BP dental program

IMS#65525

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Dental Program

Regular checkups and good dental hygiene are an important part of your overall health

Regular checkups and good dental hygiene are an important part of your overall health. To help you get the dental care you need, bp gives you the option to purchase dental coverage through the Dental Program.

The Dental Program has two options that are both administered by Cigna:

- The Dental PPO (previously called the BP Dental Plan), and
- If available in your area, the Dental Health Maintenance Organization (DHMO).

If you do not enroll, you and your eligible dependents will not have coverage. You may enroll in this bp dental program whether or not you are enrolled in any other bp coverage.

Throughout this summary, “you” generally refers to:

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

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

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 dental program

Who is eligible

You are eligible to participate in the Dental Program 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.

Eligible dependents

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

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

Except for COBRA continuation, you must participate in the Dental Program for your dependents to also be eligible.

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

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

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

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

- On active duty in the military.
- Covered as a bp employee in a bp-sponsored dental plan.
- Covered as a dependent of another bp employee in a bp-sponsored dental plan.

Special rules apply if your spouse/domestic partner is also an eligible bp employee. You may do either of the following:

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

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

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 Dental 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: Under the Dental Plan, and pursuant to federal law, a civil union must be treated by the plan the same as a domestic partnership.

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

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Who is not eligible

Regardless of your employee classification, you are not eligible to participate in the BP Dental Program 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 employee on an unpaid leave of absence not approved by bp.

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

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

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 a BP Dental Program option, 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: • Enroll in bp health and protection benefits. • Change or reset your bp Benefits Center password. • View your coverage details. • Find out which network providers are located near your home or work. • Review and/or request a change in your current coverage. • Change most dependent information, including name, birth date and relationship.	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. • Change all dependent information, including Social Security number or Medicare-eligibility status. • Make changes to your current coverage based on qualifying status changes or relocation.

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

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

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

You can enroll:

- **When you first become eligible.** If you do not enroll within 30 days of your initial eligibility (generally your date of hire or the date you change or transfer into an eligible position), you will not have coverage until you enroll during 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.
- **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 are not allowed to change your reimbursement option (Debit Card vs. Streamline) under the Health Care Flexible Spending Account. **Note:** You cannot use the HCFSA Debit Card outside the U.S. You must make changes within 30 days of the qualifying status change. If you do not enroll within 30 days of a qualifying event, you may not enroll again until the next annual enrollment. For more information on qualifying status changes, review the "Life Events" tab on the LifeBenefits website or contact the bp Benefits Center. You must submit appropriate documentation if you are adding coverage for a dependent.

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

All coverage under the Dental Program is based on the truthfulness of statements made by you and your dependents. Coverage may be terminated, including retroactively, if such statements are found to be false, and intentional falsehoods will be considered a violation of the bp

Code of Conduct, subjecting you to disciplinary actions, up to and including termination of employment.

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When coverage 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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Paying for coverage

You and BP each pay 50% of the cost of dental coverage.

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

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

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

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

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When you can change coverage

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. Here is an example:

Sean got married (a HIPAA special enrollment qualifying event) on May 1, 2020, but did not add his new spouse to his medical coverage within 30 days as allowed by bp rules. Assume the national emergency lasts until the end of 2021. Sean's "Outbreak Period" will end on May 1, 2021. He will then have 30 days (the normal HIPAA special enrollment period) after that to add his new dependent to his medical coverage. However, he would then need to pay retroactive premiums back to the date of the qualifying event.

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

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

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

Qualifying status changes that require action

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

You must disenroll a dependent within 30 days if you ...	Restrictions/notes ...
Need to **remove** an individual who is no longer an eligible dependent due to: l Legal divorce or annulment. l End of a domestic partnership. l Death of spouse/domestic partner/child. l Child no longer meeting the eligibility requirements.	l You may not switch medical or dental options. l You may not disenroll from the Dental Program with respect to any other family member who remains eligible, although your contribution tier may change.

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

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

- You will not be refunded any contributions for dependent coverage. Once you notify the BP Benefits Center of the loss of eligibility, your contribution will change as of the date of notification.
- You are liable for claims incurred.
- The plan administrator may impose sanctions against you — including potential loss of your coverage.
- No COBRA coverage will be offered to your former eligible dependent (solely for COBRA purposes notice will be considered to be timely if the BP Benefits Center is notified up to 60 days following the event date).
- BP may take remedial action against you with respect to your employment.

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:

If you want to make an enrollment change, you must contact the bp benefits center within 30 days if …	Restrictions/notes …

• You want to **enroll** yourself in coverage, or **add** an eligible dependent to your coverage if you are already enrolled because:
  ¡ You are newly eligible.
  ¡ Marriage.
  ¡ Your establishment of your domestic partnership.
  ¡ Birth/adoption/legal guardianship of your child.
• You or an eligible dependent experiences a non-voluntary loss of eligibility under another (non-bp) plan.
	• Contact the bp 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 Dental Program options.
	• If you miss the 30-day enrollment window, you may add a new eligible dependent to your Dental Program coverage if you already have You + spouse/domestic partner, You + child(ren) or You + family coverage.

• Your spouse/domestic partner's employer's plan does not have an April 1 plan year start date. • Your child becomes eligible again under the bp plan (for example the child is newly eligible under federal health care reform rules).	If you already have coverage but are adding an eligible dependent, you may not switch Dental Program coverage options.
You are in the BP Dental HMO and you move outside the Dental HMO service area.	You may elect another Dental Program Option.
You are rehired in the same plan year.	If you are rehired within the same plan year, your previous Dental Program coverage will be reinstated to the options in which you were enrolled before you left.
You return from a leave of absence where you did not maintain coverage while on leave.	If you were on medical leave/family medical leave/military leave and return during the same plan year, you will be re-enrolled in the same benefits in which you participated before the leave unless you experienced a qualifying status change between the date you went on leave and the date you return. If you choose to change your elections when you return, you need to enroll within 30 days of returning to work.
You are in the Dental HMO (DHMO) and you move outside the DHMO service area.	You may elect the Dental PPO option.

