BP vision plan

IMS#65525

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BP Vision Plan

You have the opportunity to enroll in vision coverage provided by VSP

To help you get the eye care you need, bp gives you the option to purchase vision coverage through the Vision Plan. The Vision Plan is insured and administered by VSP and provides benefits for routine eye exams, eyeglasses and contact lenses regardless of which provider you choose. How much you pay for eye care services and supplies will depend on the provider you select.

If you do not enroll, you and your eligible dependents will not have coverage.

You may enroll in the BP Vision Plan 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., what is covered and what is not).

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 vision plan

Who is eligible

You are eligible to participate in the Vision Plan 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 Vision Plan, you may also enroll your eligible dependents under your vision 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 Vision Plan 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 vision plan.
- Covered as a dependent of another bp employee in a bp-sponsored vision 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 Vision Plan; 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 Vision 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 Vision Plan 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 the Vision Plan, 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 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 Vision Plan is based on the truthfulness of statements made by you and your dependents. Coverage may be terminated, including retroactively, if such statements are found to be false, 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 pay 100% of the cost of vision coverage for you and any eligible dependents.

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: - Legal divorce or annulment. - End of a domestic partnership. - Death of spouse/domestic partner/child. - Child no longer meeting the eligibility requirements.	You may not disenroll from the Vision Plan 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 are rehired in same plan year	If you are rehired within the same plan year, your previous Vision Plan coverage will be reinstated if you were enrolled before you left.
l You want to **enroll** yourself in coverage, or **add** an eligible dependent to your coverage if you are already enrolled because: l You are newly eligible. l Marriage. l Your establishment of your domestic partnership. l Birth/adoption/legal guardianship of your child. l You or an eligible dependent experiences a non-voluntary loss of eligibility under another (non-bp) plan.	l Contact the bp benefits center for a domestic partner affidavit for establishment of a domestic partnership before enrolling. l If you miss the 30-day enrollment window, you may add a new eligible dependent to your BP Vision Plan coverage if you already have You + spouse/domestic partner, You + child(ren) or You + family coverage.
l Your spouse/domestic partner's employer's plan does not have an April 1 plan year start date. l Your child becomes eligible again under the bp plan.	N/A
You return from a leave of absence where you did not maintain coverage while on leave.	N/A

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 ...
l Marriage, if you/your dependents will be covered under your new spouse's employer's plan. l Establishment of a domestic partnership, if you/your dependents will be covered under your new domestic partner's employer's plan. l Birth/adoption/legal guardianship, if you and/or your dependents will be covered under your spouse's/domestic partner's employer's plan. l 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. l Mid-year plan enrollment in spouse's/domestic partner's plan that is not on an April 1 – March 31 basis. l You go on a leave of absence and do not want to maintain coverage while on leave.	N/A

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 Vision Plan 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 Vision Plan.
- 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 Vision Plan, whether or not you report your dependent's change in eligibility status.
- The date you begin an unpaid leave of absence not approved by bp.

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

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How the BP Vision Plan works

Important information about how the vision plan works

The BP Vision Plan gives you a choice when it comes to getting eye care. You can go to:

- Any network provider — that is, any licensed eye care professional whom VSP has designated as part of its network — and receive a higher level of benefit for a covered expense.
- Any out-of-network provider — that is, any licensed eye care professional whom VSP has not designated as part of its network — and receive a lower level of benefit.

Vision Plan at-a-glance

The Vision Plan pays the following benefits per plan year (the plan year runs from April 1 to March 31):

