

Form 5500 Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code). ▶ Complete all entries in accordance with the instructions to the Form 5500.	OMB Nos. 1210-0110 1210-0089 2024 This Form is Open to Public Inspection
--	---	---

Part I	Annual Report Identification Information
For calendar plan year 2024 or fiscal plan year beginning 04/01/2024 and ending 03/31/2025	
A	This return/report is for: ☐ a multiemployer plan ☒ a single-employer plan ☐ a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.) ☐ a DFE (specify) _____
B	This return/report is: ☐ the first return/report ☐ the final return/report ☐ an amended return/report ☐ a short plan year return/report (less than 12 months)
C	If the plan is a collectively-bargained plan, check here.▶ ☒
D	Check box if filing under: ☐ Form 5558 ☐ automatic extension ☐ the DFVC program ☐ special extension (enter description)
E	If this is a retroactively adopted plan permitted by SECURE Act section 201, check here.▶ ☐

Part II	Basic Plan Information—enter all requested information
1a	Name of plan BP CONSOLIDATED WELFARE BENEFIT PLAN
1b	Three-digit plan number (PN) ▶ 504
1c	Effective date of plan 03/01/1967
2a	Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) BP CORPORATION NORTH AMERICA INC. 501 WESTLAKE PARK BLVD. ATTN L CARGILL HOUSTON, TX 77079
2b	Employer Identification Number (EIN) 36-1812780
2c	Plan Sponsor's telephone number 281-366-2000
2d	Business code (see instructions) 324110

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.	10/15/2025	GREGORY DAGLEY
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address ☐ Same as Plan Sponsor EMPLOYEE BENEFITS PLAN ADMINISTRATOR BP CORPORATION NORTH AMERICA INC. 501 WESTLAKE PARK BLVD HOUSTON, TX 77079	3b Administrator's EIN 74-3259348 3c Administrator's telephone number 281-366-2000
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name	4b EIN 4d PN
5 Total number of participants at the beginning of the plan year	5 15121
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). a(1) Total number of active participants at the beginning of the plan year a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. f Total. Add lines 6d and 6e g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6a(1) 12317 6a(2) 13215 6b 2916 6c 0 6d 16131 6e 6f 6g(1) 6g(2) 6h
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:

4A 4B 4D 4E 4F 4H 4L 4Q

9a Plan funding arrangement (check all that apply) (1) ☒ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☒ Trust (4) ☒ General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) ☒ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☒ Trust (4) ☐ General assets of the sponsor
---	--

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules

- (1) ☐ **R** (Retirement Plan Information)
- (2) ☐ **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
- (3) ☐ **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary
- (4) ☐ **DCG** (Individual Plan Information) – Number Attached _____
- (5) ☐ **MEP** (Multiple-Employer Retirement Plan Information)

b General Schedules

- (1) ☒ **H** (Financial Information)
- (2) ☐ **I** (Financial Information – Small Plan)
- (3) ☒ **A** (Insurance Information) – Number Attached 14
- (4) ☒ **C** (Service Provider Information)
- (5) ☐ **D** (DFE/Participating Plan Information)
- (6) ☐ **G** (Financial Transaction Schedules)

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) ☐ Yes ☒ No

If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) ☐ Yes ☐ No

11c Enter the Receipt Confirmation Code for the 2024 Form M-1 annual report. If the plan was not required to file the 2024 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code _____

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
--	--	--

For calendar plan year 2024 or fiscal plan year beginning 04/01/2024 and ending 03/31/2025		
A Name of plan BP CONSOLIDATED WELFARE BENEFIT PLAN	B Three-digit plan number (PN) ▶	504
C Plan sponsor's name as shown on line 2a of Form 5500 BP CORPORATION NORTH AMERICA INC.	D Employer Identification Number (EIN) 36-1812780	

Part I	Information Concerning Insurance Contract Coverage, Fees, and Commissions	Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.
--------	---	--

1 Coverage Information:

(a) Name of insurance carrier HEALTHCARE SERVICE CORPORATION

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
36-1236610	70670	H50831	1514	04/01/2024	03/31/2025

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
--

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
--

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end.....	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶ 0

b Premiums paid to carrier	6b	
c Premiums due but unpaid at the end of the year	6c	
d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d	

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity
(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee
(3) ☐ guaranteed investment (4) ☐ other ▶

b Balance at the end of the previous year	7b	0
c Additions: (1) Contributions deposited during the year	7c(1)	
(2) Dividends and credits.....	7c(2)	
(3) Interest credited during the year.....	7c(3)	
(4) Transferred from separate account	7c(4)	
(5) Other (specify below)..... ▶	7c(5)	
(6) Total additions	7c(6)	0
d Total of balance and additions (add lines 7b and 7c(6))	7d	0
e Deductions:		
(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
(2) Administration charge made by carrier.....	7e(2)	
(3) Transferred to separate account	7e(3)	
(4) Other (specify below)..... ▶	7e(4)	
(5) Total deductions	7e(5)	0
f Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f	0

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a** ☐ Health (other than dental or vision)
b ☐ Dental
c ☐ Vision
d ☐ Life insurance
e ☐ Temporary disability (accident and sickness)
f ☐ Long-term disability
g ☐ Supplemental unemployment
h ☐ Prescription drug
i ☐ Stop loss (large deductible)
j ☒ HMO contract
k ☐ PPO contract
l ☐ Indemnity contract
m ☐ Other (specify) ▶

9 Experience-rated contracts:

a Premiums: (1) Amount received	9a(1)		
(2) Increase (decrease) in amount due but unpaid	9a(2)		
(3) Increase (decrease) in unearned premium reserve	9a(3)		
(4) Earned ((1) + (2) - (3))		9a(4)	0
b Benefit charges (1) Claims paid	9b(1)		
(2) Increase (decrease) in claim reserves	9b(2)		
(3) Incurred claims (add (1) and (2))		9b(3)	0
(4) Claims charged		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions	9c(1)(A)		
(B) Administrative service or other fees	9c(1)(B)		
(C) Other specific acquisition costs	9c(1)(C)		
(D) Other expenses	9c(1)(D)		
(E) Taxes	9c(1)(E)		
(F) Charges for risks or other contingencies	9c(1)(F)		
(G) Other retention charges	9c(1)(G)		
(H) Total retention		9c(1)(H)	0
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)	
(2) Claim reserves		9d(2)	
(3) Other reserves		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e	

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	10005204
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
--	--	--

For calendar plan year 2024 or fiscal plan year beginning 04/01/2024 and ending 03/31/2025		
A Name of plan BP CONSOLIDATED WELFARE BENEFIT PLAN	B Three-digit plan number (PN) ▶ 504	
C Plan sponsor's name as shown on line 2a of Form 5500 BP CORPORATION NORTH AMERICA INC.	D Employer Identification Number (EIN) 36-1812780	

Part I	Information Concerning Insurance Contract Coverage, Fees, and Commissions	Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.
--------	---	--

1 Coverage Information:

(a) Name of insurance carrier KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST
--

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
93-0798039	95540	1057	30	04/01/2024	03/31/2025

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
--

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
--

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	4	
5	Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶ 0

b	Premiums paid to carrier	6b	
c	Premiums due but unpaid at the end of the year	6c	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d	

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity
(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee
(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year	7b	0
c	Additions: (1) Contributions deposited during the year	7c(1)	
	(2) Dividends and credits	7c(2)	0
	(3) Interest credited during the year	7c(3)	
	(4) Transferred from separate account	7c(4)	
	(5) Other (specify below)	7c(5)	
	(6) Total additions	7c(6)	0
d	Total of balance and additions (add lines 7b and 7c(6))	7d	0
e	Deductions:		
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
	(2) Administration charge made by carrier	7e(2)	
	(3) Transferred to separate account	7e(3)	
	(4) Other (specify below)	7e(4)	
	(5) Total deductions	7e(5)	0
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)	7f	0

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a** ☐ Health (other than dental or vision)
b ☐ Dental
c ☐ Vision
d ☐ Life insurance
e ☐ Temporary disability (accident and sickness)
f ☐ Long-term disability
g ☐ Supplemental unemployment
h ☐ Prescription drug
i ☐ Stop loss (large deductible)
j ☒ HMO contract
k ☐ PPO contract
l ☐ Indemnity contract
m ☐ Other (specify) ▶

9 Experience-rated contracts:

a Premiums: (1) Amount received	9a(1)		
(2) Increase (decrease) in amount due but unpaid	9a(2)		
(3) Increase (decrease) in unearned premium reserve	9a(3)		
(4) Earned ((1) + (2) - (3))		9a(4)	0
b Benefit charges (1) Claims paid	9b(1)		
(2) Increase (decrease) in claim reserves	9b(2)		
(3) Incurred claims (add (1) and (2))		9b(3)	0
(4) Claims charged		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions	9c(1)(A)		
(B) Administrative service or other fees	9c(1)(B)		
(C) Other specific acquisition costs	9c(1)(C)		
(D) Other expenses	9c(1)(D)		
(E) Taxes	9c(1)(E)		
(F) Charges for risks or other contingencies	9c(1)(F)		
(G) Other retention charges	9c(1)(G)		
(H) Total retention		9c(1)(H)	0
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)	
(2) Claim reserves		9d(2)	
(3) Other reserves		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e	

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	190028
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
--	--	--

For calendar plan year 2024 or fiscal plan year beginning 04/01/2024 and ending 03/31/2025	
A Name of plan BP CONSOLIDATED WELFARE BENEFIT PLAN	B Three-digit plan number (PN) ▶ 504
C Plan sponsor's name as shown on line 2a of Form 5500 BP CORPORATION NORTH AMERICA INC.	D Employer Identification Number (EIN) 36-1812780

Part I	Information Concerning Insurance Contract Coverage, Fees, and Commissions	Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.
--------	---	--

1 Coverage Information:

(a) Name of insurance carrier KAISER FOUNDATION HEALTH PLAN INC
--

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
94-1340523	00000	38782	53	04/01/2024	03/31/2025

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
--

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
--

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	4	
5	Current value of plan's interest under this contract in separate accounts at year end.....	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶ 0

b	Premiums paid to carrier	6b	
c	Premiums due but unpaid at the end of the year	6c	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d	

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity
(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee
(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year	7b	0
c	Additions: (1) Contributions deposited during the year	7c(1)	
	(2) Dividends and credits.....	7c(2)	0
	(3) Interest credited during the year.....	7c(3)	
	(4) Transferred from separate account	7c(4)	
	(5) Other (specify below)..... ▶	7c(5)	
	(6) Total additions	7c(6)	0
d	Total of balance and additions (add lines 7b and 7c(6))	7d	0
e	Deductions:		
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
	(2) Administration charge made by carrier.....	7e(2)	
	(3) Transferred to separate account	7e(3)	
	(4) Other (specify below)..... ▶	7e(4)	
	(5) Total deductions	7e(5)	0
f	Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f	0

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a** ☐ Health (other than dental or vision)
b ☐ Dental
c ☐ Vision
d ☐ Life insurance
e ☐ Temporary disability (accident and sickness)
f ☐ Long-term disability
g ☐ Supplemental unemployment
h ☐ Prescription drug
i ☐ Stop loss (large deductible)
j ☒ HMO contract
k ☐ PPO contract
l ☐ Indemnity contract
m ☐ Other (specify) ▶

9 Experience-rated contracts:

a Premiums: (1) Amount received	9a(1)		
(2) Increase (decrease) in amount due but unpaid	9a(2)		
(3) Increase (decrease) in unearned premium reserve	9a(3)		
(4) Earned ((1) + (2) - (3))		9a(4)	0
b Benefit charges (1) Claims paid	9b(1)		
(2) Increase (decrease) in claim reserves	9b(2)		
(3) Incurred claims (add (1) and (2))		9b(3)	0
(4) Claims charged		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions	9c(1)(A)		
(B) Administrative service or other fees	9c(1)(B)		
(C) Other specific acquisition costs	9c(1)(C)		
(D) Other expenses	9c(1)(D)		
(E) Taxes	9c(1)(E)		
(F) Charges for risks or other contingencies	9c(1)(F)		
(G) Other retention charges	9c(1)(G)		
(H) Total retention		9c(1)(H)	0
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)	
(2) Claim reserves		9d(2)	
(3) Other reserves		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e	

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	474438
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
--	--	--

For calendar plan year 2024 or fiscal plan year beginning 04/01/2024 and ending 03/31/2025		
A Name of plan BP CONSOLIDATED WELFARE BENEFIT PLAN	B Three-digit plan number (PN) ▶	504
C Plan sponsor's name as shown on line 2a of Form 5500 BP CORPORATION NORTH AMERICA INC.	D Employer Identification Number (EIN) 36-1812780	

Part I	Information Concerning Insurance Contract Coverage, Fees, and Commissions	Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.
--------	---	--

1 Coverage Information:

(a) Name of insurance carrier
KAISER FOUNDATION HEALTH PLAN INC

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
94-1340523	00000	102094	46	04/01/2024	03/31/2025

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end.....	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶ 0

b Premiums paid to carrier	6b	
c Premiums due but unpaid at the end of the year	6c	
d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d	

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity
(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee
(3) ☐ guaranteed investment (4) ☐ other ▶

b Balance at the end of the previous year	7b	0
c Additions: (1) Contributions deposited during the year	7c(1)	
(2) Dividends and credits.....	7c(2)	
(3) Interest credited during the year.....	7c(3)	
(4) Transferred from separate account	7c(4)	
(5) Other (specify below)..... ▶	7c(5)	
(6) Total additions	7c(6)	0
d Total of balance and additions (add lines 7b and 7c(6))	7d	0
e Deductions:		
(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
(2) Administration charge made by carrier.....	7e(2)	
(3) Transferred to separate account	7e(3)	
(4) Other (specify below)..... ▶	7e(4)	
(5) Total deductions	7e(5)	0
f Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f	0