If you want to disenroll yourself and/or a covered dependent as the result of one of the events below, you must contact the bp benefits center within 30 days of the event …	Restrictions/notes …
• Marriage, if you/your dependents will be covered under your new spouse's employer's plan. • Establishment of a domestic partnership, if you/your dependents will be covered under your new domestic partner's employer's plan. • Birth/adoption/legal guardianship, if you and/or your dependents will be covered under your spouse's/domestic partner's employer's plan. • Employment-related change of spouse/domestic partner or your child's other parent allowing you or your dependent to become covered under the non-bp plan. • Mid-year plan enrollment in spouse's/domestic partner's plan that is not on a April 1 – March 31 basis. • You go on a leave of absence and do not want to maintain coverage while on leave.	

When coverage begins/ends after a qualifying status change

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

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

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

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

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

- The last day of the month in which your coverage ends.
- The last day of the month in which you drop the dependent's coverage due to a qualifying status change.
- The last day of the month in which your covered dependent is no longer eligible for coverage under the Dental Program, whether or not you report your dependent's change in eligibility status.

If you or a covered dependent becomes ineligible for coverage under the Dental Program, continuation of dental coverage at your own expense may be available through COBRA (see Leaving bp).

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How the Dental Program works

Important information about how the Dental Program works

The Dental Program has two options that are both administered by Cigna:

- The Dental PPO (previously called the BP Dental Plan), and
- If available in your area, the Dental Health Maintenance Organization (DHMO).

The options available to you will be reflected on your Personalized Enrollment Worksheet included in your annual enrollment packet each year.

Dental Program at-a-glance

This chart compares how treatments and services are covered under the two dental options:

	Dental PPO		Dental Health Maintenance Organization (DHMO)
	In-network	**Out-of-network**	
General information			
Plan-year deductible	$25/person $75 family maximum	$100/person $300 family maximum	None
Plan-year maximum benefit	$3,000/person for diagnostic and preventive services and for basic and major restoration services combined (in-network and out-of-network combined)	$1,500/person for diagnostic and preventive services and for basic and major restoration services combined (in-network and out-of-network combined)	None
Lifetime maximum benefit	$2,000/person for orthodontia (in-network and out-of-network combined)	$1,500/person for orthodontia (in-network and out-of-network combined)	None
For the following treatments and services, the dental options pay:			
Covered services			
Diagnostic and preventive services (e.g., routine oral exams, preventive cleanings, X-rays, fluoride treatments, periodontal maintenance)	100% with no deductible **Note:** Participants are eligible for three regular cleanings and one periodontal maintenance per plan year (in-network and out-of-network combined)	100% with no deductible **Note:** Participants are eligible for three regular cleanings and one periodontal maintenance per plan year (in-network and out-of-network combined)	100% after scheduled preset charge** **Note:** Participants are eligible for one cleaning every six months (two per plan year). Additional cleanings are available, but are subject to a copay
Basic restoration (e.g., fillings, extractions, oral surgery, treatment of gums, additional periodontal services, root canal therapy) (In the DHMO, some root canals fall into major restoration group.)	90% after deductible	70% after deductible*	100% after scheduled preset charge**
Major restoration (e.g., crowns and caps to repair teeth, dentures, bridgework, implants, prosthetics)	70% after deductible	50% after deductible*	100% after scheduled preset charge**
Orthodontia for adults and children (e.g., braces, retainers, oral exams, X-rays)	50% with no deductible, up to $2,000 per lifetime maximum shown above	50% with no deductible*, up to $1,500 per lifetime maximum shown above	100% after scheduled preset charge**

* Coinsurance benefit levels are subject to maximum allowable charge limits for services or supplies provided by an out-of-network provider.

** Provided in the patient charge schedule from Cigna Dental Health.

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Dental PPO

With the Dental PPO, administered by Cigna, you can choose to see any licensed dentist you wish whenever you need dental care. The plan also gives you access to a broad nationwide network of dentists who participate in the Cigna Dental Health Network and who have agreed with Cigna to charge contracted rates for dental services. When you see an in-network dentist, your deductible will be lower, the annual maximum benefit (what the plan pays) will be higher, and basic and major services will be covered at a higher coinsurance amount. The plan also pays a higher lifetime maximum for in-network orthodontia services.

Whether you see an in-network dentist or an out-of-network dentist, the Dental PPO covers a broad range of dental services, including emergency dental care.

While in-network dentists typically file claims for you, you are responsible for filing claims when you see out-of-network dentists.

How to choose a network dentist

To learn more about the dentists who participate in the Cigna Dental Health Network, call Cigna Dental Health or access the Cigna website at www.cigna.com.

Keep in mind that network dentists occasionally change, so you will want to make sure the dentist you choose is still in the Cigna network before you make an appointment. For the most up-to-date information, including whether a dentist is accepting new patients, call the dentist directly.

What the Dental PPO pays

Whether you see an in-network dentist or an out-of-network dentist, the Dental PPO covers the same broad range of dental services, including emergency dental care. As summarized below and described more fully in the Dental Program at-a-glance chart, benefits are paid based on whether services are received from in-network or out-of-network dentists.

Dental PPO		
	In-network	**Out-of-network**
For the following treatments and services, the plan pays:		
Diagnostic and preventive services (up to three regular cleanings and one periodontal maintenance per plan year)	100% with no deductible	100% with no deductible
Basic restoration	90% after deductible	70% after deductible*
Major restoration	70% after deductible	50% after deductible*
Orthodontia for adults and children	50% with no deductible, up to $2,000 per lifetime (in-network and out-of-network combined)	50% with no deductible*, up to $1,500 per lifetime (in-network and out-of-network combined)

* Coinsurance benefit levels are subject to maximum allowable charge limits for services or supplies provided by an out-of-network provider.

