EMPLOYEE BENEFIT NOTICES

BP Supply, Inc.
11710 Tower Road, Midland, TX 79707
432-523-5612

The following pages provide employee benefit plan notices. Please read them carefully as we generally provide these once a year during annual open enrollment. You may see some of these notices in other documents as well, but we consolidate the following notices here for your convenience:

- MEDICARE PART D PRESCRIPTION DRUG CREDITABILITY/NON-CREDITABILITY
- CONTINUATION COVERAGE RIGHTS UNDER COBRA
- OUR PLAN PAYS SECONDARY TO DISABILITY-BASED MEDICARE AFTER BEING SOCIAL SECURITY DISABLED FOR 24 MONTHS
- NON-GRANDFATHERED MEDICAL PLAN APPEALS PROCESSES
- WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)
- PUBLIC HEALTH INSURANCE MARKETPLACE
- PREMIUM ASSISTANCE UNDER MEDICAID OR THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)
- SPECIAL MEDICAL ENROLLMENT RIGHTS AND RESPONSIBILITIES UNDER HIPAA
- SECTION 125
- HIPAA PRIVACY NOTICE

If you (and/or your dependents) have Medicare or will be eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 2 for more details.

Throughout these pages you are invited to "contact HR" for assistance. For any questions or requests you may have about the pages below, including a request for a paper copy of this notice packet, contact Cameron McQueen in human resources (HR) at 432-523-5612.

Before we get into the notices, some basic rules governing our plan are summarized below:

- You may only enroll when first eligible or during our annual open enrollment each September.
- **Your election is locked** for the entire plan year, October 1 to September 30.
- You can generally submit an election change form **within 30 days of a qualifying life event** to request a benefit change during the plan year. We may require substantiating documentation of the event, and we may determine the event does not qualify to make the requested change.
- At any time, we may audit dependent status and require current substantiating documentation.
- Declining to enroll in coverage will require your signature each year.
- **Please keep us informed of address or beneficiary changes**.

- When first enrolling in health coverage, a **general notice of rights and responsibilities to continue health coverage under COBRA** is mailed to the home. It explains that when certain life events make an enrolled individual no longer eligible to stay on the plan, coverage might be able to continue for a limited time under COBRA so long as you or your spouse follow our procedures to notify us within 30 days of the qualifying life event.
- Your rights and responsibilities under the FMLA and our company specific FMLA policies are discussed in our employee handbook.

MEDICARE PART D PRESCRIPTION DRUG CREDITABILITY/NON-CREDITABILITY

When you or a family member becomes eligible for Part D (Medicare's prescription drug benefit), it is important to understand when to enroll in Part D. You can wait as long as you maintain "creditable" coverage (i.e., coverage which on average pays at least as well as Part D pays on average). But if you do not have creditable coverage, you need to enroll in Part D at the earliest opportunity.

Below are highlights to note:

- A continuous break in creditable coverage of 63 or more days will trigger a late enrollment penalty payable for life.
- The longer you go without creditable coverage, the higher the penalty. For the rest of your life, you would be charged an additional 1% of Part D base premium for each month you are late.
- When creditable coverage ends, a special enrollment period of two (2) months may be provided to enroll in Part D (but note that this is only available when normal coverage ends, not when retiree or COBRA coverage ends).
- The Part D annual open enrollment occurs each year from October 15th through December 7th for coverage to begin January 1st.

The information below indicates whether prescription drug coverage under our plan is creditable.

Creditable Coverage	Non-Creditable Coverage
MTBCB038 Base Plan **MTBCP007 Buy-up Plan**	**None (all plans are creditable)**

Anyone needing to learn more about Medicare should contact a Medicare-approved counselor in their state at https://www.medicare.gov/Contacts/#resources/ships.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

INTRODUCTION

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;

- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Cameron McQueen.

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. A written request of extension must be received by Cameron McQueen 60 days prior to the end of the initial 18 month period.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

CAN I ENROLL IN MEDICARE INSTEAD OF COBRA CONTINUATION COVERAGE AFTER MY GROUP HEALTH PLAN COVERAGE ENDS?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

PLAN CONTACT INFORMATION

Attn: Cameron McQueen
11710 Tower Road, Midland, TX 79707
432-523-5612

OUR PLAN PAYS SECONDARY TO DISABILITY-BASED MEDICARE AFTER BEING SOCIAL SECURITY DISABLED FOR 24 MONTHS

When you or a dependent are determined disabled by the Social Security Administration, it is imperative such individual have Medicare begin immediately after 24 months of Social Security disability. Regardless whether the individual is enrolled in Medicare or not, our plan will calculate how much Medicare would have paid and then pay secondary (meaning it will pay very little or nothing).