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a** ☐ Health (other than dental or vision) **b** ☐ Dental **c** ☐ Vision **d** ☐ Life insurance
e ☐ Temporary disability (accident and sickness) **f** ☐ Long-term disability **g** ☐ Supplemental unemployment **h** ☐ Prescription drug
i ☐ Stop loss (large deductible) **j** ☒ HMO contract **k** ☐ PPO contract **l** ☐ Indemnity contract
m ☐ Other (specify) ▶

9 Experience-rated contracts:

a Premiums: (1) Amount received	9a(1)		
(2) Increase (decrease) in amount due but unpaid	9a(2)		
(3) Increase (decrease) in unearned premium reserve	9a(3)		
(4) Earned ((1) + (2) - (3))		9a(4)	0
b Benefit charges (1) Claims paid	9b(1)		
(2) Increase (decrease) in claim reserves	9b(2)		
(3) Incurred claims (add (1) and (2))		9b(3)	0
(4) Claims charged		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions	9c(1)(A)		
(B) Administrative service or other fees	9c(1)(B)		
(C) Other specific acquisition costs	9c(1)(C)		
(D) Other expenses	9c(1)(D)		
(E) Taxes	9c(1)(E)		
(F) Charges for risks or other contingencies	9c(1)(F)		
(G) Other retention charges	9c(1)(G)		
(H) Total retention		9c(1)(H)	0
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)	
(2) Claim reserves		9d(2)	
(3) Other reserves		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e	

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	277177
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
--	--	--

For calendar plan year 2024 or fiscal plan year beginning 04/01/2024 and ending 03/31/2025		
A Name of plan BP CONSOLIDATED WELFARE BENEFIT PLAN	B Three-digit plan number (PN) ▶	504
C Plan sponsor's name as shown on line 2a of Form 5500 BP CORPORATION NORTH AMERICA INC.	D Employer Identification Number (EIN) 36-1812780	

Part I	Information Concerning Insurance Contract Coverage, Fees, and Commissions	Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.
--------	---	--

1 Coverage Information:

(a) Name of insurance carrier
VISION SERVICE PLAN

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
06-1227840	39616	12086364	9853	04/01/2024	03/31/2025

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	4	
5	Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶ 0

b	Premiums paid to carrier	6b	
c	Premiums due but unpaid at the end of the year	6c	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d	

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity
(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee
(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year	7b	0
c	Additions: (1) Contributions deposited during the year	7c(1)	
	(2) Dividends and credits	7c(2)	0
	(3) Interest credited during the year	7c(3)	
	(4) Transferred from separate account	7c(4)	
	(5) Other (specify below)	7c(5)	
	(6) Total additions	7c(6)	0
d	Total of balance and additions (add lines 7b and 7c(6))	7d	0
e	Deductions:		
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
	(2) Administration charge made by carrier	7e(2)	
	(3) Transferred to separate account	7e(3)	
	(4) Other (specify below)	7e(4)	
	(5) Total deductions	7e(5)	0
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)	7f	0

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a** ☐ Health (other than dental or vision)
b ☐ Dental
c ☒ Vision
d ☐ Life insurance
e ☐ Temporary disability (accident and sickness)
f ☐ Long-term disability
g ☐ Supplemental unemployment
h ☐ Prescription drug
i ☐ Stop loss (large deductible)
j ☐ HMO contract
k ☐ PPO contract
l ☐ Indemnity contract
m ☐ Other (specify) ▶

9 Experience-rated contracts:

a Premiums: (1) Amount received	9a(1)		
(2) Increase (decrease) in amount due but unpaid	9a(2)		
(3) Increase (decrease) in unearned premium reserve	9a(3)		
(4) Earned ((1) + (2) - (3))		9a(4)	0
b Benefit charges (1) Claims paid	9b(1)		
(2) Increase (decrease) in claim reserves	9b(2)		
(3) Incurred claims (add (1) and (2))		9b(3)	0
(4) Claims charged		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions	9c(1)(A)		
(B) Administrative service or other fees	9c(1)(B)		
(C) Other specific acquisition costs	9c(1)(C)		
(D) Other expenses	9c(1)(D)		
(E) Taxes	9c(1)(E)		
(F) Charges for risks or other contingencies	9c(1)(F)		
(G) Other retention charges	9c(1)(G)		
(H) Total retention		9c(1)(H)	0
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)	
(2) Claim reserves		9d(2)	
(3) Other reserves		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e	

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	1946257
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
--	--	--

For calendar plan year 2024 or fiscal plan year beginning 04/01/2024 and ending 03/31/2025		
A Name of plan BP CONSOLIDATED WELFARE BENEFIT PLAN	B Three-digit plan number (PN) ▶	504
C Plan sponsor's name as shown on line 2a of Form 5500 BP CORPORATION NORTH AMERICA INC.	D Employer Identification Number (EIN) 36-1812780	

Part I	Information Concerning Insurance Contract Coverage, Fees, and Commissions	Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.
--------	---	--

1 Coverage Information:

(a) Name of insurance carrier LIFE INSURANCE COMPANY OF NORTH AMERICA
--

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
23-1503749	65498	LK030287	11765	04/01/2024	03/31/2025

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
--

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
--

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end.....	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶ 0

b Premiums paid to carrier	6b	
c Premiums due but unpaid at the end of the year	6c	
d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d	

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity
(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee
(3) ☐ guaranteed investment (4) ☐ other ▶

b Balance at the end of the previous year	7b	0
c Additions: (1) Contributions deposited during the year (2) Dividends and credits..... (3) Interest credited during the year..... (4) Transferred from separate account (5) Other (specify below) ▶	7c(1)	
	7c(2)	0
	7c(3)	
	7c(4)	
	7c(5)	
(6) Total additions	7c(6)	0
d Total of balance and additions (add lines 7b and 7c(6))	7d	0
e Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year (2) Administration charge made by carrier..... (3) Transferred to separate account (4) Other (specify below) ▶	7e(1)	
	7e(2)	
	7e(3)	
	7e(4)	
	(5) Total deductions	7e(5)
f Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f	0

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a** ☐ Health (other than dental or vision)
 b ☐ Dental
 c ☐ Vision
 d ☐ Life insurance
e ☐ Temporary disability (accident and sickness)
 f ☒ Long-term disability
 g ☐ Supplemental unemployment
 h ☐ Prescription drug
i ☐ Stop loss (large deductible)
 j ☐ HMO contract
 k ☐ PPO contract
 l ☐ Indemnity contract
m ☐ Other (specify) ▶

9 Experience-rated contracts:

a Premiums: (1) Amount received	9a(1)		
(2) Increase (decrease) in amount due but unpaid	9a(2)		
(3) Increase (decrease) in unearned premium reserve	9a(3)		
(4) Earned ((1) + (2) - (3))		9a(4)	0
b Benefit charges (1) Claims paid	9b(1)		
(2) Increase (decrease) in claim reserves	9b(2)		
(3) Incurred claims (add (1) and (2))		9b(3)	0
(4) Claims charged		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions	9c(1)(A)		
(B) Administrative service or other fees	9c(1)(B)		
(C) Other specific acquisition costs	9c(1)(C)		
(D) Other expenses	9c(1)(D)		
(E) Taxes	9c(1)(E)		
(F) Charges for risks or other contingencies	9c(1)(F)		
(G) Other retention charges	9c(1)(G)		
(H) Total retention		9c(1)(H)	0
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)	
(2) Claim reserves		9d(2)	
(3) Other reserves		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e	

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	6490650
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
--	--	--

For calendar plan year 2024 or fiscal plan year beginning 04/01/2024 and ending 03/31/2025	
A Name of plan BP CONSOLIDATED WELFARE BENEFIT PLAN	B Three-digit plan number (PN) ▶ 504
C Plan sponsor's name as shown on line 2a of Form 5500 BP CORPORATION NORTH AMERICA INC.	D Employer Identification Number (EIN) 36-1812780

Part I	Information Concerning Insurance Contract Coverage, Fees, and Commissions	Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.
--------	---	--

1 Coverage Information:

(a) Name of insurance carrier
METROPOLITAN LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-5581829	65978	0151411	13505	04/01/2024	03/31/2025

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
0	30047

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
MERCER HEALTH & BENEFITS LLC 4565 PAYSPHERE CIR
CHICAGO, IL 60674-0001

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	29947	SUPPLEMENTAL COMPENSATION	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
MERCER HEALTH & BENEFITS LLC 4565 PAYSPHERE CIR
CHICAGO, IL 60674-0001

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	100	NON-MONETARY COMPENSATION	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	4	
5	Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶ 0

b	Premiums paid to carrier	6b	
c	Premiums due but unpaid at the end of the year	6c	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d	

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity
(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee
(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year	7b	0												
c	Additions: (1) Contributions deposited during the year (2) Dividends and credits (3) Interest credited during the year (4) Transferred from separate account (5) Other (specify below) ▶ <table border="1" style="width: 150px; border-collapse: collapse;"> <tr><td style="text-align: center;">7c(1)</td><td></td></tr> <tr><td style="text-align: center;">7c(2)</td><td style="text-align: right; color: blue;">0</td></tr> <tr><td style="text-align: center;">7c(3)</td><td></td></tr> <tr><td style="text-align: center;">7c(4)</td><td></td></tr> <tr><td style="text-align: center;">7c(5)</td><td></td></tr> <tr><td colspan="2" style="height: 40px;"></td></tr> </table>	7c(1)		7c(2)	0	7c(3)		7c(4)		7c(5)					
7c(1)															
7c(2)	0														
7c(3)															
7c(4)															
7c(5)															
	(6) Total additions	7c(6)	0												
d	Total of balance and additions (add lines 7b and 7c(6))	7d	0												
e	Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year (2) Administration charge made by carrier (3) Transferred to separate account (4) Other (specify below) ▶ <table border="1" style="width: 150px; border-collapse: collapse;"> <tr><td style="text-align: center;">7e(1)</td><td></td></tr> <tr><td style="text-align: center;">7e(2)</td><td></td></tr> <tr><td style="text-align: center;">7e(3)</td><td></td></tr> <tr><td style="text-align: center;">7e(4)</td><td></td></tr> <tr><td colspan="2" style="height: 40px;"></td></tr> </table>	7e(1)		7e(2)		7e(3)		7e(4)							
7e(1)															
7e(2)															
7e(3)															
7e(4)															
	(5) Total deductions	7e(5)	0												
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)	7f	0												

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a** ☐ Health (other than dental or vision)
b ☐ Dental
c ☐ Vision
d ☒ Life insurance
e ☐ Temporary disability (accident and sickness)
f ☐ Long-term disability
g ☐ Supplemental unemployment
h ☐ Prescription drug
i ☐ Stop loss (large deductible)
j ☒ HMO contract
k ☐ PPO contract
l ☐ Indemnity contract
m ☐ Other (specify) ▶

9 Experience-rated contracts:

a Premiums: (1) Amount received	9a(1)		
(2) Increase (decrease) in amount due but unpaid	9a(2)		
(3) Increase (decrease) in unearned premium reserve	9a(3)		
(4) Earned ((1) + (2) - (3))		9a(4)	0
b Benefit charges (1) Claims paid	9b(1)		
(2) Increase (decrease) in claim reserves	9b(2)		
(3) Incurred claims (add (1) and (2))		9b(3)	0
(4) Claims charged		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions	9c(1)(A)		
(B) Administrative service or other fees	9c(1)(B)		
(C) Other specific acquisition costs	9c(1)(C)		
(D) Other expenses	9c(1)(D)		
(E) Taxes	9c(1)(E)		
(F) Charges for risks or other contingencies	9c(1)(F)		
(G) Other retention charges	9c(1)(G)		
(H) Total retention		9c(1)(H)	0
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)	
(2) Claim reserves		9d(2)	
(3) Other reserves		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e	

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	3632341
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
--	--	--

For calendar plan year 2024 or fiscal plan year beginning 04/01/2024 and ending 03/31/2025		
A Name of plan BP CONSOLIDATED WELFARE BENEFIT PLAN	B Three-digit plan number (PN) ▶	504
C Plan sponsor's name as shown on line 2a of Form 5500 BP CORPORATION NORTH AMERICA INC.	D Employer Identification Number (EIN) 36-1812780	

Part I	Information Concerning Insurance Contract Coverage, Fees, and Commissions	Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.
--------	---	--

1 Coverage Information:

(a) Name of insurance carrier CIGNA HEALTH AND LIFE INSURANCE COMPANY AND AFFILIATES

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
59-1031071	67369	2501767,3215856	1620	04/01/2024	03/31/2025

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
--

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
--

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	4	
5	Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶ 0

b	Premiums paid to carrier	6b	
c	Premiums due but unpaid at the end of the year	6c	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d	

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity
(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee
(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year	7b	0												
c	Additions: (1) Contributions deposited during the year (2) Dividends and credits (3) Interest credited during the year (4) Transferred from separate account (5) Other (specify below) ▶ <table border="1" style="width: 150px; border-collapse: collapse;"> <tr><td style="text-align: center;">7c(1)</td><td></td></tr> <tr><td style="text-align: center;">7c(2)</td><td style="text-align: right; color: blue;">0</td></tr> <tr><td style="text-align: center;">7c(3)</td><td></td></tr> <tr><td style="text-align: center;">7c(4)</td><td></td></tr> <tr><td style="text-align: center;">7c(5)</td><td></td></tr> <tr><td colspan="2" style="height: 40px;"></td></tr> </table>	7c(1)		7c(2)	0	7c(3)		7c(4)		7c(5)					
7c(1)															
7c(2)	0														
7c(3)															
7c(4)															
7c(5)															
	(6) Total additions	7c(6)	0												
d	Total of balance and additions (add lines 7b and 7c(6))	7d	0												
e	Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year (2) Administration charge made by carrier (3) Transferred to separate account (4) Other (specify below) ▶ <table border="1" style="width: 150px; border-collapse: collapse;"> <tr><td style="text-align: center;">7e(1)</td><td></td></tr> <tr><td style="text-align: center;">7e(2)</td><td></td></tr> <tr><td style="text-align: center;">7e(3)</td><td></td></tr> <tr><td style="text-align: center;">7e(4)</td><td></td></tr> <tr><td colspan="2" style="height: 40px;"></td></tr> </table>	7e(1)		7e(2)		7e(3)		7e(4)							
7e(1)															
7e(2)															
7e(3)															
7e(4)															
	(5) Total deductions	7e(5)	0												
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)	7f	0												