Note: Your out-of-pocket costs are usually lower if you see an in-network dentist, because:

- In-network dentists have agreed with Cigna to charge plan participants contracted rates for dental services.
- The fees charged by in-network dentists for non-covered services cannot exceed maximum allowable charge limits.

Regardless of which dentist you see, benefits paid by the Dental PPO are subject to the $3,000 in-network/$1,500 out-of-network plan-year benefit maximums (the maximum dental benefit payable for a covered person in one plan year). Other limits apply; see Eligible/ineligible expenses for details.

Deductible

Your annual deductible depends on whether you see an in-network or out-of-network dentist. You pay the first $25 in-network or $100 out-of-network of covered expenses incurred by you and each covered dependent during the plan year for all basic restoration services and major restoration services combined.

There is no deductible for diagnostic and preventive services or for orthodontic treatment.

The maximum family deductible is $75 in-network or $300 out-of-network each plan year. Once at least three covered family members meet their individual deductibles, the family maximum has been met. This means that no other covered family member is required to meet his/her individual deductible for that plan year before the Dental PPO pays benefits.

Maximum allowable charge limits

Cigna determines maximum allowable charge limits. The maximum allowable charge is the least of:

- The amount charged by the dentist for a covered service.
- The usual amount charged by the dentist for dental services which are the same as, or similar to, the covered service.
- The usual amount charged by other dentists in the same geographical area for dental services which are the same as, or similar to, the covered service.

If an in-network dentist performs a covered service, the plan benefit is based on the applicable coinsurance. You are responsible for paying the deductible (if applicable) before you and the plan begin to share costs.

If an out-of-network dentist performs a covered service, the plan benefit is based on the covered applicable coinsurance of the maximum allowable charge. An out-of-network dentist may charge you more than what Cigna determines is the maximum allowable charge. If an out-of-network dentist performs a covered service, you are responsible for paying:

- The deductible (if applicable).
- Any part of the maximum allowable charge for which the plan does not pay benefits.
- Any amount in excess of the maximum allowable charge that is charged by the out-of-network dentist.

Maximum allowable charge limits apply only when you see an out-of-network dentist. The Dental PPO does not cover charges above maximum allowable limits — they are your responsibility.

Emergency care

The Dental PPO provides coverage if you or a covered dependent needs emergency dental care for temporary relief of pain. Emergency dental care is services that are provided by a non-participating provider that are needed immediately, and the time required to reach a participating provider would have meant serious deterioration or risk of permanent damage to the participant's health.

The plan will reimburse you up to 100% for emergency treatment, up to the plan-year benefit maximum. Benefits provided by the plan are based on the treatment provided; however, you may be required to meet your plan deductible before you and the Dental PPO begin to share expenses.

Predetermination of benefits

Predetermination of benefits gives you an estimate in advance of how much the plan will pay for recommended dental services before the work is performed. You and your dentist should request a predetermination of benefits if total charges for the planned course of treatment are expected to be more than $300.

Here is how predetermination of benefits works:

- When deciding on a treatment plan, your dentist should submit a predetermination claim form to Cigna showing the proposed course of treatment and related charges.
- Cigna will send both you and your dentist a written Explanation of Benefits (EOB), which shows an estimate of how much of the proposed charges the plan will pay. In making this determination, Cigna may consider any alternate procedure to the one your dentist is proposing which can accomplish the same objective, meets generally accepted dental standards and costs less. If a lower-cost option is a viable alternative, the plan will provide benefits based on that lower-cost procedure.
- When the dental work is completed, you or your dentist will need to resubmit the predetermination form, showing which services were actually provided and the date each service was performed. This will serve as the claim for payment.

Predetermination does not guarantee that benefits will be paid. Actual benefits may differ from the estimated benefits, depending on:

- The actual services provided.
- The amount of the deductible.
- Plan provisions at the time of service.
- Whether the plan-year benefit maximum has been met.
- Whether the patient is covered by more than one dental plan.

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Dental Health Maintenance Organization (DHMO)

With the DHMO, which is administered by Cigna Dental Health, you and your covered dependents must receive dental care from the Cigna Dental HMO network of dentists in order to receive benefits. When you enroll in the DHMO, you choose a primary care dentist (PCD) from the Cigna Dental Health network for yourself, and the same or a different PCD for each family member you cover. The PCD directs all of your dental care.

If you receive care without the proper referral from your PCD, no benefits will be paid, except in the event of certain emergencies.

The DHMO provides coverage for a broad range of dental services, as detailed in the patient charge schedule you receive when you enroll. It is also available on the LifeBenefits site (see the Dental Comparison Chart). There is no annual deductible or plan-year dollar maximum and, in most cases, there are no required claim forms.

The DHMO is subject to the same rules relating to health care claims that apply to the Dental PPO. Because the DHMO is insured, it may also be subject to state insurance rules that provide DHMO participants even greater procedural protection. Contact Cigna Dental Health directly for its rules and procedures regarding health care claims.

How to choose a primary care dentist (PCD)

To select a PCD or to learn more about the dentists who participate in the Cigna Dental Health network, call Cigna Dental Health or access the Cigna web site at www.cigna.com.

Keep in mind that network dentists occasionally change, so you will want to make sure the PCD you choose is still in the Cigna DHMO network. For the most up-to-date information, including whether a dentist is accepting new Cigna Dental Health patients, call the dentist directly.

If you have an eligible dependent who does not live with you, you should call Cigna Dental Health to determine whether a DHMO network is available where your dependent lives.

Changing PCDs

If you want to change your primary care dentist (PCD), call Cigna Dental Health or visit www.mycigna.com. You can change your PCD as often as you wish. Generally, the change will take effect on the first of the month after you request the change.

If your PCD leaves the network, you will be notified by Cigna Dental Health and asked to select another PCD. If you do not make an election, a new PCD will automatically be assigned to you, based on your ZIP code.