If we employ 100 or more full- and part-time employees during 50% or more of business days during the previous calendar year, then we will give everyone an update that our plan will begin paying primary (not secondary) to disability-based Medicare.

Anyone needing to learn more about Medicare should contact a Medicare-approved counselor in their state at https://www.medicare.gov/Contacts/#resources/ships.

NON-GRANDFATHERED MEDICAL PLAN APPEALS PROCESSES

Your medical plan booklet will explain how to appeal a claim denial through the plan, through a government-authorized third party, and with the help of a consumer assistance office.

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

Enrolled individuals may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and co-insurance applicable to other medical and surgical benefits provided under the medical plan. If you would like more information on WHCRA benefits, please contact HR.

PUBLIC HEALTH INSURANCE MARKETPLACE

For individuals needing to purchase health insurance on their own, the Affordable Care Act (ACA) created a new public health insurance Marketplace. This website and call center helps individuals shop for private health insurance, helps individuals enroll in Medicaid or the Children's Health Insurance Program (CHIP), and evaluates eligibility for new tax credits. Open enrollment for public Marketplace coverage occurs each fall for coverage starting January 1, but special enrollment periods may be available for certain life events. Learn more or request assistance at www.healthcare.gov.

Please note that insurance companies are not required to participate in the public Marketplace, so you are unlikely to see all plans available in the community when shopping the public Marketplace.

The public Marketplace can help you determine whether you may be eligible for tax credits under section 36B of the Internal Revenue Code for Marketplace coverage. One tax credit can lower your monthly premium, and the other can lower your cost sharing (such as your deductible). Since tax credits are based on your projected household income and typically paid in advance to the insurance company, there is a chance you may have to repay some or all tax credits on your tax return if your income for the year ends up higher than anticipated.

Tax credits are not available to those eligible for "affordable, minimum value" medical coverage. "Minimum value" means our plan is intended to pay, on average, at least 60% of the costs of medical care received. "Affordable" means our lowest-cost minimum value plan costs you no more than 9.5% (indexed annually) of your household income to be enrolled in single (not family) coverage.

Our plan is intended to be affordable and minimum value. As a result, if you or someone in your family wanted to compare your health insurance options in the public Marketplace to the insurance offered through us, you'll need to remember that:

- You might pay full retail price for public Marketplace insurance (without the new tax credits)
    a) You would no longer be paying for insurance on a pre-tax basis
    b) You would no longer have an employer contribution toward your insurance (note that employer contributions are typically excludable from income for federal income tax)
- You would navigate any questions you have directly with the insurance company you choose…HR will not be able to assist you with your public Marketplace plan
- Should you desire to come back to our plan in the future, you will either need to:
    a) experience a "qualifying event" recognized by our plan as a mid-year election change, or
    b) wait until our next annual open enrollment

PREMIUM ASSISTANCE UNDER MEDICAID OR THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions

about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-800-541-5555	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
IOWA – Medicaid and CHIP (Hawki)	**MONTANA – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084

EMPLOYEE BENEFIT NOTICES

KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp [Under ELIGIBILITY tab, see "what if I have other health insurance?"] Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100

EMPLOYEE BENEFIT NOTICES

MISSOURI – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and

Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

SPECIAL MEDICAL ENROLLMENT RIGHTS AND RESPONSIBILITIES UNDER HIPAA

When you are eligible to participate in our group medical plan, you may have to enroll and agree to pay part of the premium through payroll deduction in order to actually participate.

A federal law called the Health Insurance Portability and Accountability Act (HIPAA) requires that we notify you of your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

SPECIAL ENROLLMENT PROVISION

- **Loss of Eligibility under Medicaid or a State Children's Health Insurance Program (CHIP).** If you decline enrollment for yourself or for an eligible dependent (including your spouse) while coverage under Medicaid or CHIP is in effect, you may be able to enroll yourself and your dependents in this plan **if eligibility is lost for the other coverage**. However, **you must request enrollment within 60 days** after the other coverage ends.
- **Loss of Eligibility for Other Coverage.** If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other medical coverage is in effect, you may be able to enroll yourself and your dependents in this plan **if eligibility is lost for the other coverage (or if the employer stops contributing toward it)**. However, **you must request enrollment within 30 days** after the other coverage ends (or after the employer stops contributing toward it).
- **New Dependent by Marriage, Birth, Adoption, or Placement for Adoption.** If you have a new dependent as a result of marriage, birth, adoption, or placement with you for adoption, you may

be able to enroll yourself and your new dependents. However, **you must request enrollment within 30 days** after the marriage, birth, adoption, or placement for adoption.