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a** ☐ Health (other than dental or vision)
b ☒ Dental
c ☐ Vision
d ☐ Life insurance
e ☐ Temporary disability (accident and sickness)
f ☐ Long-term disability
g ☐ Supplemental unemployment
h ☐ Prescription drug
i ☐ Stop loss (large deductible)
j ☒ HMO contract
k ☒ PPO contract
l ☒ Indemnity contract
m ☒ Other (specify) ▶ **PREPAID DENTAL**

9 Experience-rated contracts:

a Premiums: (1) Amount received	9a(1)		
(2) Increase (decrease) in amount due but unpaid	9a(2)		
(3) Increase (decrease) in unearned premium reserve	9a(3)		
(4) Earned ((1) + (2) - (3))		9a(4)	0
b Benefit charges (1) Claims paid	9b(1)		
(2) Increase (decrease) in claim reserves	9b(2)		
(3) Incurred claims (add (1) and (2))		9b(3)	0
(4) Claims charged		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions	9c(1)(A)		
(B) Administrative service or other fees	9c(1)(B)		
(C) Other specific acquisition costs	9c(1)(C)		
(D) Other expenses	9c(1)(D)		
(E) Taxes	9c(1)(E)		
(F) Charges for risks or other contingencies	9c(1)(F)		
(G) Other retention charges	9c(1)(G)		
(H) Total retention		9c(1)(H)	0
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)	
(2) Claim reserves		9d(2)	
(3) Other reserves		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e	

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	462452
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
--	--	--

For calendar plan year 2024 or fiscal plan year beginning 04/01/2024 and ending 03/31/2025	
A Name of plan BP CONSOLIDATED WELFARE BENEFIT PLAN	B Three-digit plan number (PN) ▶ 504
C Plan sponsor's name as shown on line 2a of Form 5500 BP CORPORATION NORTH AMERICA INC.	D Employer Identification Number (EIN) 36-1812780

Part I	Information Concerning Insurance Contract Coverage, Fees, and Commissions	Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.
--------	---	--

1 Coverage Information:

(a) Name of insurance carrier METROPOLITAN LIFE INSURANCE COMPANY					
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-5581829	65978	0095520	8383	04/01/2024	03/31/2025

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
0	47725

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
MERCER HEALTH & BENEFITS LLC 4565 PAYSPHERE CIR CHICAGO, IL 60674-0001

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	47625	SUPPLEMENTAL COMPENSATION	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
MERCER HEALTH & BENEFITS LLC 4565 PAYSPHERE CIR CHICAGO, IL 60674-0001

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	100	NON-MONETARY COMPENSATION	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end.....	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier	6b	
c Premiums due but unpaid at the end of the year	6c	
d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d	

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity
(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee
(3) ☐ guaranteed investment (4) ☐ other ▶

b Balance at the end of the previous year	7b	0
c Additions: (1) Contributions deposited during the year	7c(1)	
(2) Dividends and credits.....	7c(2)	
(3) Interest credited during the year.....	7c(3)	
(4) Transferred from separate account	7c(4)	
(5) Other (specify below)..... ▶	7c(5)	
(6) Total additions	7c(6)	0
d Total of balance and additions (add lines 7b and 7c(6))	7d	0
e Deductions:		
(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
(2) Administration charge made by carrier.....	7e(2)	
(3) Transferred to separate account	7e(3)	
(4) Other (specify below)..... ▶	7e(4)	
(5) Total deductions	7e(5)	0
f Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f	0

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a** ☐ Health (other than dental or vision)
b ☐ Dental
c ☐ Vision
d ☒ Life insurance
e ☐ Temporary disability (accident and sickness)
f ☐ Long-term disability
g ☐ Supplemental unemployment
h ☐ Prescription drug
i ☐ Stop loss (large deductible)
j ☐ HMO contract
k ☐ PPO contract
l ☐ Indemnity contract
m ☐ Other (specify) ▶

9 Experience-rated contracts:

a Premiums: (1) Amount received	9a(1)		
(2) Increase (decrease) in amount due but unpaid	9a(2)		
(3) Increase (decrease) in unearned premium reserve	9a(3)		
(4) Earned ((1) + (2) - (3))		9a(4)	0
b Benefit charges (1) Claims paid	9b(1)		
(2) Increase (decrease) in claim reserves	9b(2)		
(3) Incurred claims (add (1) and (2))		9b(3)	0
(4) Claims charged		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions	9c(1)(A)		
(B) Administrative service or other fees	9c(1)(B)		
(C) Other specific acquisition costs	9c(1)(C)		
(D) Other expenses	9c(1)(D)		
(E) Taxes	9c(1)(E)		
(F) Charges for risks or other contingencies	9c(1)(F)		
(G) Other retention charges	9c(1)(G)		
(H) Total retention		9c(1)(H)	0
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)	
(2) Claim reserves		9d(2)	
(3) Other reserves		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e	

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	6700143
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
--	--	--

For calendar plan year 2024 or fiscal plan year beginning 04/01/2024 and ending 03/31/2025		
A Name of plan BP CONSOLIDATED WELFARE BENEFIT PLAN		B Three-digit plan number (PN) ▶ 504
C Plan sponsor's name as shown on line 2a of Form 5500 BP CORPORATION NORTH AMERICA INC.		D Employer Identification Number (EIN) 36-1812780

Part I	Information Concerning Insurance Contract Coverage, Fees, and Commissions	Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.
--------	---	--

1 Coverage Information:

(a) Name of insurance carrier METLIFE LEGAL PLANS, INC					
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
34-1650967	00000	7800010	3036	04/01/2024	03/31/2025

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid 67984	(b) Total amount of fees paid 13253
---	--

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid	
MERCER H&B ADMINISTRATION	PO BOX 850502 MINNEAPOLIS, MN 55485

(b) Amount of sales and base commissions paid 67984	Fees and other commissions paid		(e) Organization code 3
	(c) Amount 0	(d) Purpose N/A	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid	
MERCER H&B ADMINISTRATION	PO BOX 850502 MINNEAPOLIS, MN 55485

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code 3
	(c) Amount 14430	(d) Purpose SUPPLEMENTAL COMPENSATION	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

MERCER HEALTH & BENEFITS ADMINISTRA

1100 REYNOLDS BLVD
WINSTON-SALEM, NC 27105

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	197	NON-MONETARY COMPENSATION	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

MERCER HEALTH & BENEFITS, LLC

PO BOX 100260
PASADENA, CA 91189

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	-1374	SUPPLEMENTAL COMPENSATION	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end.....	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier	6b	
c Premiums due but unpaid at the end of the year	6c	
d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d	

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity
(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee
(3) ☐ guaranteed investment (4) ☐ other ▶

b Balance at the end of the previous year	7b	0
c Additions: (1) Contributions deposited during the year	7c(1)	
(2) Dividends and credits.....	7c(2)	
(3) Interest credited during the year.....	7c(3)	
(4) Transferred from separate account	7c(4)	
(5) Other (specify below)..... ▶	7c(5)	
(6) Total additions	7c(6)	0
d Total of balance and additions (add lines 7b and 7c(6))	7d	0
e Deductions:		
(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
(2) Administration charge made by carrier.....	7e(2)	
(3) Transferred to separate account	7e(3)	
(4) Other (specify below)..... ▶	7e(4)	
(5) Total deductions	7e(5)	0
f Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f	0

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a** ☐ Health (other than dental or vision)
b ☐ Dental
c ☐ Vision
d ☐ Life insurance
e ☐ Temporary disability (accident and sickness)
f ☐ Long-term disability
g ☐ Supplemental unemployment
h ☐ Prescription drug
i ☐ Stop loss (large deductible)
j ☐ HMO contract
k ☐ PPO contract
l ☐ Indemnity contract
m ☒ Other (specify) ▶ **LEGAL**

9 Experience-rated contracts:

a Premiums: (1) Amount received	9a(1)		
(2) Increase (decrease) in amount due but unpaid	9a(2)		
(3) Increase (decrease) in unearned premium reserve	9a(3)		
(4) Earned ((1) + (2) - (3))		9a(4)	0
b Benefit charges (1) Claims paid	9b(1)		
(2) Increase (decrease) in claim reserves	9b(2)		
(3) Incurred claims (add (1) and (2))		9b(3)	0
(4) Claims charged		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions	9c(1)(A)		
(B) Administrative service or other fees	9c(1)(B)		
(C) Other specific acquisition costs	9c(1)(C)		
(D) Other expenses	9c(1)(D)		
(E) Taxes	9c(1)(E)		
(F) Charges for risks or other contingencies	9c(1)(F)		
(G) Other retention charges	9c(1)(G)		
(H) Total retention		9c(1)(H)	0
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)	
(2) Claim reserves		9d(2)	
(3) Other reserves		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e	

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	675670
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
--	--	--

For calendar plan year 2024 or fiscal plan year beginning 04/01/2024 and ending 03/31/2025	
A Name of plan BP CONSOLIDATED WELFARE BENEFIT PLAN	B Three-digit plan number (PN) ▶ 504
C Plan sponsor's name as shown on line 2a of Form 5500 BP CORPORATION NORTH AMERICA INC.	D Employer Identification Number (EIN) 36-1812780

Part I	Information Concerning Insurance Contract Coverage, Fees, and Commissions	Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.
--------	---	--

1 Coverage Information:

(a) Name of insurance carrier
METROPOLITAN LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-5581829	65978	0215543	13350	04/01/2024	03/31/2025

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
0	4205

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
MERCER HEALTH & BENEFITS LLC 4565 PAYSPHERE CIR
CHICAGO, IL 60674-0001

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	4105	SUPPLEMENTAL COMPENSATION	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
MERCER HEALTH & BENEFITS LLC 4565 PAYSPHERE CIR
CHICAGO, IL 60674-0001

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	100	NON-MONETARY COMPENSATION	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end.....	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. **6d**
Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity
(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee
(3) ☐ guaranteed investment (4) ☐ other ▶

b Balance at the end of the previous year	7b	0
c Additions: (1) Contributions deposited during the year (2) Dividends and credits..... (3) Interest credited during the year..... (4) Transferred from separate account (5) Other (specify below)..... ▶	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	7c(5)	
(6) Total additions	7c(6)	0
d Total of balance and additions (add lines 7b and 7c(6))	7d	0
e Deductions:		
(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
(2) Administration charge made by carrier.....	7e(2)	
(3) Transferred to separate account	7e(3)	
(4) Other (specify below)..... ▶	7e(4)	
(5) Total deductions	7e(5)	0
f Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f	0

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a** ☐ Health (other than dental or vision)
b ☐ Dental
c ☐ Vision
d ☒ Life insurance
e ☒ Temporary disability (accident and sickness)
f ☐ Long-term disability
g ☐ Supplemental unemployment
h ☐ Prescription drug
i ☐ Stop loss (large deductible)
j ☐ HMO contract
k ☐ PPO contract
l ☐ Indemnity contract
m ☐ Other (specify) ▶

9 Experience-rated contracts:

a Premiums: (1) Amount received	9a(1)		
(2) Increase (decrease) in amount due but unpaid	9a(2)		
(3) Increase (decrease) in unearned premium reserve	9a(3)		
(4) Earned ((1) + (2) - (3))		9a(4)	0
b Benefit charges (1) Claims paid	9b(1)		
(2) Increase (decrease) in claim reserves	9b(2)		
(3) Incurred claims (add (1) and (2))		9b(3)	0
(4) Claims charged		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions	9c(1)(A)		
(B) Administrative service or other fees	9c(1)(B)		
(C) Other specific acquisition costs	9c(1)(C)		
(D) Other expenses	9c(1)(D)		
(E) Taxes	9c(1)(E)		
(F) Charges for risks or other contingencies	9c(1)(F)		
(G) Other retention charges	9c(1)(G)		
(H) Total retention		9c(1)(H)	0
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)	
(2) Claim reserves		9d(2)	
(3) Other reserves		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e	

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	550086
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
--	--	--

For calendar plan year 2024 or fiscal plan year beginning 04/01/2024 and ending 03/31/2025	
A Name of plan BP CONSOLIDATED WELFARE BENEFIT PLAN	B Three-digit plan number (PN) ▶ 504
C Plan sponsor's name as shown on line 2a of Form 5500 BP CORPORATION NORTH AMERICA INC.	D Employer Identification Number (EIN) 36-1812780

Part I	Information Concerning Insurance Contract Coverage, Fees, and Commissions	Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.
--------	---	--

1 Coverage Information:

(a) Name of insurance carrier
METROPOLITAN LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-5581829	65978	0215544	14437	04/01/2024	03/31/2025

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
0	2532

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
MERCER HEALTH & BENEFITS LLC 4565 PAYSPHERE CIR
CHICAGO, IL 60674-0001

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	2432	SUPPLEMENTAL COMPENSATION	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
MERCER HEALTH & BENEFITS LLC 4565 PAYSPHERE CIR
CHICAGO, IL 60674-0001

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	100	NON-MONETARY COMPENSATION	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end.....	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. **6d**
Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity
(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee
(3) ☐ guaranteed investment (4) ☐ other ▶

b Balance at the end of the previous year	7b	0
c Additions: (1) Contributions deposited during the year (2) Dividends and credits..... (3) Interest credited during the year..... (4) Transferred from separate account (5) Other (specify below)..... ▶	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	7c(5)	
(6) Total additions	7c(6)	0
d Total of balance and additions (add lines 7b and 7c(6))	7d	0
e Deductions:		
(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
(2) Administration charge made by carrier.....	7e(2)	
(3) Transferred to separate account	7e(3)	
(4) Other (specify below)..... ▶	7e(4)	
(5) Total deductions	7e(5)	0
f Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f	0