What the DHMO pays

Network dentists

When you receive care from your primary care dentist (PCD) or any other Cigna Dental Health network provider, you pay the preset charge (detailed in the patient charge schedule provided by Cigna Dental Health) required at the time you receive services. The preset charges vary by the type of service. There are no deductibles, no plan-year dollar maximum and no claim forms to file.

Out-of-network dentists

Except in an emergency situation, the DHMO does not pay any benefits if:

- You go to an out-of-network dentist.
- You receive care from a network dentist without the proper referral from your PCD.

This is the case even if you have a covered dependent who does not live with you and there is no DHMO network where your dependent lives.

Emergency care

The DHMO provides coverage if you or a covered dependent requires emergency dental care to:

- Relieve severe pain.
- Eliminate acute infection.
- Control excessive bleeding.

	If you receive care from an in-network dentist:	**If you receive care from an out-of-network dentist:**
What you pay for emergency care	- During regular business hours, your care is covered 100% by the plan. - After regular business hours, you pay a $68 copay. You are not responsible for any costs over the maximum allowable charge.	- During regular business hours, the plan will reimburse up to $50 for emergency care services. You are responsible for any amount over $50. - After regular business hours, you pay a $68 copay, plus any amount over $50.
Filing a claim for emergency care	If you see an in-network dentist, you do not need to file a claim.	If you see an out-of-network dentist, you must provide Cigna with a written notice of claim within 30 days of the dental emergency. Once Cigna receives your notice of claim, it will provide you with the necessary claim forms. You have 90 days from the date of the emergency to submit your claim forms.

After you receive emergency care you must return to your PCD to discuss any follow-up treatment.

Orthodontia transition services

If you switch from the Dental PPO to the DHMO and you or a covered dependent is receiving orthodontic treatment, you may be able to continue receiving care from your provider even if he or she is not a DHMO network member. Call Cigna Dental Health for information on prorated benefits (if any) and charges.

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Eligible/ineligible expenses

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

The dental options available to you cover a wide range of dental services at specified costs to you. To see what is and is not covered, refer to the categories on the left navigation, or see below if you're reading a printed copy.

Publication date: April 2019

Expenses covered under the bp plan(s)

Regardless of the dentist you choose, the Dental PPO provides coverage for the following services and supplies:

- Diagnostic and preventive services.
- Basic restoration services.
- Major restoration services.
- Orthodontic treatment.

Diagnostic and preventive services

Diagnostic and preventive services include the following procedures that help your dentist evaluate your dental health and prevent the deterioration of teeth and gums:

- Routine oral exams, including preventive cleanings and bitewing X-rays, up to three times each plan year (adult bitewing X-rays are covered one time per calendar year).
- One periodontal maintenance each plan year.
- Full-mouth X-rays, limited to one set every 36 months.
- One topical fluoride treatment each plan year for adults and children.
- Space maintainers for covered children to prevent teeth from drifting after the early loss of a primary tooth (up to age 25).
- Sealants for children up to age 19, with a replacement frequency of 60 months.
- Emergency treatment to temporarily relieve pain but not cure the condition.

TMJ (temporomandibular joint) disorder

If you suffer from a TMJ (temporomandibular joint) disorder and incur dental expenses relating to TMJ, you should first file a medical plan claim to your medical plan claims administrator. Once you receive an Explanation of Benefits relating to your claim under your medical plan, you can then submit any TMJ-related dental expenses not covered under your medical coverage to Cigna for consideration under the Dental PPO. These expenses could include:

- Diagnostic services, such as examinations of the jaws and supporting structure.
- Basic and major restoration services, such as fillings, oral surgery, extractions and crowns.
- Initial installation of and follow-up adjustments to a removable appliance, such as a space maintainer or braces.

Basic restoration services

Basic restoration services include the following procedures necessary to restore the teeth (other than crowns or cast restorations) and to treat the soft tissues (gums):

- Fillings (other than gold) — amalgam, silicate, acrylic, synthetic porcelain and composite filling restoration (composite fillings only on molar teeth).
- Extractions — the removal of natural teeth.
- Oral surgery — surgical procedures, including incision and drainage of an abscess and removal of a cyst or tumor.
- Periodontics — treatment of diseases of the gums and soft tissues of the mouth, including periodontal scaling, gingivectomy, osseous surgery and periodontal grafting. **Note:** One periodontal maintenance is covered each plan year as a preventive service.
- Endodontics — treatment of dental pulp infections, including root canal therapy.

Most periodontal services, restorative services and some other services are subject to consultant review. Cigna, as the claims administrator, will undertake professional review by licensed dentists to determine dental necessity.

Major restoration services

Major restoration services include the following restoration and prosthodontic procedures:

- Crowns and precious-metal restorations:
  - Initial installation of crowns or onlays to restore diseased or fractured teeth that cannot be restored with a standard filling.
  - Replacement of an existing crown or gold restoration (if is more than 60 months old), as long as it cannot be made serviceable. The 60-month rule will not apply if the replacement of an existing denture or bridge is required because additional natural teeth are being removed.
- Prosthodontics:
  - Initial installation of full or partial dentures and fixed bridgework to replace natural teeth (excluding wisdom teeth).
  - Replacement of an existing denture or bridge (if more than 60 months old), as long as it cannot be made serviceable. The 60-month rule will not apply if the replacement of an existing denture or bridge is required because additional natural teeth are being removed.
- Dental implants placed into the upper or lower jaw for the purpose of attaching a denture or a tooth. The decision to insert a dental implant is made to address a definitive dental need that is considered necessary and appropriate, by general standards of care, for the maintenance, repair, restoration, replacement or health of the dental structure and associated tissues of the mouth and jaw. The decision will also be based on the diagnostic determination that the purpose served by the dental implant cannot be similarly met by the use of more conventional dental techniques.