- **Eligibility for Medicaid or CHIP State Premium Assistance Subsidy.** If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through CHIP with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, **you must request enrollment within 60 days** after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact HR.

If You Decline Coverage, You Must Complete a "Form for Employee to Decline Coverage"

- If you decline enrollment for yourself or for an eligible dependent, you must complete a "Form for Employee to Decline Coverage."
- On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or CHIP) is the reason for declining enrollment, and you are asked to identify that coverage.
- If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or CHIP with respect to coverage under this plan, as described above.
- If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or CHIP with respect to coverage under this plan.

125 PREMIUM ONLY PLAN (POP) ACKNOWLEDGEMENT

125 Premium Only Plan (POP) Acknowledgement BP Supply, Inc. elects to deduct employee contributions for medical, dental, and vision, if applicable, coverage, under Section 125 of the Federal Tax Law. This allows BP Supply, Inc. to deduct the employee contributions from employee wages before taxes are calculated. For a more detailed account of BP Supply, Inc. Premium Only Plan, an employee may request a copy of the Plan Document. This plan prohibits an employee from changing his/her before-tax elections during the plan year unless a qualifying life event occurs. This qualifying life event must also directly affect or relate to the change being requested.

You will be asked to give permission for BP Supply, Inc. to deduct your employee contributions under these benefit plans, before tax. Please also be advised that BP Supply, Inc. may reduce, or cancel this election if necessary to comply with provisions of the Internal Revenue Service.

HIPAA PRIVACY NOTICE

PRIVACY NOTICE THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice is being provided to you in accordance with the requirements of the Standards for Privacy of Individually Identifiable Health Information of the Health Insurance Portability and Accountability Act (the "HIPAA Privacy Rules"). The HIPAA Privacy Rules are federal laws that seek to ensure the privacy and confidentiality of your health information. The HIPAA Privacy Rules require BP Supply, Inc. (the Plan) to take certain actions to protect the privacy of your health information. This Notice has been prepared to advise you of the uses and disclosures of your Protected Health Information (as defined below) that may be made by the Plan and to advise you of your rights and the Plan legal duties relating to the privacy of your Protected Health Information.

Protected Health Information means information related to a past or present health condition that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in written, electronic or any other form.

As an individual enrolled in the Plan, you should be aware that the Plan may have access to your Protected Health Information from time to time and may receive your Protected Health Information in a variety of ways. An example of how the Plan may receive this information is when your health care provider, such as your doctor or your hospital, submits bills for services rendered to you to be paid by the Plan.

The law permits the Plan to use or disclose Protected Health Information to carry out "treatment," "payment" and other "health care operations". When the Plan makes uses or disclosures of your Protected Health Information for treatment, payment or health care operations purposes, the Plan is not required to notify you or obtain your Authorization (discussed further below).

Treatment means the provision, coordination, or management of health care and related services by health care providers, including the coordination or management of health care by a health care provider with a third party (such as an insurer of the Plan), consultation between providers with respect to a patient, and the referral of a patient for health care from one provider to another. The Plan itself does not engage directly in "treatment" under the HIPAA Privacy Rules. However, the Plan may interact with a health care provider in treatment transactions.

Payment means activities undertaken by the Plan to determine or fulfill its responsibility for coverage and provision of benefits under the Plan. Examples of when the Plan might use or disclose Protected Health Information for payment purposes include disclosures to facilitate the payment of claims made

on the Plan by health care providers, the Plan's activities to obtain or provide reimbursement for the provision of health care, or the Plan's activities in obtaining premiums. When the Plan discloses information for payment purposes, the Plan will attempt only to disclose that Protected Health Information which is minimally necessary to ensure proper and timely payment of claims.

The term "health care operations" means those other functions and activities that the Plan performs in connection with providing health care benefits. Examples of what constitute health care operations during which the Plan might use or disclose your Protected Health Information include activities relating to creation, renewal or replacement of a contract of health insurance or health benefits, business planning and development relating to the Plan, and compliance with the HIPAA Privacy Rules. Another example would include the Plan's use or disclosure of Protected Health Information to better manage its operations, such as when the Plan discloses information with a vendor or consultant (commonly referred to as a "Business Associate") to ensure proper accounting and record-keeping relating to the Plan's provision of health care benefits.