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a** ☐ Health (other than dental or vision) **b** ☐ Dental **c** ☐ Vision **d** ☐ Life insurance
e ☒ Temporary disability (accident and sickness) **f** ☐ Long-term disability **g** ☐ Supplemental unemployment **h** ☐ Prescription drug
i ☐ Stop loss (large deductible) **j** ☐ HMO contract **k** ☐ PPO contract **l** ☐ Indemnity contract
m ☐ Other (specify) ▶

9 Experience-rated contracts:

a Premiums: (1) Amount received	9a(1)		
(2) Increase (decrease) in amount due but unpaid	9a(2)		
(3) Increase (decrease) in unearned premium reserve	9a(3)		
(4) Earned ((1) + (2) - (3))		9a(4)	0
b Benefit charges (1) Claims paid	9b(1)		
(2) Increase (decrease) in claim reserves	9b(2)		
(3) Incurred claims (add (1) and (2))		9b(3)	0
(4) Claims charged		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions	9c(1)(A)		
(B) Administrative service or other fees	9c(1)(B)		
(C) Other specific acquisition costs	9c(1)(C)		
(D) Other expenses	9c(1)(D)		
(E) Taxes	9c(1)(E)		
(F) Charges for risks or other contingencies	9c(1)(F)		
(G) Other retention charges	9c(1)(G)		
(H) Total retention		9c(1)(H)	0
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)	
(2) Claim reserves		9d(2)	
(3) Other reserves		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e	

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	331794
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
--	--	--

For calendar plan year 2024 or fiscal plan year beginning 04/01/2024 and ending 03/31/2025	
A Name of plan BP CONSOLIDATED WELFARE BENEFIT PLAN	B Three-digit plan number (PN) ▶ 504
C Plan sponsor's name as shown on line 2a of Form 5500 BP CORPORATION NORTH AMERICA INC.	D Employer Identification Number (EIN) 36-1812780

Part I	Information Concerning Insurance Contract Coverage, Fees, and Commissions	Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.
--------	---	--

1 Coverage Information:

(a) Name of insurance carrier
LIFE INSURANCE COMPANY OF NORTH AMERICA

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
23-1503749	65498	LK0100136	939	04/01/2024	03/31/2025

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid 851	(b) Total amount of fees paid 0
---	------------------------------------

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
MERCER HEALTH & BENEFITS LLC 4565 PAYSPIRE CIRCLE
CHICAGO, IL 60674

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
851	0	SUPPLEMENTAL COMMISSIONS	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end.....	5	
6 Contracts With Allocated Funds:		
a State the basis of premium rates ▶		
b Premiums paid to carrier	6b	
c Premiums due but unpaid at the end of the year	6c	
d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d	
e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity (3) ☐ other (specify) ▶		
f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐		
7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)		
a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee (3) ☐ guaranteed investment (4) ☐ other ▶		
b Balance at the end of the previous year	7b	
c Additions: (1) Contributions deposited during the year	7c(1)	
(2) Dividends and credits.....	7c(2)	
(3) Interest credited during the year.....	7c(3)	
(4) Transferred from separate account	7c(4)	
(5) Other (specify below)..... ▶	7c(5)	
(6) Total additions	7c(6)	
d Total of balance and additions (add lines 7b and 7c(6))	7d	0
e Deductions:		
(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
(2) Administration charge made by carrier.....	7e(2)	
(3) Transferred to separate account	7e(3)	
(4) Other (specify below)..... ▶	7e(4)	
(5) Total deductions	7e(5)	
f Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f	0

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a** ☐ Health (other than dental or vision) **b** ☐ Dental **c** ☐ Vision **d** ☐ Life insurance
e ☐ Temporary disability (accident and sickness) **f** ☐ Long-term disability **g** ☐ Supplemental unemployment **h** ☐ Prescription drug
i ☐ Stop loss (large deductible) **j** ☐ HMO contract **k** ☐ PPO contract **l** ☐ Indemnity contract
m ☒ Other (specify) ▶ **STD**

9 Experience-rated contracts:

a Premiums: (1) Amount received	9a(1)		
(2) Increase (decrease) in amount due but unpaid	9a(2)		
(3) Increase (decrease) in unearned premium reserve	9a(3)		
(4) Earned ((1) + (2) - (3))		9a(4)	0
b Benefit charges (1) Claims paid	9b(1)		
(2) Increase (decrease) in claim reserves	9b(2)		
(3) Incurred claims (add (1) and (2))		9b(3)	0
(4) Claims charged		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions	9c(1)(A)		
(B) Administrative service or other fees	9c(1)(B)		
(C) Other specific acquisition costs	9c(1)(C)		
(D) Other expenses	9c(1)(D)		
(E) Taxes	9c(1)(E)		
(F) Charges for risks or other contingencies	9c(1)(F)		
(G) Other retention charges	9c(1)(G)		
(H) Total retention		9c(1)(H)	0
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)	
(2) Claim reserves		9d(2)	
(3) Other reserves		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e	

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	373748
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
--	--	--

For calendar plan year 2024 or fiscal plan year beginning 04/01/2024 and ending 03/31/2025		
A Name of plan BP CONSOLIDATED WELFARE BENEFIT PLAN	B Three-digit plan number (PN) ▶	504
C Plan sponsor's name as shown on line 2a of Form 5500 BP CORPORATION NORTH AMERICA INC.	D Employer Identification Number (EIN) 36-1812780	

Part I	Information Concerning Insurance Contract Coverage, Fees, and Commissions	Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.
--------	---	--

1 Coverage Information:

(a) Name of insurance carrier
LIFE INSURANCE COMPANY OF NORTH AMERICA

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
23-1503749	65498	COP800500	410	01/01/2024	12/31/2024

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end.....	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. **6d**
Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity
(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee
(3) ☐ guaranteed investment (4) ☐ other ▶

b Balance at the end of the previous year	7b	
c Additions: (1) Contributions deposited during the year (2) Dividends and credits..... (3) Interest credited during the year..... (4) Transferred from separate account (5) Other (specify below)..... ▶	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	7c(5)	
(6) Total additions	7c(6)	0
d Total of balance and additions (add lines 7b and 7c(6))	7d	0
e Deductions:		
(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
(2) Administration charge made by carrier.....	7e(2)	
(3) Transferred to separate account	7e(3)	
(4) Other (specify below)..... ▶	7e(4)	
(5) Total deductions	7e(5)	0
f Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f	0

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a** ☐ Health (other than dental or vision) **b** ☐ Dental **c** ☐ Vision **d** ☐ Life insurance
e ☐ Temporary disability (accident and sickness) **f** ☐ Long-term disability **g** ☐ Supplemental unemployment **h** ☐ Prescription drug
i ☐ Stop loss (large deductible) **j** ☐ HMO contract **k** ☐ PPO contract **l** ☐ Indemnity contract
m ☒ Other (specify) ▶ **PAID FAMILY LEAVE**

9 Experience-rated contracts:

a Premiums: (1) Amount received	9a(1)		
(2) Increase (decrease) in amount due but unpaid	9a(2)		
(3) Increase (decrease) in unearned premium reserve	9a(3)		
(4) Earned ((1) + (2) - (3))		9a(4)	0
b Benefit charges (1) Claims paid	9b(1)		
(2) Increase (decrease) in claim reserves	9b(2)		
(3) Incurred claims (add (1) and (2))		9b(3)	0
(4) Claims charged		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions	9c(1)(A)		
(B) Administrative service or other fees	9c(1)(B)		
(C) Other specific acquisition costs	9c(1)(C)		
(D) Other expenses	9c(1)(D)		
(E) Taxes	9c(1)(E)		
(F) Charges for risks or other contingencies	9c(1)(F)		
(G) Other retention charges	9c(1)(G)		
(H) Total retention		9c(1)(H)	0
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)	
(2) Claim reserves		9d(2)	
(3) Other reserves		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e	

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	394936
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

SCHEDULE C (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Service Provider Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500.	OMB No. 1210-0110
		2024
		This Form is Open to Public Inspection.

For calendar plan year 2024 or fiscal plan year beginning 04/01/2024 and ending 03/31/2025

A Name of plan BP CONSOLIDATED WELFARE BENEFIT PLAN	B Three-digit plan number (PN) 504
C Plan sponsor's name as shown on line 2a of Form 5500 BP CORPORATION NORTH AMERICA INC.	D Employer Identification Number (EIN) 36-1812780

Part I Service Provider Information (see instructions)

You must complete this Part, in accordance with the instructions, to report the information required for **each person** who received, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of monetary value) in connection with services rendered to the plan or the person's position with the plan during the plan year. If a person received **only** eligible indirect compensation for which the plan received the required disclosures, you are required to answer line 1 but are not required to include that person when completing the remainder of this Part.

1 Information on Persons Receiving Only Eligible Indirect Compensation

a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions)..... ☒ Yes ☐ No

b If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

HEALTHCARE SERVICE CORPORATION

36-1236610

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

AETNA LIFE INSURANCE COMPANY

06-6033492

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 15 50	N/A	10289583	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

(a) Enter name and EIN or address (see instructions)

EXPRESS SCRIPTS, INC

43-1420563

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 15 50	N/A	3115554	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

(a) Enter name and EIN or address (see instructions)

WEBMD HEALTH CORP/WEBMD GLOBAL LLC

20-2783228

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13 50	N/A	3017041	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

CIGNA HEALTH AND LIFE INSURANCE COM

59-1031071

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 31 38 49 50 62	N/A	383323	Yes ☒ No ☐	Yes ☒ No ☐	0	Yes ☒ No ☐

(a) Enter name and EIN or address (see instructions)

KEPRO ACQUISITIONS

25-1796254

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13 50	N/A	359097	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

(a) Enter name and EIN or address (see instructions)

HEALTH CARE SERVICE CORPORATION

36-1236610

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 15 50	N/A	172022	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

LIFE INSURANCE CO. OF NORTH AMERICA

23-1503749

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 15 50	N/A	100418	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

(a) Enter name and EIN or address (see instructions)

INSPIRA FINANCIAL HEALTH, INC

91-1774434

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 15 50	N/A	62319	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

(a) Enter name and EIN or address (see instructions)

PROGYNY, INC

27-2220139

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13 15 50	N/A	45387	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

JPMORGAN CHASE BANK N.A.

13-4994650

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
21 25 50 62 72	N/A	12334	Yes ☒ No ☐	Yes ☒ No ☐	3975	Yes ☒ No ☐

(a) Enter name and EIN or address (see instructions)

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐

(a) Enter name and EIN or address (see instructions)

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐

Part I Service Provider Information (continued)

3. If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
JPMORGAN CHASE BANK, N.A.	72	3975
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
JPMORGAN INVESTMENT MANAGEMENT INC. 13-3200244	REVENUE SHARE ON MUTUAL FUNDS	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE	62	0
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
CITIBANK NA ONE PENNS WAY NEW CASTLE, DE 19720	EARNINGS CREDITS ON DAILY FUND ASSOCIATED: \$1.97 PER PARTICIPANT WITH THE AVERAGE ANNUAL RATE OF THE EARNINGS CREDIT AT 3.66%	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE	49	0
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
OMADA COMPLETE 500 SANSOME ST. #200 SAN FRANCISCO, CA 94111	COMPENSATION FOR EXPLAINING SERVICES AND ENCOURAGING AND FACILITATING ENROLLMENT IN DIABETES AND HYPERTENSION CIGNA: \$0.17 PER PARTICIPANT	

Part I Service Provider Information (continued)

3. If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE	62	0
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
CITIBANK NA (OMNIBUS) ONE PENNS WAY NEW CASTLE, DE 19720	EARNINGS CREDITS ON DAILY BALANCES: \$0.01 PER PARTICIPANT WITH THE AVERAGE ANNUAL RATE OF THE EARNINGS CREDIT AT 3.66%	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE	62	0
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
JPMORGAN CHASE 3 CHASE METRO TECH CENTER 5TH FLOOR BROOKLYN, NY 11245	EARNINGS CREDITS ON DAILY FUND BALANCES: \$4.38 PER PARTICIPANT WITH THE AVERAGE ANNUAL RATE OF THE EARNINGS CREDIT AT 3.54%	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE	62	0
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
DEUTSCHE BANK 60 WALL ST NEW YORK, NY 10005-2836	EARNINGS CREDITS ASSOCIATED WITH BANK ACCOUNTS: \$0.00 PER PARTICIPANT WITH THE AVERAGE ANNUAL RATE OF THE EARNINGS CREDIT AT .50%	

Part I Service Provider Information (continued)

3. If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE	62	0
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
BANK OF AMERICA (LOCKBOX) 540 WEST MADISON STREET CHICAGO, IL 60661	EARNINGS CREDITS ASSOCIATED WITH BANK ACCOUNTS: \$0.37 PER PARTICIPANT WITH THE AVERAGE ANNUAL RATE OF THE EARNINGS CREDIT AT 4.00%	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE	49	0
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
AMPLIFON HEARING HEALTHCARE 85-0437037	VOLUME BASED MARKETING FEES FOR PARTICIPATION IN THE CIGNA HEALTHY REWARDS PROGRAM: \$0.00 PER MEMBER PER YEAR	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE	49	0
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
CASTLIGHT HEALTH 26-1989091	DEFRAY CIGNA'S COST FOR THE INFRASTRUCTURE CHANGES; REIMBURSEMENT FOR CIGNA DESIGNATION (CCD) INFORMATION; REIMBURSEMENT CUSTOMER ACCESS TO COST ESTIMATE INFORMATION; REIMBURSED FOR ACCESS TO CLIENT PAID CLAIM FILES: \$3.24 PER PARTICIPANT	

Part I Service Provider Information (continued)

3. If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE	49	0
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
OMADA HEALTH, INC. 45-2355015	COMPENSATION FOR EXPLAINING SERVICES AND ENCOURAGING AND FACILITATING ENROLLMENT IN DIGITAL DIABETES PREVENTIVE CARE SERVICES PROVIDER: \$1.23 PER PARTICIPANT	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE	12 13 31 38 49	0
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
SAGAMORE HEALTH NETWORK HOSPITALS 11595 NORTH MERIDIAN ST. SUITE 600 CARMEL, IN 46032	NETWORK ADMINISTRATION FEES: \$0.06 PER PARTICIPANT	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE	62	0
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
PNC BANK (CHLIC - COR DEPOSITS) 1600 MARKET ST. 19TH FL PHILADELPHIA, PA 19103	EARNINGS CREDITS ASSOCIATED WITH BANK ACCOUNTS: \$1.02 PER PARTICIPANT WITH THE AVERAGE ANNUAL RATE OF THE EARNINGS CREDIT AT 3.25%	

Part II Service Providers Who Fail or Refuse to Provide Information

4 Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.