Orthodontic treatment

Orthodontic treatment for adults and children includes the following procedures and appliances used to straighten or realign teeth that otherwise would not function properly:

- Diagnostic procedures, including oral exams and X-rays.
- Treatment, including appliances (for example, braces and retainers).

Expenses in connection with extractions, oral surgery and surgical therapy that are required in connection with the orthodontic treatment will be considered basic restoration services and will not count toward the lifetime maximum orthodontia benefit.

Payment for orthodontia treatment will be handled as follows:

- Under the Dental PPO and DHMO, repetitive orthodontia payments for appliance-adjustment visits will be paid at the end of a three-month period, rather than monthly.
- Payment amounts for comprehensive orthodontia treatment will be calculated using the plan's orthodontia lifetime maximum, rather than the actual fee charged by the orthodontist.

Please call the claims administrator for further details.

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Expenses not covered under the bp plan(s)

Dentally necessary means that a dental service or treatment is performed in accordance with generally accepted dental standards as determined by the claims administrator and is:

- Necessary to treat decay, disease or injury of the teeth; or
- Essential for the care of teeth and supporting tissues of the teeth.

While the Dental PPO provides benefits for many dental services, some services are not covered. These exclusions include:

- Any treatment that is not necessary according to accepted standards of dental practice, as determined by the claims administrator.
- Any treatment that is not recommended and approved by the attending dentist.
- Charges by a hospital or similar institution in connection with injuries or diseases of a dental nature.
- Charges for cleaning or sterilization of equipment/supplies.
- Charges for completion of claim forms.
- Charges for failure to keep appointments.
- Dental work covered by Workers' Compensation or other federal, state or local laws.
- Dental work done for cosmetic purposes.
- Dental work resulting from a military action, unless such dental work results from being an innocent bystander in the situation.
- Drugs and medicines.
- Education or training in dietary or nutritional counseling, personal oral hygiene or dental plaque control.
- Expenses that are in excess of maximum allowable charge/reasonable and customary limits, as determined by the claims administrator.
- Extra sets of dentures or other appliances.
- Periodontal splinting.
- Replacement of a lost or stolen appliance.
- Services for a course of treatment that began before coverage became effective (except for orthodontia services) and is completed after coverage starts — for example, a tooth that has been opened for root canal therapy or a tooth that has been prepared for a crown or gold restoration).
- Services or supplies for which there is no charge.
- Services rendered before coverage became effective.
- Services rendered by a family member. A family member includes your spouse, or any member of your immediate family including your and/or your spouse's parents, children (natural, step or adopted), siblings, grandparents or grandchildren.
- 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.
- Treatment from a dentist as the result of a non-occupational injury that is covered under one of the company's medical plan options.
- Treatments, procedures or devices considered experimental or investigational in nature, as determined by Cigna.

If you receive dental care as the result of a non-occupational injury and you are covered under the BP Medical Plan, dental benefits under the Dental PPO will be coordinated with the benefits you receive from the Medical Plan. The dental benefits will be determined after the medical claim is processed.

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Expenses covered under the DHMO

Expenses covered under the DHMO

The DHMO covers a wide range of dental services when you see your PCD for any dental service or have your PCD coordinate your care with another DHMO network dentist. These include:

- Diagnostic and preventive services.
- Basic restoration services.
- Major restoration services.
- Orthodontic treatment.

For a comprehensive list of the DHMO's covered services and patient charges, see the patient schedule. The schedule is provided when you enroll. If you are not enrolled or cannot locate your schedule, a copy is available by contacting Cigna or referring to the LifeBenefits site under the dental plan comparison chart.

Expanded services

Effective April 1, 2014, DHMO services have expanded to include:

- TMJ diagnosis and treatment procedures.
- Athletic mouth guards.
- Expanded coverage for periodontal maintenance.
- Reduced copay for teeth whitening.
- Additional fluoride services.
- Coverage for same day, in-office CAD/CAM services for crowns, inlays, onlays, post and cores and veneers.

Expenses not covered under the DHMO

While the DHMO provides benefits for many dental services, some services are not covered. For a list of expenses not covered by the DHMO, call the bp Benefits Center for a copy of Cigna's plan booklet.

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Coordination of benefits

The BP Dental Program coordinates with other dental coverage in which you may participate

Dental PPO

If you have dental coverage in addition to the Dental PPO, coverage under the Dental PPO 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 dental 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 plan adjusts its benefits so that the total benefits paid by both 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 all plans coordinate benefits, the bp plan is the primary plan for an active employee.
- If you have COBRA coverage under the bp plan and other group health coverage, the bp plan will not be the primary plan.
- If your spouse/domestic partner is enrolled in his/her employer-sponsored 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 both the bp plan and your spouse's/domestic partner's employer-sponsored 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 dental care, the plan of that parent becomes the primary plan.

With coordination of benefits, if the bp plan is the secondary (or tertiary) plan and another plan covering you or a covered dependent is the primary plan, it is possible that the bp plan will not pay any benefits if the primary plan's benefits are in all cases equal to or better than the bp plan's benefits.

DHMO

If you are enrolled in the DHMO, call Cigna Dental Health for information about how that plan coordinates benefits.

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How to file a claim

Claims for dental care 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.

Deadline for filing claims

To receive benefits under the Dental Program, 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.

Note: A claim/appeal can be made by you or your authorized representative (as determined by the claims administrator).

Need help with claims issues?

The Advocacy Service is available to help you with issues regarding health care claims and services. Advocacy team members work with you and the claims administrator to understand, research and resolve claims issues.

You must make at least one attempt to contact and resolve your issue directly with the appropriate claims administrator before contacting the Advocacy Service.

To reach the Advocacy Service, call the bp Benefits Center. Keep in mind that your issue may not necessarily be resolved in your favor, as the terms of the plan will apply in all situations.