	Network provider	**Out-of-network provider**
Eye exam (once every plan year)	100%	Reimbursed up to $45
Lenses* (once every plan year) - Single-Vision - Lined Bifocal - Lined Trifocal - Lenticular **Frames**** (adults: once every other plan year; dependent children: once every plan year)	- 100% after $30 copay for lenses and/or frames - 20% to 25% discount on non-covered lens options - 100% up to $200 allowance - 20% off amount over your allowance	Reimbursed after $30 copay for lenses and/or frames: - Up to $30 - Up to $50 - Up to $65 - Up to $100 Up to $70
Contact lenses (once every plan year) - Medically Necessary (when certain benefit criteria are met, subject to doctor's approval)*** - Elective	- 100% after $30 copay - 100% up to $160****	- Reimbursed up to $210, after $30 copay - Reimbursed up to $160
Laser correction surgery discounts	VSP has arranged for members to receive PRK, LASIK and Custom LASIK surgery at a discounted fee. Discounts vary by location, but average 15% off of the contracted laser center's usual and customary price. Additionally, if the participating laser center is offering a temporary price reduction, VSP members will receive 5% off of the promotional price. The maximum fee is: - $1,500 per eye for PRK. - $1,800 per eye for LASIK. - $2,300 per eye for Custom LASIK.	The laser vision surgery discount is not available if you go to an out-of-network provider.

* Lenses may be glass or plastic.
** If you choose a frame valued at more than the plan's allowance, the difference you pay is based on VSP's preferred member pricing. VSP offers valuable savings, including a 20% discount on non-covered pairs of prescription glasses (lenses and frames) and sunglasses. Services are available from any VSP provider within 12 months of your last eye exam.
*** Medically necessary contact lenses are covered in full when VSP benefit criteria is met and verified by a VSP network doctor for eye conditions that would prohibit the use of glasses. The conditions covered include aphakia, anisometropia, high ametropia, nystagmus, keratoconus and other eye conditions that make contact lenses necessary.
**** You receive a 15% discount on contact lens professional services before the maximum allowance is applied. No copay applies. This benefit is instead of the lenses and frames benefit.

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Network providers

To take advantage of the cost savings available through the VSP network, you will need to select a licensed ophthalmologist or optometrist from the more than 22,000 eye-care professionals nationwide whom VSP has designated as part of its network. The provider you choose will examine your eyes and, if necessary, order and fit glasses or contact lenses.

To learn more about the providers who participate in the VSP network, contact VSP.

Keep in mind that network providers occasionally change, so you should make sure the provider you choose is still in the VSP network before you make an appointment. For the most up-to-date information, including whether a provider is accepting new patients, call the provider directly.

When you see a network provider

To make an appointment with a network provider, contact the provider and identify yourself as a VSP member. The provider's office will ask for your first and last name, your date of birth and possibly the last four digits of your Social Security number. Then, the provider will contact VSP to verify your eligibility for benefits and plan coverage. The provider's office will also obtain authorization for services and supplies. If you are not eligible for benefits at that time, the provider's office will notify you.

If you go to one network provider for your eye exam and a different network provider to have your glasses made or your contact lens prescription filled, be sure to identify yourself as a VSP member when making each appointment. To avoid any confusion, you should also inform the second provider that you are seeking materials only and confirm that he/she will fill another provider's prescription.

The provider will examine your eyes and, if necessary, order and fit glasses or contact lenses. There are no claim forms to complete. Just pay the required copay at the time of the visit, and VSP will pay your network provider directly for all covered eye-care services and eyewear provided.

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Out-of-network providers

If you go to an out-of-network provider, you pay for any eye-care services and eyewear at the time you receive them, then file a claim for reimbursement from VSP.

If you go to one out-of-network provider for your eye exam and a different out-of-network provider to have your glasses made or your contact lens prescription filled, you should inform the second provider that you are seeking eyewear only and confirm that he/she will fill another provider's prescription.

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What the Vision Plan pays

You do not have to use the same provider for your eye exam and your eyeglasses or contact lenses. Additionally, you are not required to receive your eye exam and purchase your eyeglasses/contact lenses at the same time.

Lenses and frames

The Vision Plan's lens and frames benefit covers a wide range of frames and lenses on the market today.

Network providers

With a network provider, you will pay a copay for single-vision and multi-focal lenses — which may be glass or plastic — once every plan year. A wide selection of frames is available to you once every other plan year for adults and once every plan year for dependent children.