(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)
(complete as many entries as needed)

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

SCHEDULE H (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	OMB No. 1210-0110
		2024
		This Form is Open to Public Inspection
For calendar plan year 2024 or fiscal plan year beginning 04/01/2024 and ending 03/31/2025		
A Name of plan BP CONSOLIDATED WELFARE BENEFIT PLAN		B Three-digit plan number (PN) ▶ 504
C Plan sponsor's name as shown on line 2a of Form 5500 BP CORPORATION NORTH AMERICA INC.		D Employer Identification Number (EIN) 36-1812780

Part I	Asset and Liability Statement		
1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.			
Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a	0	0
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)		
(2) Participant contributions.....	1b(2)	0	78007
(3) Other	1b(3)	10361220	12641964
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	457346	670478
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	2332271	4143950
(14) Value of funds held in insurance company general account (unallocated contracts).....	1c(14)		
(15) Other.....	1c(15)		

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e		
f Total assets (add all amounts in lines 1a through 1e)	1f	13150837	17534399
Liabilities			
g Benefit claims payable	1g	22929946	26863210
h Operating payables	1h	985807	417186
i Acquisition indebtedness	1i		
j Other liabilities	1j		
k Total liabilities (add all amounts in lines 1g through 1j)	1k	23915753	27280396
Net Assets			
l Net assets (subtract line 1k from line 1f)	1l	-10764916	-9745997

Part II Income and Expense Statement

2 Plan income, expenses, and changes in net assets for the year. Include all income and expenses of the plan, including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

Income		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: (A) Employers	2a(1)(A)	222095099	
(B) Participants	2a(1)(B)	55861584	
(C) Others (including rollovers)	2a(1)(C)		
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)		277956683
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	290633	
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)		
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		290633
(2) Dividends: (A) Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		0
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		
(5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)		
(B) Other	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		
c Other income	2c		
d Total income. Add all income amounts in column (b) and enter total	2d		278247316

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	225882408	
(2) To insurance carriers for the provision of benefits	2e(2)	33802409	
(3) Other	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		259684817
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses:			
(1) Salaries and allowances	2i(1)		
(2) Contract administrator fees	2i(2)	17531245	
(3) Recordkeeping fees	2i(3)		
(4) IQPA audit fees	2i(4)		
(5) Investment advisory and investment management fees	2i(5)		
(6) Bank or trust company trustee/custodial fees	2i(6)	12335	
(7) Actuarial fees	2i(7)		
(8) Legal fees	2i(8)		
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses	2i(11)		
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		17543580
j Total expenses. Add all expense amounts in column (b) and enter total	2j		277228397

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		1018919
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

3 Complete lines 3a through 3c if the opinion of an independent qualified public accountant is attached to this Form 5500. Complete line 3d if an opinion is not attached.

a The attached opinion of an independent qualified public accountant for this plan is (see instructions):

(1) ☒ Unmodified (2) ☐ Qualified (3) ☐ Disclaimer (4) ☐ Adverse

b Check the appropriate box(es) to indicate whether the IQPA performed an ERISA section 103(a)(3)(C) audit. Check both boxes (1) and (2) if the audit was performed pursuant to both 29 CFR 2520.103-8 and 29 CFR 2520.103-12(d). Check box (3) if pursuant to neither.

(1) ☐ DOL Regulation 2520.103-8 (2) ☐ DOL Regulation 2520.103-12(d) (3) ☒ neither DOL Regulation 2520.103-8 nor DOL Regulation 2520.103-12(d).

c Enter the name and EIN of the accountant (or accounting firm) below:

(1) Name: **DELOITTE & TOUCHE, LLP**

(2) EIN: **13-3891517**

d The opinion of an independent qualified public accountant is **not attached** as part of Schedule H because:

(1) ☐ This form is filed for a CCT, PSA, DCG or MTIA. (2) ☐ It will be attached to the next Form 5500 pursuant to 29 CFR 2520.104-50.

Part IV Compliance Questions

4 CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not complete lines 4a, 4e, 4f, 4g, 4h, 4k, 4m, 4n, or 5. 103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete line 4l. DCGs do not complete lines 4e, 4f, 4k, 4l, and 5, and DCGs generally complete the rest of Part IV collectively for all plans in the DCG, except as otherwise provided (see instructions).

During the plan year:

	Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)		☒	
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)		☒	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)		☒	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)		☒	
e Was this plan covered by a fidelity bond?	☒		500000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		☒	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?		☒	
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?		☒	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	☒		
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)	☒		
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		☒	
l Has the plan failed to provide any benefit when due under the plan?		☒	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)		☒	
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.			

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year?..... ☐ Yes ☒ No
If "Yes," enter the amount of any plan assets that reverted to the employer this year _____.

5b If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

5b(1) Name of plan(s)	5b(2) EIN(s)	5b(3) PN(s)

5c Was the plan a defined benefit plan covered under the PBGC insurance program at any time during this plan year? (See ERISA section 4021 and instructions.) ☐ Yes ☐ No ☐ Not determined

If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year _____.

BP CONSOLIDATED WELFARE BENEFIT PLAN

Financial Statements as of March 31, 2025 and 2024, and for the Year Ended March 31, 2025
with Independent Auditor's Report and Supplemental Schedules

EIN 36-1812780
Plan No. 504

INDEPENDENT AUDITOR'S REPORT

To BP Consolidated Welfare Benefit Plan

Opinion

We have audited the financial statements of BP Consolidated Welfare Benefit Plan (the "Plan"), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the statements of net assets available for benefits and statements of benefit obligations as of March 31, 2025 and 2024, and the related statement of changes in net assets available for benefits and statement of changes in benefit obligations for the year ended March 31, 2025, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the net assets available for benefits and the benefit obligations of the Plan as of March 31, 2025 and 2024, and the changes in its net assets available for benefits and changes in its benefit obligations for the year ended March 31, 2025, in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Plan and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Plan's ability to continue as a going concern for one year after the date that the financial statements are available to be issued.

Management is also responsible for maintaining a current plan instrument, including all plan amendments, administering the Plan, and determining that the Plan's transactions that are presented and disclosed in the financial statements are in conformity with the Plan's provisions, including maintaining sufficient records with respect to each of the participants, to determine the benefits due or which may become due to such participants.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Plan's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Plan's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Supplemental Schedules Required by ERISA

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedules of assets (held at end of year) as of March 31, 2025 and reportable transactions for the year ended March 31, 2025 are presented for purposes of additional analysis and are not a required part of the financial statements but are supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with GAAS.

In forming our opinion on the supplemental schedules, we evaluated whether the supplemental schedules, including their form and content, are presented in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.

In our opinion, the information in the accompanying schedules is fairly stated, in all material respects, in relation to the financial statements as a whole, and the form and content are presented in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.

Deloitte + Touche LLP

September 25, 2025

BP CONSOLIDATED WELFARE BENEFIT PLAN

STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS

	March 31	
	2025	2024
Assets:		
Cash	\$ 670,478	\$ 457,346
Rebates and other receivables	12,719,971	10,361,220
Investments at fair value -		
JPMorgan U.S. Government Money Market Fund	4,143,950	2,332,271
Total assets	17,534,399	13,150,837
Liabilities:		
Payable - Other	—	597,939
Accrued administrative expenses	417,186	387,868
Total liabilities	417,186	985,807
Net assets available for benefits	17,117,213	12,165,030

The accompanying notes are an integral part of these financial statements.

BP CONSOLIDATED WELFARE BENEFIT PLAN

STATEMENT OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS

Year Ended March 31, 2025

Additions to assets attributed to:

Employer contributions	\$ 222,095,099
Participant contributions	55,861,584
Interest income	290,633

Total additions	278,247,316
-----------------	-------------

Deductions of assets attributed to:

Claim payments	221,959,572
HMO premium payments	11,411,143
Insurance premium payments	22,380,838
Administrative expenses	17,543,580

Total deductions	273,295,133
------------------	-------------

Net increase in net assets during the year	4,952,183
--	-----------

Net assets available for benefits:

Beginning of year	12,165,030
End of year	\$ 17,117,213

The accompanying notes are an integral part of these financial statements.

BP CONSOLIDATED WELFARE BENEFIT PLAN

STATEMENTS OF BENEFIT OBLIGATIONS

	March 31	
	2025	2024
Amounts currently payable to or for participants, beneficiaries, and dependents:		
Claims and premiums payable	\$ 7,787,632	\$ 5,852,772
Claims incurred but not reported	19,075,578	17,077,174
Total amounts currently payable	26,863,210	22,929,946
Post-employment benefit obligation reserve for long-term disability claims, net of amounts currently payable	9,400,000	10,000,000
COBRA Benefits	1,300,000	300,000
Total post-employment benefits obligation	10,700,000	10,300,000
Total benefit obligations	\$ 37,563,210	\$ 33,229,946

The accompanying notes are an integral part of these financial statements.

BP CONSOLIDATED WELFARE BENEFIT PLAN

STATEMENT OF CHANGES IN BENEFIT OBLIGATIONS

Year Ended March 31, 2025

Amounts currently payable to or for participants, beneficiaries, and dependents:

Balance at beginning of year	\$ 22,929,946
Increase/(decrease) during the year attributable to:	
Claims and premiums incurred, including claims reclassified from actuarial reserve for long-term disability claims	257,686,413
Claims and premiums paid	(255,751,553)
Claims incurred but not reported	1,998,404
Balance at end of year	26,863,210

Post-employment benefit obligation reserve for long-term disability claims:

Balance at beginning of year	10,000,000
Increase/(decrease) during the year attributable to:	
Claims reclassified to amounts currently payable	(1,500,000)
Interest cost	500,000
Changes in actuarial assumptions	400,000
Balance at end of year	9,400,000

COBRA Benefits:

Balance at beginning of year	300,000
Increase during year attributable to - benefits earned	1,000,000
Balance at end of year	1,300,000

Total benefit obligations at end of year	\$ 37,563,210
--	---------------

The accompanying notes are an integral part of these financial statements.

BP CONSOLIDATED WELFARE BENEFIT PLAN

NOTES TO FINANCIAL STATEMENTS

1. DESCRIPTION OF PLAN

The BP Consolidated Welfare Benefit Plan (the “Plan”) is a welfare plan established for the purpose of paying various benefits to eligible participants, surviving spouses, dependents, spouses, and domestic partners who meet eligibility requirements as described in the Plan documents.

The following brief description of the Plan provides general information about the Plan’s provisions. Participants should refer to the Plan document and an applicable summary plan description for a more complete description of the Plan’s provisions, copies of which may be obtained from the Plan Administrator.

The Plan is subject to and complies with the provisions of the Employee Retirement Income Security Act of 1974, as amended (“ERISA”). The Plan is sponsored by BP Corporation North America Inc. (the “Company”), an indirect wholly owned subsidiary of BP p.l.c. The Plan Administrator is the Company’s Reward Delivery Manager. Alight Solutions is the benefits administrator responsible for recording and processing participants’ Plan elections.

Cash and investments of the Plan are held in separate accounts within the BP Corporation North America Inc. VEBA Master Trust (the “Trust”). The trustee of the Master Trust is JPMorgan Chase Bank (“the Trustee”).

The Company believes the Plan will continue indefinitely but reserves the right to amend, modify, or terminate the Plan, or any of the programs under the Plan, at any time. In the event of Plan termination, the assets of the Plan will be used to pay outstanding claims, other Plan liabilities, or other welfare plan benefits as determined at the Company’s sole discretion. Under present law and the terms of the Company’s agreement with the trustee, the assets of the Plan may not revert to the Company. The Company will fund benefit payments to the extent there are not sufficient assets in the Trust to pay such benefits.

Medical Benefits

The Plan offers comprehensive medical (including prescription drug) benefit coverage to eligible employees of the Company and its affiliates that elect to participate (“participating affiliates”) in the Plan. Eligible participants are those employees of the Company and participating affiliates who meet eligibility requirements defined in the summary plan descriptions and pursuant to the policies of the Company and participating affiliates. Benefits are also offered to eligible dependents, spouses, and domestic partners of participants.

Participant contributions are made through payroll deduction, or direct payment according to contribution schedules established periodically by the Plan Administrator. Participant contribution rates vary depending upon the coverage elected.

BP CONSOLIDATED WELFARE BENEFIT PLAN

The Plan offers individuals, who would otherwise lose group health coverage as the result of a qualifying event, the opportunity to elect to continue coverage under the Consolidated Omnibus Budget Reconciliation Act (“COBRA”).

The medical coverage options under the Plan are generally self-insured. The Company has entered into administrative services contracts with various third-party administrators under which claims processing services are provided. Payments for medical benefits are reviewed by the third-party administrators for propriety of coverage and are funded by the Trust. There are also certain insured coverage options under the Plan, including several health maintenance organization (“HMO”) options. The terms and conditions of benefit payments are described in applicable plan documents, including HMO and insurance policies where relevant.

Dental Benefits

The Plan offers dental and orthodontic benefit coverage to eligible employees of the Company and participating affiliates. Eligible participants are those employees of the Company and participating affiliates who meet eligibility requirements defined in the summary plan descriptions and pursuant to the policies of the Company and participating affiliates. Benefits are also offered to eligible dependents, spouses, and domestic partners of participants. COBRA coverage is offered to qualified beneficiaries in accordance with the requirements of COBRA.

Participant contributions are made through payroll deduction, or direct payment according to contribution schedules established periodically by the Plan Administrator. Participant contribution rates vary according to coverage level. The dental assistance plan offered is self-insured and is administered by a third-party administrator. The Plan also offers a dental HMO option. The terms and conditions of benefit payments are described in applicable plan documents, including HMO and insurance policies where relevant.