For uses or disclosures of Protected Health Information that are not made for treatment, payment, or health care operations purposes and for which no exception regarding Authorization applies, the law requires the Plan to obtain your Authorization. An Authorization is your approval for the Plan's disclosure of your Protected Health Information to a particular person or entity for a particular purpose. You may revoke an Authorization at any time, but a revocation is not effective if the Plan has already reasonably relied on your Authorization to make a particular use or disclosure. Examples of when an Authorization would be required include when the uses or disclosures are made to your employer for disability, fitness for duty or drug testing purposes. Additionally, if you request that the Plan make a use or disclosure of your Protected Health Information to a third party, the Plan may require that you sign an Authorization that permits the Plan to honor your request.

The Plan is not required to obtain your Authorization to make uses or disclosures of your Protected Health Information for treatment, payment or health care operations purposes. Additionally, there are some limited exceptions in which the law allows the Plan to make uses or disclosures of your Protected Health Information for purposes other than treatment, payment, or health care operations and without your Authorization. Most of these uses or disclosures are permitted to promote the government's need to ensure a safe and healthy society. In some cases, you may be given on opportunity to agree or object before the use or disclosure is made; in other cases, you may not be given this opportunity. Whenever the Plan makes these types if uses and disclosures, the Plan will ensure that it meets any necessary prerequisites and will not use or disclose your Protected Health Information more than is otherwise permitted under the law. The types of uses or disclosures of Protected Health Information that may be made without your Authorization and without giving you the opportunity to object include those made: to avert communicable or spreading diseases; for public health activities; for federal intelligence, counter-intelligence and national security purposes; to properly assist law enforcement to carry out their duties; when a judge or administrative tribunal orders the release of such Protected Health Information; for cadaveric organ, eye and tissue donations (where appropriate); to help apprehend criminals; to assist armed forces personnel and operations; for military service, veterans affairs separation/discharge matters; for coroner/medical examiner purposes; for health oversight purposes (such as when the government requests certain information

from the Plan to determine its compliance with applicable laws); to assist victims of abuse, neglect or domestic violence; to address work-related illness/workplace injuries and for workers' compensation purposes; to carry out clinical research that involves treatment where the proper body has determined the importance for doing so; for FDA-related purposes; for certain health and safety purposes; for funeral/funeral director purposes; to help determine veterans eligibility status; to protect Presidential and other high-ranking officials; and for reporting to correctional institutions/law enforcement officials acting in a custodian capacity.

There are also several types of uses or disclosures of Protected Health Information that the Plan may make without your authorization, as long as, whenever possible, you are given an opportunity to agree or object before the Plan makes the use or disclosure. These exceptions are very limited and generally involve the release of a limited amount of Protected Health Information to aid your family members, close personal friends, or disaster relief personnel in locating you in the event of an emergency or in case of your incapacity.

The Plan has the right to disclose your Protected Health Information to the Plan Sponsor, which is usually your employer, subject to certain limitations. The Plan may generally disclose to the Plan Sponsor information regarding whether you are enrolled in the Plan and "summary health information," which means information that summarizes the claims history and experiences of the individuals enrolled in the plan without specifically identifying you or other plan participants. The Plan may disclose this information without your Authorization, and the Plan Sponsor may only use the information for its activities relating its sponsorship of the Plan. For example, the Plan Sponsor may use this information to seek bids from health insurers or to analyze its health plan expenses. If the Plan Sponsor needs more than "summary health information" or enrollment information to carry out its responsibilities, then documents that govern the Plan will determine the extent to which Protected Health Information may be used or disclosed, except that in no case may the Plan Sponsor use or disclose your Protected Health Information for employment-related decisions or for any other purpose other than as permitted by the Plan documents or by law. Additionally, Plan Sponsors that receive Protected Health Information from the Plan must make certain certifications to the Plan regarding the uses and disclosures of the information and must ensure that any agents or subcontractors of the Plan Sponsor agree to the same restrictions and conditions that apply to the Plan Sponsor.

While the Plan does not anticipate using or disclosing your Protected Health Information for marketing, fundraising or other similar purposes, under the HIPAA Privacy Rules, the Plan may only make such uses or disclosures with your Authorization, unless the Plan communicates with you face-to-face or provides you with some promotional gift of nominal value, in which case your Authorization would not be required.