Be sure to ask which lenses and/or frames are fully covered under the Vision Plan. If you select a frame or lens that is not fully covered, you will pay more than the copay. You also should expect to incur additional out-of-pocket costs with an average savings of 20% to 25% for certain cosmetic options, such as:

- Scratch coating.
- Anti-reflective coating.
- Polycarbonate lenses for adults.
- Progressive lenses.
- Photochromic lenses.
- Transitions® lenses.
- Oversized lenses.
- Any frame or lens that exceeds the plan allowance.

For a complete listing of cosmetic options available for additional cost, contact VSP.

Out-of-network providers

With an out-of-network provider, the Vision Plan reimburses only up to a maximum benefit for each covered service or supply. You pay a copay for single-vision and multi-focal lenses — which may be glass, plastic or polycarbonate — once every plan year. Frames are covered every other plan year for adults and every plan year for dependent children.

Contact lenses

The Vision Plan's contact lens benefit includes contact lens evaluation, contact lens materials and dispensing.

Network providers

When you go to a network provider, you will pay a copay, and the Vision Plan will cover medically necessary contact lenses at 100% once per plan year.

Medically necessary contact lenses are those that are used for eye conditions verified by a VSP network doctor that would prohibit the use of glasses. Covered conditions include:

- Aphakia;
- Anisometropia;
- High ametropia;
- Nystagmus;
- Keratoconus; and
- Other eye conditions that make contact lenses necessary.

If you choose to purchase elective contact lenses — contacts that are not medically necessary — the Vision Plan will cover up to $160 towards the cost of your contact lenses and contact lens exam (fitting and evaluation) once per plan year. Additionally, you are eligible for a 15% discount off the contact lens exam.

If you purchase contact lenses, the Vision Plan will not cover lenses and/or frames as well.

Out-of-network providers

If you receive care from an out-of-network provider, the Vision Plan reimburses you up to a specified amount. This amount is based on whether the contacts are medically necessary or elective. This benefit is paid once per plan year.

Laser correction surgery

Through VSP's Laser VisionCare^{SM} Program, you and your covered dependents may be a candidate to have laser vision correction surgery. Make an appointment with your VSP doctor to see if you qualify. If you are a candidate for the surgery and decide to have it performed, your VSP doctor will work with you to make arrangements with one of many designated surgeons and centers. You will receive an average of 15% off the regular price or 5% off the promotional price. Discounts are only available from VSP contracted facilities.

To find a contracted Laser Surgery Center:

- Check with your VSP doctor for a referral; or
- Contact VSP to locate a contracted facility in your area.

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Eligible/ineligible expenses

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

The BP Vision Plan covers a wide variety of eye-care services and supplies. The amount you pay depends on whether you go to a network provider or an out-of-network provider.

Expenses covered under the BP Vision Plan

The Vision Plan helps you pay for a wide range of eye-care services and supplies, including:

- Eye exams — once every plan year.
- Lenses and frames.
  - Single-vision and multi-focal lenses — which may be glass or plastic (or polycarbonate if from an out-of-network provider) — are available once every plan year.
  - Frames are available once every other plan year for adults and once every plan year for dependent children. If you select a frame or lens that is not fully covered, you will pay more than the set copay with network providers. You also should expect to incur additional out-of-pocket costs for certain cosmetic options. The average savings on non-covered lens options is 20% to 25%.
- Contact lenses — once every plan year, instead of lenses and frames.
- Laser correction surgery discounts.

Expenses not covered under the BP Vision Plan

While the Vision Plan provides benefits for many eye-care services and supplies, some are not covered. These exclusions include:

- Any eye exam or any corrective eyewear required by an employer as a condition of employment.
- Any frame that exceeds the plan allowance.
- Blended, oversized, coated or laminated lenses.
- Certain services or supplies for low-vision care.
- Corrective vision services, treatments and materials of an experimental nature.
- Cosmetic lenses or optional cosmetic processes.
- Medical or surgical treatment of the eyes.
- Orthoptics or vision training and any related supplemental testing.
- Photochromic or tinted lenses other than Pink 1 or 2.
- Plano (non-prescription) lenses.
- Replacement of lost or broken lenses or frames provided under the Vision Plan.
- 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.
- Two pairs of single-vision eyeglasses instead of bifocals.
- Ultraviolet-protected lenses.