Group Life and Accidental Death and Dismemberment

The Plan provides group life and accidental death and dismemberment insurance coverage that provides benefits to beneficiaries of eligible employees of the Company and participating affiliates in the event of death or dismemberment.

Eligible participants include employees of the Company and those separated from the Company and participating affiliates who meet the Plan’s eligibility requirements. Life coverage under the Plan is provided through insured contracts. The Company pays the full cost of this insurance.

BP CONSOLIDATED WELFARE BENEFIT PLAN

Group Universal Life

The Plan offers a Group Universal Life (“GUL”) plan, which allows eligible employees the opportunity to purchase additional levels of coverage. Participant contributions are made through payroll deduction or direct payment according to contribution schedules established by the insurer. The Company does not contribute toward GUL coverage, which is a fully insured benefit.

Occupational Accidental Death

The Plan provides additional financial protection from an injury or death as the result of a work-related accident for eligible employees of the Company and participating affiliates and their survivors. Eligible participants are those employees of the Company and participating affiliates who meet eligibility requirements defined in the summary plan description and pursuant to the Company’s policies.

Death benefits under the Plan are provided through an insured contract. The Company pays the full cost of this insurance.

Pretax Health Care Contributions

The Plan offers eligible employees the opportunity to pay required contributions and premiums for group health coverage on a pretax basis under Section 125 of the Internal Revenue Code (the “Code”).

Vision Care

The Plan offers employee vision care benefits to eligible employees of the Company and participating affiliates. Benefits are also offered to eligible dependents, spouses, and domestic partners of participants.

Participant contributions are made through payroll deduction or direct payment according to contribution schedules established periodically by the Plan Administrator. The Company does not contribute toward vision care, which is a fully insured benefit.

Long-Term Disability

The Plan provides long-term disability for eligible employees of the Company and participating affiliates and offers eligible employees the opportunity to purchase additional levels of coverage. Benefits under the Plan are provided through an insured contract. Participant contributions for additional coverage are made through payroll deduction.

BP CONSOLIDATED WELFARE BENEFIT PLAN

For certain employees who incurred a disability prior to April 1, 2000, and for certain employees who incurred a disability prior to January 1, 2002, the Plan continues to provide long-term disability benefits on a self-insured basis. These self-insured benefits are administered by a third-party administrator pursuant to an administrative services agreement. Claims are funded through the Trust.

Short-Term Disability

The Plan provides short-term disability for eligible employees of the Company and participating affiliates. Benefits under the Plan are provided through an insured contract.

Health Care and Dependent Care Spending Accounts

The Plan offers health care and dependent care spending accounts as employee benefits established under Section 125 and Section 129 of the Code, respectively. Participants may set aside money on a pretax basis to pay for certain medical, dental, vision, or dependent care expenses through this benefit.

Eligible participants are those employees of the Company and participating affiliates who meet eligibility requirements defined in the plan documents.

Participant contributions are made through payroll deduction. Amounts contributed to a spending account for a coverage period but not used during that period are forfeited. Forfeited money is used to offset costs of the Plan. Forfeitures balance is minimal and not significant.

Concurrent with the establishment of the spending accounts, the Company entered into an administrative services agreement under which claims processing services are provided. Claims are reviewed for eligibility. Reimbursements are made by the third-party administrator to the participants.

Legal Services

The Plan offers participants access to legal assistance through a national network of attorneys managed by a third-party provider. Eligible participants are those employees of the Company and participating affiliates who meet the Plan's eligibility requirements. Participant contributions are made through payroll deduction or direct payment according to contribution schedules established by the third-party provider. The Company does not contribute toward Legal Services coverage.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Accounting. The accompanying financial statements of the Plan are prepared under the accrual method of accounting in accordance with U.S. generally accepted accounting principles ("US GAAP").

BP CONSOLIDATED WELFARE BENEFIT PLAN

Use of Estimates. The preparation of financial statements in conformity with US GAAP requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results may differ from those estimates and assumptions.

Investment Valuation and Income Recognition. All investment assets held by the Plan are stated at fair value. Further information regarding valuation techniques used to measure fair value by the Plan is included in Fair Value Measurements (Note 7). Purchases and sales of securities are recorded on a trade-date basis. Interest income is recorded as earned.

Benefit Payments. Claims and premium payments are recorded when paid by the Trust. Amounts due to a third-party administrator for claims that have been paid but not yet reimbursed by the Plan are recorded as claims payable on the accompanying statements of benefit obligations. Rebates from prescription drug programs are recorded when earned and netted with claims paid in the accompanying statement of changes in net assets available for benefits.

Certain premiums and wellness incentives are paid from the general assets of the Company; however, all premiums and wellness incentives are recorded in the accompanying statement of changes in net assets available for benefits, regardless of whether they were paid from Plan assets or from the general assets of the Company.

Administrative Expenses. Plan related administrative expenses, which consist primarily of fees paid to third-party administrators and the trustee are paid by the Trust. These expenses are reported on the accompanying statement of changes in net assets available for benefits. All other administrative expenses such as professional fees are paid by the Company on behalf of the Plan.

Funding. The Company makes monthly contributions to fund the Company's estimated portion of the month's benefit and premium payments. The Plan's deficiency of net assets over benefit obligations at March 31, 2025 and 2024, will be funded through future increases in the Company's contribution and the participants' contribution rate.

Participant contributions made to a lockbox are automatically deposited into the trust account of the BP Corporation North America Inc. Retiree Welfare Benefit Plan II. Any contributions subsequently determined to relate to BP Consolidated Welfare Plan participants are recognized as an other receivable and transferred to the Plan on a monthly basis.

Subsequent Events. Management evaluated subsequent events for the Plan through September 25, 2025, the date the financial statements were available to be issued.

BP CONSOLIDATED WELFARE BENEFIT PLAN

3. BENEFIT OBLIGATIONS

Plan obligations at March 31, 2025 and 2024, for incurred but not reported claims are estimated by the Plan's actuary in accordance with accepted actuarial principles based on claims data provided by the Plan's third-party administrators. These amounts are paid by the Plan only if claims are submitted and approved for payment.

A post-employment benefit obligation has been recognized for health and welfare benefits for individuals currently on long-term disability or COBRA. Long-term disability obligations are estimated by an actuary based on reserve reports prepared from historical long-term disability benefits data. Estimated Plan obligations for long-term disability claims are calculated using the SOA 95A Table. Discount rates of 5.07% and 5.11% were applied for plan years ended March 31, 2025 and 2024, respectively. The obligation for COBRA benefits is estimated by an actuary based on the actual number of employees utilizing COBRA benefits as of the measurement date and claim payment history and includes an estimate for claims incurred by COBRA participants that have not yet been reported.

4. FEDERAL INCOME TAX STATUS

The Trust that funds the Plan has received an exemption letter from the Internal Revenue Service ("IRS") dated August 14, 2000, stating that the Trust is tax-exempt under the provisions of Section 501(c)(9) of the Code as a Voluntary Employee Beneficiary Association. The Plan and Trust are required to operate in conformity with the Code to maintain the tax-exempt status of the Trust. The Plan Administrator believes the Plan is being operated in compliance with the applicable requirements of the Code and, therefore, believes the related Trust is tax-exempt. The Company reserves the right to make any amendments necessary to maintain the qualification of the Trust.

5. RISKS AND UNCERTAINTIES

The Plan invests in a money market mutual fund. This investment is exposed to various risks such as interest rate, market volatility, and credit risks. Market risks include global events which could impact the value of investment securities, such as pandemic or international conflict. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the amounts reported in the statements of net assets available for benefits.

The actuarial present value of benefit obligations is reported based on certain assumptions pertaining to interest rates and employee demographics, both of which are subject to change. Due to uncertainties inherent in the estimation and assumptions processes, it is at least reasonably possible that changes in these estimates and assumptions in the near term could materially affect the amounts reported and disclosed in the financial statements.

BP CONSOLIDATED WELFARE BENEFIT PLAN

6. EXEMPT PARTY-IN-INTEREST TRANSACTIONS

The Plan holds a money market mutual fund in its investment portfolio at March 31, 2025 and 2024, which is managed by the trustee of the Plan. These transactions qualify as party-in-interest transactions. Fees paid for investment management services were included as a reduction of the return earned on the fund.

7. FAIR VALUE MEASUREMENTS

Accounting Standards Codification Topic 820, *Fair Value Measurement*, established a framework for measuring fair value. That framework provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. Inputs broadly refer to the assumptions that market participants use to make pricing decisions, including assumptions about risk. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are described below:

Level 1 inputs are observable inputs that reflect unadjusted quoted prices for identical assets or liabilities in active markets as of the reporting date. Active markets are those in which transactions for the asset or liability occur in sufficient frequency and volume to provide pricing information on an ongoing basis.

Level 2 inputs are observable market-based inputs or unobservable inputs that are corroborated by market data. These are inputs other than quoted prices in active markets included within Level 1, which are either directly or indirectly observable at the reporting date.

Level 3 inputs are unobservable inputs that are not corroborated by market data and may be used with internally developed methodologies that result in management's best estimate of fair value.

In measuring fair value, the Plan uses valuation techniques that maximize the use of observable inputs.

The Plan held an investment in a money market mutual fund at March 31, 2025 and 2024, of \$4,143,950 and \$2,555,515, respectively. This investment is classified as Level 1 of the fair value hierarchy. Money market mutual funds are valued using the quoted price in an active market.

Money market mutual funds invest in high-quality, U.S. dollar denominated money market instruments with short-term maturities that emphasize maintaining liquidity and preservation of capital. Redemptions can be made daily with no notice period required.

BP CONSOLIDATED WELFARE BENEFIT PLAN

8. RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500

The following is a reconciliation of net assets available for benefits as of March 31, 2025 and 2024, per the financial statements to the Form 5500:

	March 31	
	2025	2024
Net assets available for benefits as stated in the financial statements	\$ 17,117,213	\$ 12,165,030
Less: Claims and premiums payable	(7,787,632)	(5,852,772)
Less: Claims incurred but not reported	(19,075,578)	(17,077,174)
Net assets available for benefits per the Plan's Form 5500	<u>\$ (9,745,997)</u>	<u>\$ (10,764,916)</u>

The following is a reconciliation of claims and premiums paid for the year ended March 31, 2025, per the financial statements to the Form 5500:

Claims payments as stated in the financial statements	\$ 221,959,572
HMO premium payments as stated in the financial statements	11,411,143
Insurance premium payments as stated in the financial statements	22,380,838
Claims payable at March 31, 2025	6,348,941
Premiums payable at March 31, 2025	1,438,691
Claims and premiums payable at March 31, 2025	<u>7,787,632</u>
Claims payable at March 31, 2024	(4,424,509)
Premiums payable at March 31, 2024	(1,428,263)
Claims and premiums payable at March 31, 2024	<u>(5,852,772)</u>
Claims incurred but not reported at March 31, 2025	19,075,578
Claims incurred but not reported at March 31, 2024	(17,077,174)
Benefits paid as stated in the Plan's Form 5500	<u>\$ 259,684,817</u>

Claims and premiums that have been processed and approved for payment, but not yet paid at year-end, and claims incurred but not reported are not presented as liabilities or claims paid in the statements of net assets available for benefits in accordance with US GAAP, but are recorded on the Form 5500 as benefits payable.

BP CONSOLIDATED WELFARE BENEFIT PLAN

SCHEDULE H, LINE 4i – SCHEDULE OF ASSETS (HELD AT END OF YEAR)

March 31, 2025

Identity of Issue, Borrower, Lessor or Similar Party	Description of Investment, including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value	Cost	Current Value
* JPMorgan Chase Bank	JPMorgan U.S. Government Money Market Fund - Capital Shares	\$4,143,950	\$4,143,950

* Indicates party-in-interest.

FD493 SCHEDULE H (FORM 5500 - 4J-1) SCHEDULE OF REPORTABLE TRANSACTIONS SINGLE TRANSACTIONS				BP CONSOLIDATED WELFARE PLAN 504		THROUGH		PAGE 7 P 47376 MARCH 31, 2024 MARCH 31, 2025
DESCRIPTION OF ASSET IDENTITY OF PARTY INVOLVED				BASED ON MARKET VALUE OF PURCHASE PRICE SELLING PRICE	1,751,901 COST OF ASSET	5% VALUE OF CURRENT VALUE	87,595 NET GAIN OR (LOSS)	
46699A9A6 JPMORGAN US GOVT MMKT FUND CAPITAL SHARES - FUND MONTHLY VARIABLE 12/31/2049 BROKER 0800003 MEMO-MASTER NOTES/POOLED FUNDS 1,059,201 04/01/24 BUY 71172427 100.0000				0	1,059,201	1,059,201	0	
46699A9A6 JPMORGAN US GOVT MMKT FUND CAPITAL SHARES - FUND MONTHLY VARIABLE 12/31/2049 BROKER 0800003 MEMO-MASTER NOTES/POOLED FUNDS 4,026,959 04/02/24 BUY 71172434 100.0000				0	4,026,959	4,026,959	0	
46699A9A6 JPMORGAN US GOVT MMKT FUND CAPITAL SHARES - FUND MONTHLY VARIABLE 12/31/2049 BROKER 0800003 MEMO-MASTER NOTES/POOLED FUNDS 446,383 04/03/24 SELL 71172439 100.0000				0	446,383	446,383	0	
46699A9A6 JPMORGAN US GOVT MMKT FUND CAPITAL SHARES - FUND MONTHLY VARIABLE 12/31/2049 BROKER 0800003 MEMO-MASTER NOTES/POOLED FUNDS 271,608 04/04/24 SELL 71172442 100.0000				0	271,608	271,608	0	
46699A9A6 JPMORGAN US GOVT MMKT FUND CAPITAL SHARES - FUND MONTHLY VARIABLE 12/31/2049 BROKER 0800003 MEMO-MASTER NOTES/POOLED FUNDS 3,061,843 04/05/24 SELL 71172467 100.0000				0	3,061,843	3,061,843	0	
46699A9A6 JPMORGAN US GOVT MMKT FUND CAPITAL SHARES - FUND MONTHLY VARIABLE 12/31/2049 BROKER 0800003 MEMO-MASTER NOTES/POOLED FUNDS 395,097 04/08/24 SELL 71172470 100.0000				0	395,097	395,097	0	
46699A9A6 JPMORGAN US GOVT MMKT FUND CAPITAL SHARES - FUND MONTHLY VARIABLE 12/31/2049 BROKER 0800003 MEMO-MASTER NOTES/POOLED FUNDS 1,794,109 04/09/24 SELL 71172477 100.0000				0	1,794,109	1,794,109	0	
46699A9A6 JPMORGAN US GOVT MMKT FUND CAPITAL SHARES - FUND MONTHLY VARIABLE 12/31/2049 BROKER 0800003 MEMO-MASTER NOTES/POOLED FUNDS 703,778 04/10/24 SELL 71172482 100.0000				0	703,778	703,778	0	
JPMorgan Investor Services				J.P.Morgan				