What else you should know about the claims administrator

Cigna, the claims administrator for the Dental Program, is a business entity independent of bp. The claims administrator is solely responsible for making determinations regarding benefits based on the provisions of the Dental Program — moreover, because the DHMO is insured, Cigna is responsible for funding benefits under the DHMO. Neither bp nor the plan administrator will interfere in the decisions made by the claims administrator regarding benefits. Therefore, if you do not agree with the claims administrator's determination regarding benefits, you must pursue the matter through the claims and appeals process.

If the DHMO fails to pay its network provider for services you receive, you may be individually liable to pay for such services. Additional financial assistance from bp will not be provided.

Submitting claims for 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:

For ...	Submit claims for expenses incurred with out-of-network providers to ...	If you have questions about how to file a claim, call ...
Dental PPO and DHMO claims	Cigna Dental Health Client Services 300 NW 82nd Ave. Plantation, FL 33324	1-800-367-1037

If you file a claim for benefits, an Explanation of Benefits (EOB) will be generated. The Cigna website also allows you to print this information, which you can keep for your records or use to file a claim for reimbursement from your Health Care Flexible Spending Account (HCFSA).

Health Savings Account (HSA) Debit Card

Your share of the cost for eligible dental 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.

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bp plan(s) claims

Network dentists

If you are enrolled in the Dental PPO, you typically do not need to file a claim if you go to a network dentist for a covered expense. He/she will submit your dental expense claim directly to the claims administrator.

Out-of-network dentists

You may be responsible for filing dental expense claims when you see an out-of-network dentist. To file a dental expense claim for reimbursement, you will need to submit the following to Cigna:

- A completed claim form.
- All itemized bills indicating the date of service, description of service provided, diagnosis, name of the dentist and charges incurred.

You can download claim forms, including predetermination of benefits forms, by visiting www.cigna.com.

If you have other dental coverage

Periodically, the claims administrator will ask you to provide information about other dental 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 dental coverage information, including an Explanation of Benefits (EOB) from the other coverage's administrator, is required before your claim can be processed.

Your claim will not be processed until you comply with the claims administrator's request.

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DHMO claims

If you are enrolled in the DHMO, you do not need to file a dental expense claim unless you are filing a claim for emergency care you received from an out-of-network dentist. To be reimbursed for emergency care, you will need to submit an itemized bill to Cigna Dental Health within 90 days of the date of service.

For instructions on how and where to file a dental expense claim, call Cigna Dental Health and speak with a Participant Services Representative.

Emergency claims in the DHMO

If you see an in-network dentist for emergency dental care, you do not need to file a claim. However, if you see an out-of-network dentist, you must provide Cigna with a written notice of claim within 30 days of the dental emergency. Once Cigna receives your notice of claim, it will provide you with the necessary claim forms. You have 90 days from the date of the emergency to submit your claim forms.

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Process for formal benefit claims

Pre-service claims

- **Urgent-care claims —** If the option under which you are enrolled requires approval in advance of a service, supply or procedure before a benefit will be payable, and if the claim is an urgent-care claim, the claims administrator will notify the claimant not later than 72 hours after the claim is received by the claims administrator. If there is not sufficient information to decide the claim, the claimant will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after the receipt of the claim. The claimant will be given a reasonable additional amount of time — but not less than 48 hours — to provide the requested information. The claimant will be notified of the decision not later than 48 hours after the end of that additional time period (or after the receipt of the information, if earlier). Notification may be oral, with written or electronic communication furnished to the claimant not later than three days after the oral notification.

An **urgent-care claim** is a claim for care that has not been provided and where failing to make a determination quickly could seriously jeopardize the claimant's life or health or the ability of the claimant to regain maximum function, or in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that could not be adequately managed without the requested care or treatment. A claim will be determined to be an urgent-care claim if a physician with knowledge of the claimant's medical condition expresses as such to the claims administrator or if the claims administrator determines that the claim is an urgent-care claim.

- **Pre-service claims —** If the option under which you are enrolled requires approval in advance of a service, supply or procedure, a request for advance approval is considered a pre-service claim. The claims administrator will notify the claimant of its determination within 15 days after receiving the request. However, if more time is needed due to matters beyond the claims administrator's control, the claims administrator will notify the claimant within 15 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 30 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 the claimant fails to follow the claims administrator's procedures for filing a pre-service care claim but the specific claimant, condition and service or supply for which approval is requested is identified in the request, the claims administrator will notify the claimant of the failure and describe the proper procedures for filing within five days after receiving the request. This notice may be provided orally, unless the claimant requests written notification.

- **Concurrent-care claims —** If you are receiving an approved ongoing course of treatment, you will be notified by the claims administrator in advance if the plan intends to terminate or reduce benefits for the course of treatment so that you will have an opportunity to file a concurrent-care claim and appeal the decision before the termination or reduction takes effect. If the course of treatment involves an urgent-care claim and you request an extension of the course of treatment at least 24 hours before its expiration, the claims administrator will notify you of the decision within 24 hours of the receipt of the request.

Post-service claims

When a claimant files a post-service 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.

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 If your claim is denied for more information on the appeals process.

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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, 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.

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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.

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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. Here is an example:

Amelia experienced a COBRA qualifying event on August 31, 2020, but did not elect COBRA. Assume the national emergency lasts until the end of 2021. Amelia's Outbreak Period will end on August 31, 2021. She will then have 60 days (the normal COBRA election period) after that to elect COBRA, and another 45 days to pay her retroactive COBRA premiums. If she pays for only part of her COBRA coverage, the payments will be applied to the earliest months first (starting with September, 2020).

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

When you leave bp, you may be eligible for coverage continuation based on the provisions of COBRA. If you retire from bp, you may also elect the Voluntary Retiree Dental Plan.

COBRA coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985 (referred to as "COBRA") allows you and your eligible dependents to elect a temporary continuation of group health coverage, under certain circumstances, when coverage would otherwise end. For purposes of bp health care programs, domestic partners and civil union partners are offered continuation coverage comparable to the coverage offered to covered spouses under COBRA. For convenience, this summary plan description refers to the continuation coverage generally as "COBRA" coverage.