In some cases, when you purchase any of the services or materials listed above, you will be responsible only for the additional charge that exceeds the plan allowance. You may be eligible for a discount on any of the services or materials purchased from a network provider. Savings average 20% to 25% off non-covered lens options.

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Coordination of benefits

The BP Vision Plan does not coordinate with other vision coverage in which you may participate

There is no coordination of benefits under the Vision Plan.

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How to file a claim

Claims for vision 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 BP Vision Plan, you must submit all claims to VSP within six months of the date of service. Any claims that the claims administrator receives more than six months after the date of service will not be paid.

Network providers

If you are enrolled in the BP Vision Plan, you do not need to file a claim if you go to a network provider for a covered expense. He/she will submit your vision expense claim directly to VSP.

Out-of-network providers

If you go to an out-of-network provider, you will have to pay the provider for eye-care services and supplies at the time you receive them, and then submit an original itemized bill to VSP. No claims forms are necessary. Simply submit required information to VSP for reimbursement. However, for faster reimbursement, you can visit www.vsp.com to input your claim information and print a claim form to submit to VSP. When filing a claim for reimbursement, you must submit the following information on or with the original bill:

- Your name, address and telephone number.
- Your birth date.
- The last four digits of your Social Security number.
- The patient's name.
- The patient's birth date.
- The patient's relationship to you.
- An itemized list of the services received.
- The name, address and telephone number of the provider.

Submit vision expense bills incurred with out-of-network providers to:

VSP
P.O. Box 385018
Birmingham, AL 35238-5018

If you have any questions about how to file a vision expense claim, call VSP at:

- Within the U.S.: 1-800-877-7195.
- Outside the U.S.: 916-635-7373.

Health Savings Account (HSA) Debit Card

Your share of the cost for eligible vision 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.

What else you should know about the BP Vision Plan

VSP — the insurer and claims administrator of the BP Vision Plan — is a business entity independent of bp. VSP is solely responsible for making determinations regarding benefits based on the provisions of the Vision Plan. Neither bp nor the plan administrator will interfere in the decisions made by VSP regarding benefits. Therefore, if you do not agree with VSP's determination regarding benefits, you must pursue the matter through the claims and appeals process.

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Process for formal benefit claims

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

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

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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 benefits under the plan, you may file a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). You may not file a civil action unless you have exhausted the plan’s claims and appeals procedure.

Publication date: April 2019

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 COBRA continuation coverage.

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

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

Paying for COBRA coverage

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

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

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

Extending COBRA coverage

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

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

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

For disability

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

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

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

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

End of COBRA coverage

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

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

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Administrative information

Detailed information about plan administration and your rights

Name of plan	BP Vision Plan, a component benefit program of the BP Corporation North America Inc. Consolidated Welfare Benefit Plan
Type of plan	Welfare benefit plan (vision care) — 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 administrator	VSP P.O. Box 997105 Sacramento, CA 95899-7105 http://www.vsp.com - Within the U.S.: 1-800-877-7195 - Outside the U.S.: 916-635-7373
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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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 Vision Plan is required by federal law (known as the “HIPAA Privacy Rules”) to maintain the privacy of participants’ “Protected Health Information” (PHI) and to provide participants with notice of its legal duties and privacy practices regarding PHI. HIPAA stands for the Health Insurance Portability and Accountability Act of 1996.

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

Complaints

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

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

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

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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.

Publication date: April 2019

Power of attorney (POA) and anti-assignment matters

Power of attorney (POA)

Occasionally participants need assistance from a third party (agent) with benefits matters. If you wish to designate an agent to act on your behalf for your bp health and protection benefits, please contact the bp 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 Vision Plan at any time without advance notice. The decision to do so may be the result of changes in federal or state laws governing benefits, or any other factor.

If the Vision Plan 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 Vision Plan.

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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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