FD493 SCHEDULE H (FORM 5500 - 4J-1) SCHEDULE OF REPORTABLE TRANSACTIONS SINGLE TRANSACTIONS			BP CONSOLIDATED WELFARE PLAN 504			PAGE 8 P 47376 MARCH 31, 2024 MARCH 31, 2025	
			THROUGH				

FD493 SCHEDULE H (FORM 5500 - 4J-1) SCHEDULE OF REPORTABLE TRANSACTIONS SINGLE TRANSACTIONS			BP CONSOLIDATED WELFARE PLAN 504			PAGE 9 P 47376 MARCH 31, 2024 MARCH 31, 2025	
			THROUGH				

FD493 SCHEDULE H (FORM 5500 - 4J-1) SCHEDULE OF REPORTABLE TRANSACTIONS SINGLE TRANSACTIONS			BP CONSOLIDATED WELFARE PLAN 504			PAGE 10 P 47376 MARCH 31, 2024 MARCH 31, 2025	
			THROUGH				

FD493 SCHEDULE H (FORM 5500 - 4J-1) SCHEDULE OF REPORTABLE TRANSACTIONS SINGLE TRANSACTIONS				BP CONSOLIDATED WELFARE PLAN 504		THROUGH		PAGE 11 P 47376 MARCH 31, 2024 MARCH 31, 2025	
DESCRIPTION OF ASSET				BASED ON MARKET VALUE OF	1,751,901	5% VALUE OF	87,595		
IDENTITY OF PARTY INVOLVED				PURCHASE PRICE	COST OF ASSET	CURRENT VALUE	NET GAIN		
				SELLING PRICE			OR (LOSS)		
46699A9A6 JPMORGAN US GOVT MMKT FUND CAPITAL SHARES - FUND									
MONTHLY VARIABLE 12/31/2049									
BROKER 0800003 MEMO-MASTER NOTES/POOLED FUNDS									
394,070 05/15/24 SELL 71172705				100.0000	0	394,070	394,070	0	
46699A9A6 JPMORGAN US GOVT MMKT FUND CAPITAL SHARES - FUND									
MONTHLY VARIABLE 12/31/2049									
BROKER 0800003 MEMO-MASTER NOTES/POOLED FUNDS									
277,915 05/16/24 SELL 71172707				100.0000	0	277,915	277,915	0	
46699A9A6 JPMORGAN US GOVT MMKT FUND CAPITAL SHARES - FUND									
MONTHLY VARIABLE 12/31/2049									
BROKER 0800003 MEMO-MASTER NOTES/POOLED FUNDS									
4,507,330 05/17/24 BUY 71172739				100.0000	0	4,507,330	4,507,330	0	
46699A9A6 JPMORGAN US GOVT MMKT FUND CAPITAL SHARES - FUND									
MONTHLY VARIABLE 12/31/2049									
BROKER 0800003 MEMO-MASTER NOTES/POOLED FUNDS									
208,579 05/20/24 SELL 71172742				100.0000	0	208,579	208,579	0	
46699A9A6 JPMORGAN US GOVT MMKT FUND CAPITAL SHARES - FUND									
MONTHLY VARIABLE 12/31/2049									
BROKER 0800003 MEMO-MASTER NOTES/POOLED FUNDS									
2,726,811 05/21/24 SELL 71172748				100.0000	0	2,726,811	2,726,811	0	
46699A9A6 JPMORGAN US GOVT MMKT FUND CAPITAL SHARES - FUND									
MONTHLY VARIABLE 12/31/2049									
BROKER 0800003 MEMO-MASTER NOTES/POOLED FUNDS									
316,998 05/22/24 SELL 71172759				100.0000	0	316,998	316,998	0	
46699A9A6 JPMORGAN US GOVT MMKT FUND CAPITAL SHARES - FUND									
MONTHLY VARIABLE 12/31/2049									
BROKER 0800003 MEMO-MASTER NOTES/POOLED FUNDS									
1,676,956 05/23/24 BUY 71172763				100.0000	0	1,676,956	1,676,956	0	
46699A9A6 JPMORGAN US GOVT MMKT FUND CAPITAL SHARES - FUND									
MONTHLY VARIABLE 12/31/2049									
BROKER 0800003 MEMO-MASTER NOTES/POOLED FUNDS									
520,266 05/24/24 SELL 71172787				100.0000	0	520,266	520,266	0	
JPMorgan Investor Services									
J.P.Morgan									

FD493 SCHEDULE H (FORM 5500 - 4J-1) SCHEDULE OF REPORTABLE TRANSACTIONS SINGLE TRANSACTIONS			BP CONSOLIDATED WELFARE PLAN 504			PAGE 12 P 47376 MARCH 31, 2024 MARCH 31, 2025	
			THROUGH				

FD493 SCHEDULE H (FORM 5500 - 4J-1) SCHEDULE OF REPORTABLE TRANSACTIONS SINGLE TRANSACTIONS			BP CONSOLIDATED WELFARE PLAN 504			PAGE 13 P 47376 MARCH 31, 2024 MARCH 31, 2025	
			THROUGH				

FD493 SCHEDULE H (FORM 5500 - 4J-1) SCHEDULE OF REPORTABLE TRANSACTIONS SINGLE TRANSACTIONS				BP CONSOLIDATED WELFARE PLAN 504		THROUGH		PAGE 14 P 47376 MARCH 31, 2024 MARCH 31, 2025	
DESCRIPTION OF ASSET IDENTITY OF PARTY INVOLVED				BASED ON MARKET VALUE OF PURCHASE PRICE SELLING PRICE	1,751,901 COST OF ASSET	5% VALUE OF CURRENT VALUE	87,595 NET GAIN OR (LOSS)		
46699A9A6 JPMORGAN US GOVT MMKT FUND CAPITAL SHARES - FUND MONTHLY VARIABLE 12/31/2049 BROKER 0800003 MEMO-MASTER NOTES/POOLED FUNDS 815,151 06/20/24 SELL 71172927 100.0000				0	815,151	815,151	0		
46699A9A6 JPMORGAN US GOVT MMKT FUND CAPITAL SHARES - FUND MONTHLY VARIABLE 12/31/2049 BROKER 0800003 MEMO-MASTER NOTES/POOLED FUNDS 241,850 06/21/24 BUY 71172959 100.0000				0	241,850	241,850	0		
46699A9A6 JPMORGAN US GOVT MMKT FUND CAPITAL SHARES - FUND MONTHLY VARIABLE 12/31/2049 BROKER 0800003 MEMO-MASTER NOTES/POOLED FUNDS 3,037,713 06/24/24 SELL 71172966 100.0000				0	3,037,713	3,037,713	0		
46699A9A6 JPMORGAN US GOVT MMKT FUND CAPITAL SHARES - FUND MONTHLY VARIABLE 12/31/2049 BROKER 0800003 MEMO-MASTER NOTES/POOLED FUNDS 1,273,408 06/25/24 SELL 71172976 100.0000				0	1,273,408	1,273,408	0		
46699A9A6 JPMORGAN US GOVT MMKT FUND CAPITAL SHARES - FUND MONTHLY VARIABLE 12/31/2049 BROKER 0800003 MEMO-MASTER NOTES/POOLED FUNDS 697,990 06/26/24 SELL 71172979 100.0000				0	697,990	697,990	0		
46699A9A6 JPMORGAN US GOVT MMKT FUND CAPITAL SHARES - FUND MONTHLY VARIABLE 12/31/2049 BROKER 0800003 MEMO-MASTER NOTES/POOLED FUNDS 1,286,238 06/27/24 SELL 71172986 100.0000				0	1,286,238	1,286,238	0		
46699A9A6 JPMORGAN US GOVT MMKT FUND CAPITAL SHARES - FUND MONTHLY VARIABLE 12/31/2049 BROKER 0800003 MEMO-MASTER NOTES/POOLED FUNDS 4,314,648 06/28/24 BUY 71173018 100.0000				0	4,314,648	4,314,648	0		
46699A9A6 JPMORGAN US GOVT MMKT FUND CAPITAL SHARES - FUND MONTHLY VARIABLE 12/31/2049 BROKER 0800003 MEMO-MASTER NOTES/POOLED FUNDS 2,773,040 07/01/24 SELL 71173026 100.0000				0	2,773,040	2,773,040	0		
JPMorgan Investor Services				J.P.Morgan					

FD493 SCHEDULE H (FORM 5500 - 4J-1) SCHEDULE OF REPORTABLE TRANSACTIONS SINGLE TRANSACTIONS			BP CONSOLIDATED WELFARE PLAN 504			PAGE 15 P 47376 MARCH 31, 2024 MARCH 31, 2025	
			THROUGH				

FD493 SCHEDULE H (FORM 5500 - 4J-1) SCHEDULE OF REPORTABLE TRANSACTIONS SINGLE TRANSACTIONS			BP CONSOLIDATED WELFARE PLAN 504			PAGE 16 P 47376 MARCH 31, 2024 MARCH 31, 2025	
			THROUGH				

FD493 SCHEDULE H (FORM 5500 - 4J-1) SCHEDULE OF REPORTABLE TRANSACTIONS SINGLE TRANSACTIONS			BP CONSOLIDATED WELFARE PLAN 504			PAGE 17 P 47376 MARCH 31, 2024 MARCH 31, 2025	
			THROUGH				

FD493 SCHEDULE H (FORM 5500 - 4J-1) SCHEDULE OF REPORTABLE TRANSACTIONS SINGLE TRANSACTIONS			BP CONSOLIDATED WELFARE PLAN 504			PAGE 18 P 47376 MARCH 31, 2024 MARCH 31, 2025		
			THROUGH					

FD493 SCHEDULE H (FORM 5500 - 4J-1) SCHEDULE OF REPORTABLE TRANSACTIONS SINGLE TRANSACTIONS			BP CONSOLIDATED WELFARE PLAN 504			PAGE 19 P 47376 MARCH 31, 2024 MARCH 31, 2025	
			THROUGH				

FD493 SCHEDULE H (FORM 5500 - 4J-1) SCHEDULE OF REPORTABLE TRANSACTIONS SINGLE TRANSACTIONS			BP CONSOLIDATED WELFARE PLAN 504			PAGE 20 P 47376 MARCH 31, 2024 MARCH 31, 2025	
			THROUGH				

FD493 SCHEDULE H (FORM 5500 - 4J-1) SCHEDULE OF REPORTABLE TRANSACTIONS SINGLE TRANSACTIONS			BP CONSOLIDATED WELFARE PLAN 504			PAGE 21 P 47376 MARCH 31, 2024 MARCH 31, 2025	
			THROUGH				

FD493 SCHEDULE H (FORM 5500 - 4J-1) SCHEDULE OF REPORTABLE TRANSACTIONS SINGLE TRANSACTIONS			BP CONSOLIDATED WELFARE PLAN 504			PAGE 22 P 47376 MARCH 31, 2024 MARCH 31, 2025	
			THROUGH				

FD493 SCHEDULE H (FORM 5500 - 4J-1) SCHEDULE OF REPORTABLE TRANSACTIONS SINGLE TRANSACTIONS			BP CONSOLIDATED WELFARE PLAN 504			PAGE 23 P 47376 MARCH 31, 2024 MARCH 31, 2025	
			THROUGH				

FD493 SCHEDULE H (FORM 5500 - 4J-1) SCHEDULE OF REPORTABLE TRANSACTIONS SINGLE TRANSACTIONS			BP CONSOLIDATED WELFARE PLAN 504			PAGE 24 P 47376 MARCH 31, 2024 MARCH 31, 2025	
			THROUGH				

FD493 SCHEDULE H (FORM 5500 - 4J-1) SCHEDULE OF REPORTABLE TRANSACTIONS SINGLE TRANSACTIONS			BP CONSOLIDATED WELFARE PLAN 504			PAGE 25 P 47376 MARCH 31, 2024 MARCH 31, 2025	
			THROUGH				

FD493 SCHEDULE H (FORM 5500 - 4J-1) SCHEDULE OF REPORTABLE TRANSACTIONS SINGLE TRANSACTIONS			BP CONSOLIDATED WELFARE PLAN 504			PAGE 26 P 47376 MARCH 31, 2024 MARCH 31, 2025	
			THROUGH				

FD493 SCHEDULE H (FORM 5500 - 4J-1) SCHEDULE OF REPORTABLE TRANSACTIONS SINGLE TRANSACTIONS			BP CONSOLIDATED WELFARE PLAN 504			PAGE 27 P 47376 MARCH 31, 2024 MARCH 31, 2025	
			THROUGH				