If you or one of your eligible dependents loses group health coverage because of a qualifying event, you may elect to continue your current group health coverage under COBRA for up to 18, 29 or 36 months, depending on the qualifying event. You or your eligible dependent must call the bp benefits center within 60 days of the loss of coverage due to the qualifying event or the date a COBRA notice is sent by the bp benefits center, whichever is later.

Qualifying events

You may elect COBRA coverage if your coverage would otherwise end because:

- Your work hours are reduced and you are no longer eligible for that coverage.
- You leave bp.

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

- Your work hours are reduced and you are no longer eligible for group health coverage.
- You leave bp.
- You and your spouse divorce or your domestic partnership/civil union ends.
- Your dependent no longer qualifies as an eligible dependent.
- You become entitled to Medicare.
- You die.

Maximum period of COBRA coverage

Your maximum period of COBRA coverage begins on the date group health coverage would otherwise be lost because of a qualifying event and ends 18, 29 or 36 months later, as summarized in the following schedule:

Who	Length of Coverage	Qualifying Event
You and/or your eligible dependents	18 months	- Your work hours are reduced. - You leave bp.
	29 months	- You or one of your eligible dependents is disabled (as defined by the Social Security Administration) at the time your work hours are reduced or you leave bp, or within 60 days of the beginning of COBRA coverage.
Your eligible dependents	36 months	- You and your spouse divorce. - Your dependent no longer qualifies as an eligible dependent. - You become entitled to Medicare.* - You die.

* The 36-month period is measured from the date you become entitled to Medicare benefits even if that event does not trigger loss of group coverage.

Electing COBRA coverage

The COBRA election process is a three-step process:

1. You or your covered dependent must experience a qualifying event that triggers COBRA eligibility. A subsequent qualifying event (such as disability, death, divorce or loss of a dependent child's eligibility status) that occurs during an initial 18- or 29-month period of COBRA coverage can also trigger an extension of COBRA coverage, up to the maximum allowed.

2. You or your dependent must notify the bp benefits center within 60 days of a qualifying event such as disability, death, divorce or loss of a dependent child's eligibility status. The bp benefits center will then mail COBRA enrollment materials to the affected family member. For certain qualifying events, such as your leaving bp or your reduction in hours causing loss of benefits eligibility, the bp benefits center will send COBRA materials, without any action required by you.

3. You or your affected dependent must contact the bp benefits center to elect COBRA within 60 days of the loss of coverage due to the qualifying event or the date the COBRA notice is sent by the bp benefits center, whichever is later. Notify the bp benefits center if the COBRA materials are not timely received.

If notice of the qualifying event is not received by the bp benefits center within 60 days of the event, the affected family members will not be allowed to elect COBRA coverage.

Paying for COBRA coverage

The cost of COBRA coverage equals 100% of the total cost of coverage plus a 2% administrative fee, for a total of 102%.

For the additional 11 months of coverage due to disability, the cost of COBRA continuation coverage equals 100% of the total cost of coverage plus a 50% administrative fee, for a total of 150%.

If you or an affected dependent elects COBRA coverage, the bp benefits center will send a monthly bill to that individual. That person will have 45 days from the date of the election to make the first payment. All future payments will be due in full on the fifth of each month, with a 30-day grace period.

Extending COBRA coverage

Your eligible dependents can extend coverage for up to an additional 18 months (for a total of 36 months) if one of the following qualifying events occurs during the initial 18-month COBRA coverage period:

- You and your spouse divorce or your domestic partnership or civil union ends.
- Your dependent no longer qualifies as an eligible dependent.
- You become entitled to Medicare.
- You die.

You or your dependents must notify the bp benefits center in writing within 60 days of the second qualifying event to elect extended COBRA coverage.

For disability

You and your eligible dependents may be eligible to extend COBRA coverage for up to an additional 11 months (for a total of 29 months) if:

- You or your eligible dependent is eligible for Social Security disability benefits when coverage first begins (or you or your eligible dependent becomes disabled within the first 60 days of COBRA coverage).
- The disability continues throughout the COBRA continuation period.

To be eligible for this 11-month extension, you or your eligible dependent must notify the bp benefits center of the person's disability within 60 days after you or your eligible dependent receives a written determination of disability — for Social Security purposes — but before the end of your initial 18-month COBRA coverage period.

The extension of COBRA coverage applies to all family members of the disabled person, even those family members who are not disabled.

End of COBRA coverage

COBRA coverage will end on the earliest of the following dates:

- The last day of the maximum period of COBRA coverage.
- The last day of the month for which the last contribution was made within the required time period.
- The last day of the month in which the covered person becomes covered under another group health plan during the COBRA coverage period, unless that plan contains an enforceable clause for pre-existing health conditions.
- The last day of the month in which a covered person ceases to be considered disabled under the Social Security Act if the COBRA continuation period has been extended for up to 11 months due to the disability.
- The last day of the month preceding the month in which the covered person first becomes entitled to Medicare during the COBRA coverage period.
- The date bp stops providing group health benefits.

Voluntary Retiree Dental Plan

bp offers the BP Voluntary Retiree Dental Plan to bp retirees. By enrolling in the plan, you benefit from the group rates offered — you will pay less for dental coverage than if you were to continue coverage under COBRA or to buy an individual policy. You will also have access to the same network of dentists that was available to you as an employee if you participated in the Dental PPO.

The BP Voluntary Retiree Dental Plan is administered by MetLife. Once enrolled, you will make payments directly to MetLife.

To enroll: Once you retire, please enroll directly at MetLife.

- Online: www.metlife.com/mybenefits
- Phone: 1-800-GET-MET8 (1-800-438-6388)

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Administrative information

Detailed information about plan administration and your rights

Name of plan	BP Dental Program, a component benefit program of the BP Corporation North America Inc. Consolidated Welfare Benefit Plan
Type of plan	Welfare benefit plan including: l Dental PPO (dental care) — self-insured. l Dental Health Maintenance Organization (DHMO) — insured.
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 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.

