center.

Complaints

If you believe the HCFSA portion of 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 941644
Houston, TX 77094-8644

You will not be penalized in any way for filing such a complaint.

Publication date: April 2021

How to convert coverage

You cannot convert coverage under the spending accounts to an individual policy.

Publication date: April 2021

Power of attorney (POA) and anti-assignment matters

Power of attorney (POA)

Occasionally participants need assistance from a third party (agent) with benefits matters. If you wish to designate an agent to act on your behalf for your bp health and protection benefits, please contact the bp Benefits Center for copies of the POA Notice (submission guide) for health and protection matters and related POA form or print copies from the LifeBenefits website Forms or Policies and programs links.

The POA Notice also explains the submission process for individually designated POAs, court orders and guardianships. Third parties may request a copy of the POA Notice by calling the bp Benefits Center at 1-800-890-4100.

Please note that generally only one person or institution at a time can be recognized to act on behalf of a participant through submission of a POA, court order or guardianship. The bp Benefits Center will not process a transaction if there is a reason to believe that the person making the transaction is not the plan participant, the participant's agent under a POA or court-appointed conservator or guardian.

Anti-assignment

The rights or benefits under this plan may not be assigned by a participant or beneficiary.

Publication date: April 2021

Governing plan documents

In the preparation of this plan summary, effort was made to provide a clear, concise description of your benefits and to avoid contract and legal terms wherever possible. The aim has been to present a simplified overview of essential information about your benefits in words that are not obscure or likely to be misunderstood. As highlighted earlier in this summary, in the event of an inconsistency between this summary and the plan document (including insurance policies as applicable), the plan document will govern.

Employees covered by collective bargaining agreements are subject to this summary to the extent consistent with the terms of bp's benefit programs, the applicable collective bargaining agreement and any applicable legal guidelines.

Publication date: April 2021

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 2021

Future of the spending accounts

The company reserves the right to change or end the spending accounts 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 HCFSA and/or the DCSA is terminated, your contributions will end as of the last pay period before the HCFSA's and/or the DCSA's termination date. However, you will be able to file reimbursement claims for eligible expenses incurred before the program's termination. Eligible claims must be received by Aetna before the specified claim-filing deadline.

All eligible expenses will be reimbursed as long as they were incurred during the period you participated in the HCFSA and/or the DCSA.

Publication date: April 2021

Your ERISA rights

As a participant in the Health Care Flexible Spending Account, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). This section does not apply to the Dependent Care Spending Account, except for one rule as noted below.

ERISA provides that all plan participants have the right to:

- Examine, without charge, at the plan administrator's office, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor.

- Obtain a copy of the summary plan description by calling the bp benefits center at 1-800-890-4100 or by downloading a copy at no cost from the "Benefits handbook" tab on the LifeBenefits website at http://www.bp.com/lifebenefits. Copies of governing plan documents can be obtained by contacting bp through the channels listed below. A reasonable fee for copying may be assessed.

  bp benefits
  Benefit Plan Documents
  P.O. Box 940669
  Houston, TX 77094-7669

  1-888-788-9278

  bpBenefitsHandbook@bp.com

- 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, and only upon exhaustion of the plan's claims and appeals procedures. (Note that this plan rule applies to both the Health Care Flexible Spending Account and the Dependent Care Spending Account.)

If you have a claim for benefits that is denied or ignored, in whole or in part, or if you disagree with the plan's decision or lack thereof concerning the qualified status of a Domestic Relations Order (DRO) or a Medical Child Support Order (MCSO), you may file suit in a state or federal court located in Harris County, Texas. (You can file suit only after you have exhausted the plan's claims and appeals procedures.) If the plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court in Harris County, Texas.

The court will decide who should pay court costs and legal fees. If you're successful, the court may order the person you have sued to pay these costs and fees. If you lose — for example, if the court finds your claim is frivolous — the court may order you to pay these costs and fees.

If you have any questions about your health and protection plans, you should contact the bp benefits center.

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or contact:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, DC 20210

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