You have the right to request additional restrictions relating to the Plan's use or disclosure of your Protected Health Information beyond those otherwise required under the HIPAA Privacy Rules. Although the Plan is not legally required to grant these requests, it is your right to make such a request. For additional information or to obtain the proper form for making such a request, please contact the Plan's Privacy Officer.

The Plan may communicate your Protected Health Information to you in a variety of ways, including by mail or telephone. If you believe that the Plan's communications to you by the usual means will endanger you or your health care and you would like the Plan to make its communications that involve Protected Health Information to you at an alternate location, you may contact the Plan's Privacy Officer to obtain the appropriate request form. The Plan will only accommodate reasonable requests and may require information as to how payment, if any, will be handled.

Generally, you have the right to request and obtain access to your Protected Health Information maintained by the Plan unless an exception applies. The Plan may deny you access to your Protected Health Information if the information is not required to be accessible under the HIPAA Privacy Rules or other applicable law. For example, you do not have a right to access information compiled by the Plan in anticipation of or for use in a civil, criminal or administrative proceeding.

The Plan may charge you a reasonable, cost-based fee for copying (including the cost of supplies and labor) any Protected Health Information required to be copied to adequately respond to your access request, as well as any postage costs and costs associated with preparing an explanation or summary of the Protected Health Information necessary to adequately respond to your access request (unless otherwise precluded by applicable State or other law). If you would like to request access to your Protected Health Information, please notify the Plan's Privacy Officer so that you can complete the appropriate forms.

You have the right to request that the Plan amend your Protected Health Information. The Plan reserves the right to deny or partially deny requests for amendments that are not required to be granted under the HIPAA Privacy Rules. For example, the Plan may deny a request for amendment when the Protected Health Information at issue is accurate and complete. If you would like to request an amendment or your Protected Health Information, please notify the Plan's Privacy Officer so that you can complete the appropriate forms.

You have the right to request and obtain a proper accounting of disclosures the Plan has made of your Protected Health Information. The Plan is not required to account for all uses and disclosures of Protected Health Information that the Plan makes. For example, the Plan is not required to provide an accounting for disclosures made for treatment, payment, or health care operations purposes or for disclosures made with your Authorization. Additionally, the Plan reserves the right to limit its accountings to disclosures made after the compliance date of the HIPAA Privacy Rules.

The Plan will provide you with your first accounting at no charge to you. If you request any additional accountings within a 12-month period, the Plan may charge you a reasonable, cost-based fee. At the time that you request a subsequent accounting, the Plan will provide you with information regarding the fees, and you will have the opportunity to withdraw or modify your request if you wish to do so.

The Plan has procedures in place for receiving and resolving complaints. If you believe that the Plan has violated your privacy rights or has acted inconsistently with its obligations under the HIPAA Privacy Rules, you may file a complaint by contacting the Plan's Privacy Officer. You may send a letter outlining your complaint to the Privacy Officer or you may call the Privacy Officer and request a complaint form.

The Plan requests that you attempt to resolve your complaint with the Plan via these complaint procedures since the Plan is in the best position to respond to your complaint. However, if you believe the Plan has violated your privacy rights, you may also file a complaint with the Office of Civil Rights ("OCR") at the United States Department of Health and Human Services ("HHS"). You may contact the HHS OCR at: Medical Privacy, Complaint Division, Office of Civil Rights, United States Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201, Voice Hotline Number (800) 368-1019, Internet Address www.hhs.gov/ocr.

It is against the policies and procedures of the Plan to retaliate against any person who has filed a privacy complaint, either with us or with HHS OCR. Should you believe that you are being retaliated against in any way upon your filing a complaint with us or the HHS OCR, please immediately contact the Plan's Privacy Officer, so that the Plan may properly address the issue.

The Plan is required to abide by the Notice that is currently in effect; however, the Plan reserves the right to change the terms of this Notice at any time and to make the new Notice effective for all Protected Health Information maintained by the Plan. If this Notice is amended, you will be provided with a copy of the new Notice through regular mail, electronic mail, posting at work site, posting on Intranet sites, or by some other reliable method intended to reach all Plan participants.

If you received this Notice via the Internet or electronic mail, you have the right to request and receive a paper copy of this Notice. If you would like to receive a paper copy of this Notice, please contact the Plan's Privacy Officer.

If you have any questions, concerns or issues relating to the privacy of your Protected Health Information that is not covered in this Notice, please contact the following:

BP Supply, Inc.
Attn: Cameron McQueen (the Plan's Privacy Officer)
11710 Tower Road, Midland, TX 79707
432-523-5612

This Privacy Notice is effective as of January 1, 2020