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Claims administrators

Administrator	Online	By phone
Dental PPO and DHMO – **Cigna Dental Health**	www.cigna.com	1-800-367-1037
Voluntary Retiree Dental Plan – **MetLife**	www.metlife.com/mybenefits	Within the U.S.: 1-800-451-3258 Outside the U.S: 1-800-942-0854

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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.

In order to determine whether a participant has engaged in improper conduct by covering an ineligible dependent, the plan administrator has the right to conduct internal or external audits of covered dependents at any time. In this regard, a participant may be asked to provide information and documentation supporting a covered dependent's status as an eligible dependent. Such documentation may include birth and marriage certificates, civil union or domestic partner registration materials, driver's licenses, passports, divorce decrees, court orders, tax records or other documents or materials supporting eligible dependent treatment. If selected for audit, the participant has the burden of establishing eligible dependent status to the satisfaction of the plan administrator. If a participant fails to respond timely to a request for information or materials, the plan administrator may take action, including but not limited to, increasing the participant's cost for dependent coverage or terminating the dependent's coverage.

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

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

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HIPAA privacy practices

The Dental Program is required by federal law (known as the “HIPAA Privacy Rules”) to maintain the privacy of participants’ “Protected Health Information” (PHI) and to provide participants with notice of its legal duties and privacy practices regarding PHI. HIPAA stands for the Health Insurance Portability and Accountability Act of 1996.

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

Complaints

If you believe the plan has violated your privacy rights, you may file a complaint with the plan, the plan’s Privacy Officer or with the Secretary of Health and Human Services. Complaints to the plan or to the Privacy Officer should be filed in writing with:

bp HIPAA Privacy Compliance Monitor
BP Corporation North America Inc.
P.O. Box 941644
Houston, TX 77094-8644

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

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Certificate of group health coverage

If you and/or your covered dependent lose bp medical and/or dental coverage, the bp Benefits Center will provide a Certificate of Group Health Coverage. This certificate states how long you and/or your covered dependent were continuously covered under the plan. Please note that the certificate shows only the most recent 18 months of coverage. You could have been covered for years, but the certificate will not show all of your coverage history. (You and/or your covered dependent who loses coverage may also be eligible for continuation coverage under COBRA.)

You and/or your covered dependent may also request a Certificate of Group Health Coverage before coverage ends or within 24 months after losing coverage.

This certificate may help reduce the amount of time you are subject to any exclusions for pre-existing health conditions if you were to become covered under a non-bp health care plan in the future, unless you have a break in coverage of more than 63 days.

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How to convert coverage

You cannot convert coverage under the Dental PPO to an individual policy. You may be able to convert coverage under the DHMO to an individual policy. Contact Cigna directly to determine if DHMO conversion is available to you.

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Qualified medical child support order (QMCSO)

A medical child support order (MCSO) is an order or judgment issued by a state court or an administrative notice issued by a state administrative agency that, when determined to be “qualified,” requires the plan administrator to provide a child with coverage or benefits under a group health plan, regardless of seasonal enrollment restrictions.

If an MCSO has been issued with respect to your child, you must forward all relevant documentation to the Qualified Order Team at the bp Benefits Center, which will determine whether the MCSO is qualified (QMCSO). If an MCSO is determined to be qualified, coverage will be subject to the terms of the QMCSO guidelines issued by the plan administrator from time to time.

If you have questions concerning a QMCSO or would like a copy of the applicable QMCSO procedures free of charge, contact the bp Benefits Center’s Qualified Order Team. They can be reached via fax at 1-847-442-0899 or regular mail at:

bp Qualified Order Team
P.O. Box 1542
Lincolnshire, IL 60069-1542

QMCSOs must be faxed or mailed to the Qualified Order Team. They may not be sent as scanned images via email. However, questions about qualified orders may be emailed to qocenter@hewitt.com.

To hear more about how to reach the Qualified Order Team, call 1-866-515-2425.

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Power of attorney (POA) and anti-assignment matters

Power of attorney (POA)

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

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

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

Anti-assignment

The rights or benefits under this plan may not be assigned by a participant or beneficiary. Any attempted assignment to a medical provider will be treated as a direction to pay benefits to such provider rather than as an assignment of rights.

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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.

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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.

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Future of the plan

The company reserves the right to change or end the Dental Program at any time without advance notice. The decision to do so may be the result of changes in federal or state laws governing benefits, or any other factor.

If the Dental Program is terminated, your contributions will end as of the last pay period before the program's termination date. However, you will be able to file reimbursement claims of covered expenses incurred before the program's termination date.

All eligible expenses will be reimbursed as long as they were incurred during the period you were covered under the Dental Program.

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Your ERISA rights

As a participant in a bp benefit plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants have the right to:

- Examine, without charge, at the plan administrator's office, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor.
- Obtain, upon written request to the bp Benefits Center, copies of governing plan documents. A reasonable fee for copying may be assessed. The address used to request plan documents is:

  bp Benefits Center
  P.O. Box 563944
  Charlotte, NC 28256-3944

  Participants may also download a copy of the summary plan description at no cost from the "Benefits handbook" tab on the LifeBenefits website at http://www.bp.com/lifebenefits.

- Receive a summary of the plan's annual financial report at no charge. Each participant is automatically provided with a copy of this summary annual report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plan. The people who operate your plans are called "fiduciaries" and have a duty to operate the plans prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or discriminate against you in any way to prevent you from obtaining benefits under the plan or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time limits.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court within Harris County, Texas. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless they were not sent because of reasons beyond the plan administrator's control.

The only proper venue for a lawsuit seeking enforcement of your rights under this plan is in federal court in Harris County, Texas.

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

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

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

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

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

Washington, DC 20210

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