FD493 SCHEDULE H (FORM 5500 - 4J-1) SCHEDULE OF REPORTABLE TRANSACTIONS SINGLE TRANSACTIONS				BP CONSOLIDATED WELFARE PLAN 504		THROUGH		PAGE 28 P 47376 MARCH 31, 2024 MARCH 31, 2025
DESCRIPTION OF ASSET IDENTITY OF PARTY INVOLVED				BASED ON MARKET VALUE OF PURCHASE PRICE SELLING PRICE	1,751,901 COST OF ASSET	5% VALUE OF CURRENT VALUE	87,595 NET GAIN OR (LOSS)	
46699A9A6 JPMORGAN US GOVT MMKT FUND CAPITAL SHARES - FUND MONTHLY VARIABLE 12/31/2049 BROKER 0800003 MEMO-MASTER NOTES/POOLED FUNDS 2,747,805 12/02/24 SELL 71174076				100.0000	0	2,747,805	2,747,805	0
46699A9A6 JPMORGAN US GOVT MMKT FUND CAPITAL SHARES - FUND MONTHLY VARIABLE 12/31/2049 BROKER 0800003 MEMO-MASTER NOTES/POOLED FUNDS 767,171 12/03/24 SELL 71174082				100.0000	0	767,171	767,171	0
46699A9A6 JPMORGAN US GOVT MMKT FUND CAPITAL SHARES - FUND MONTHLY VARIABLE 12/31/2049 BROKER 0800003 MEMO-MASTER NOTES/POOLED FUNDS 469,499 12/04/24 SELL 71174086				100.0000	0	469,499	469,499	0
46699A9A6 JPMORGAN US GOVT MMKT FUND CAPITAL SHARES - FUND MONTHLY VARIABLE 12/31/2049 BROKER 0800003 MEMO-MASTER NOTES/POOLED FUNDS 742,882 12/05/24 SELL 71174089				100.0000	0	742,882	742,882	0
46699A9A6 JPMORGAN US GOVT MMKT FUND CAPITAL SHARES - FUND MONTHLY VARIABLE 12/31/2049 BROKER 0800003 MEMO-MASTER NOTES/POOLED FUNDS 3,591,876 12/06/24 BUY 71174120				100.0000	0	3,591,876	3,591,876	0
46699A9A6 JPMORGAN US GOVT MMKT FUND CAPITAL SHARES - FUND MONTHLY VARIABLE 12/31/2049 BROKER 0800003 MEMO-MASTER NOTES/POOLED FUNDS 258,919 12/09/24 SELL 71174123				100.0000	0	258,919	258,919	0
46699A9A6 JPMORGAN US GOVT MMKT FUND CAPITAL SHARES - FUND MONTHLY VARIABLE 12/31/2049 BROKER 0800003 MEMO-MASTER NOTES/POOLED FUNDS 1,008,490 12/10/24 SELL 71174128				100.0000	0	1,008,490	1,008,490	0
46699A9A6 JPMORGAN US GOVT MMKT FUND CAPITAL SHARES - FUND MONTHLY VARIABLE 12/31/2049 BROKER 0800003 MEMO-MASTER NOTES/POOLED FUNDS 571,665 12/11/24 SELL 71174131				100.0000	0	571,665	571,665	0
JPMorgan Investor Services				J.P.Morgan				

FD493 SCHEDULE H (FORM 5500 - 4J-1) SCHEDULE OF REPORTABLE TRANSACTIONS SINGLE TRANSACTIONS			BP CONSOLIDATED WELFARE PLAN 504			PAGE 29 P 47376 MARCH 31, 2024 MARCH 31, 2025	
			THROUGH				
						</	

FD493 SCHEDULE H (FORM 5500 - 4J-1) SCHEDULE OF REPORTABLE TRANSACTIONS SINGLE TRANSACTIONS				BP CONSOLIDATED WELFARE PLAN 504		THROUGH		PAGE 30 P 47376 MARCH 31, 2024 MARCH 31, 2025	
DESCRIPTION OF ASSET IDENTITY OF PARTY INVOLVED				BASED ON MARKET VALUE OF PURCHASE PRICE SELLING PRICE	1,751,901 COST OF ASSET	5% VALUE OF CURRENT VALUE	87,595 NET GAIN OR (LOSS)		
46699A9A6 JPMORGAN US GOVT MMKT FUND CAPITAL SHARES - FUND MONTHLY VARIABLE 12/31/2049 BROKER 0800003 MEMO-MASTER NOTES/POOLED FUNDS									
3,826,098 12/24/24 SELL 71174212				100.0000	0	3,826,098	3,826,098	0	
46699A9A6 JPMORGAN US GOVT MMKT FUND CAPITAL SHARES - FUND MONTHLY VARIABLE 12/31/2049 BROKER 0800003 MEMO-MASTER NOTES/POOLED FUNDS									
1,763,091 12/26/24 BUY 71174217				100.0000	0	1,763,091	1,763,091	0	
46699A9A6 JPMORGAN US GOVT MMKT FUND CAPITAL SHARES - FUND MONTHLY VARIABLE 12/31/2049 BROKER 0800003 MEMO-MASTER NOTES/POOLED FUNDS									
585,222 12/27/24 SELL 71174237				100.0000	0	585,222	585,222	0	
46699A9A6 JPMORGAN US GOVT MMKT FUND CAPITAL SHARES - FUND MONTHLY VARIABLE 12/31/2049 BROKER 0800003 MEMO-MASTER NOTES/POOLED FUNDS									
1,320,446 12/30/24 SELL 71174245				100.0000	0	1,320,446	1,320,446	0	
46699A9A6 JPMORGAN US GOVT MMKT FUND CAPITAL SHARES - FUND MONTHLY VARIABLE 12/31/2049 BROKER 0800003 MEMO-MASTER NOTES/POOLED FUNDS									
2,078,863 01/02/25 SELL 71174295				100.0000	0	2,078,863	2,078,863	0	
46699A9A6 JPMORGAN US GOVT MMKT FUND CAPITAL SHARES - FUND MONTHLY VARIABLE 12/31/2049 BROKER 0800003 MEMO-MASTER NOTES/POOLED FUNDS									
1,747,348 01/06/25 SELL 71174329				100.0000	0	1,747,348	1,747,348	0	
46699A9A6 JPMORGAN US GOVT MMKT FUND CAPITAL SHARES - FUND MONTHLY VARIABLE 12/31/2049 BROKER 0800003 MEMO-MASTER NOTES/POOLED FUNDS									
4,599,941 01/07/25 BUY 71174338				100.0000	0	4,599,941	4,599,941	0	
46699A9A6 JPMORGAN US GOVT MMKT FUND CAPITAL SHARES - FUND MONTHLY VARIABLE 12/31/2049 BROKER 0800003 MEMO-MASTER NOTES/POOLED FUNDS									
676,541 01/08/25 SELL 71174347				100.0000	0	676,541	676,541	0	
JPMorgan Investor Services									
J.P.Morgan									

FD493 SCHEDULE H (FORM 5500 - 4J-1) SCHEDULE OF REPORTABLE TRANSACTIONS SINGLE TRANSACTIONS			BP CONSOLIDATED WELFARE PLAN 504			PAGE 31 P 47376 MARCH 31, 2024 MARCH 31, 2025	
			THROUGH				

FD493 SCHEDULE H (FORM 5500 - 4J-1) SCHEDULE OF REPORTABLE TRANSACTIONS SINGLE TRANSACTIONS			BP CONSOLIDATED WELFARE PLAN 504			PAGE 32 P 47376 MARCH 31, 2024 MARCH 31, 2025	
			THROUGH				

FD493 SCHEDULE H (FORM 5500 - 4J-1) SCHEDULE OF REPORTABLE TRANSACTIONS SINGLE TRANSACTIONS			BP CONSOLIDATED WELFARE PLAN 504			PAGE 33 P 47376 MARCH 31, 2024 MARCH 31, 2025	
			THROUGH				

FD493 SCHEDULE H (FORM 5500 - 4J-1) SCHEDULE OF REPORTABLE TRANSACTIONS SINGLE TRANSACTIONS			BP CONSOLIDATED WELFARE PLAN 504			PAGE 34 P 47376 MARCH 31, 2024 MARCH 31, 2025	
			THROUGH				

FD493 SCHEDULE H (FORM 5500 - 4J-1) SCHEDULE OF REPORTABLE TRANSACTIONS SINGLE TRANSACTIONS			BP CONSOLIDATED WELFARE PLAN 504			PAGE 35 P 47376 MARCH 31, 2024 MARCH 31, 2025	
			THROUGH				

FD493 SCHEDULE H (FORM 5500 - 4J-1) SCHEDULE OF REPORTABLE TRANSACTIONS SINGLE TRANSACTIONS			BP CONSOLIDATED WELFARE PLAN 504			PAGE 36 P 47376 MARCH 31, 2024 MARCH 31, 2025	
			THROUGH				

FD493 SCHEDULE H (FORM 5500 - 4J-1) SCHEDULE OF REPORTABLE TRANSACTIONS SINGLE TRANSACTIONS			BP CONSOLIDATED WELFARE PLAN 504			PAGE 37 P 47376 MARCH 31, 2024 MARCH 31, 2025	
			THROUGH				

DESCRIPTION OF ASSET		BASED ON MARKET VALUE OF	1,751,901	5% VALUE OF	87,595
IDENTITY OF PARTY INVOLVED	PURCHASE PRICE	EXPENSES	COST OF ASSET	CURRENT VALUE	NET GAIN OR (LOSS)
46699A9A6 JPMORGAN US GOVT MMKT FUND CAPITAL SHARES - FUND	SELLING PRICE				
MONTHLY VARIABLE 12/31/2049					
BROKER 0800003	MEMO-MASTER NOTES/POOLED FUNDS				
1,059,201	04/01/24 B BUY 71172427	100.0000	0	1,059,201	1,059,201
4,026,959	04/02/24 B BUY 71172434	100.0000	0	4,026,959	4,026,959
446,383	04/03/24 S SELL 71172439	100.0000	0	446,383	446,383
271,608	04/04/24 S SELL 71172442	100.0000	0	271,608	271,608
3,061,843	04/05/24 S SELL 71172467	100.0000	0	3,061,843	3,061,843
395,097	04/08/24 S SELL 71172470	100.0000	0	395,097	395,097
1,794,109	04/09/24 S SELL 71172477	100.0000	0	1,794,109	1,794,109
703,778	04/10/24 S SELL 71172482	100.0000	0	703,778	703,778
3,615,626	04/11/24 B BUY 71172485	100.0000	0	3,615,626	3,615,626
191,339	04/12/24 B BUY 71172507	100.0000	0	191,339	191,339
342,404	04/15/24 S SELL 71172511	100.0000	0	342,404	342,404
843,471	04/16/24 S SELL 71172514	100.0000	0	843,471	843,471
548,060	04/17/24 S SELL 71172517	100.0000	0	548,060	548,060
416,982	04/18/24 S SELL 71172519	100.0000	0	416,982	416,982
1,932,045	04/19/24 B BUY 71172551	100.0000	0	1,932,045	1,932,045
296,176	04/22/24 S SELL 71172554	100.0000	0	296,176	296,176
620,110	04/23/24 S SELL 71172557	100.0000	0	620,110	620,110
775,451	04/24/24 S SELL 71172560	100.0000	0	775,451	775,451
332,924	04/25/24 S SELL 71172562	100.0000	0	332,924	332,924
4,383,433	04/26/24 B BUY 71172597	100.0000	0	4,383,433	4,383,433
2,437,231	04/29/24 S SELL 71172608	100.0000	0	2,437,231	2,437,231
672,117	04/30/24 S SELL 71172616	100.0000	0	672,117	672,117
2,954,978	05/01/24 S SELL 71172622	100.0000	0	2,954,978	2,954,978
208,650	05/02/24 S SELL 71172628	100.0000	0	208,650	208,650
6,242,872	05/03/24 B BUY 71172648	100.0000	0	6,242,872	6,242,872
188,068	05/06/24 S SELL 71172651	100.0000	0	188,068	188,068
2,574,506	05/07/24 S SELL 71172660	100.0000	0	2,574,506	2,574,506
613,604	05/08/24 S SELL 71172663	100.0000	0	613,604	613,604
291,460	05/09/24 S SELL 71172665	100.0000	0	291,460	291,460
973,206	05/10/24 B BUY 71172692	100.0000	0	973,206	973,206
244,508	05/13/24 S SELL 71172695	100.0000	0	244,508	244,508
887,866	05/14/24 S SELL 71172698	100.0000	0	887,866	887,866
394,070	05/15/24 S SELL 71172705	100.0000	0	394,070	394,070
277,915	05/16/24 S SELL 71172707	100.0000	0	277,915	277,915
4,507,330	05/17/24 B BUY 71172739	100.0000	0	4,507,330	4,507,330
208,579	05/20/24 S SELL 71172742	100.0000	0	208,579	208,579
2,726,811	05/21/24 S SELL 71172748	100.0000	0	2,726,811	2,726,811
316,998	05/22/24 S SELL 71172759	100.0000	0	316,998	316,998
1,676,956	05/23/24 B BUY 71172763	100.0000	0	1,676,956	1,676,956
520,266	05/24/24 S SELL 71172787	100.0000	0	520,266	520,266</

FD495			BP CONSOLIDATED WELFARE PLAN 504			PAGE	39
SCHEDULE H (FORM 5500 - 4J-3)						P 47376	
SCHEDULE OF REPORTABLE TRANSACTIONS						MARCH 31, 2024	
SERIES OF TRANSACTIONS IN SAME SECURITY			THROUGH			MARCH 31, 2025	
			BASED ON MARKET	VALUE OF	1,751,901	5% VALUE OF	87,595
			PURCHASE PRICE	EXPENSES	COST OF ASSET	CURRENT VALUE	NET GAIN
IDENTITY OF PARTY INVOLVED			SELLING PRICE				OR (LOSS)
1,068,647	06/03/24	S SELL 71172835	100.0000	0	1,068,647	1,068,647	0
544,059	06/04/24	S SELL 71172840	100.0000	0	544,059	544,059	0
2,436,742	06/05/24	S SELL 71172849	100.0000	0	2,436,742	2,436,742	0
173,935	06/06/24	S SELL 71172852	100.0000	0	173,935	173,935	0
419,175	06/07/24	B BUY 71172878	100.0000	0	419,175	419,175	0
394,996	06/10/24	S SELL 71172883	100.0000	0	394,996	394,996	0
713,512	06/11/24	S SELL 71172889	100.0000	0	713,512	713,512	0
757,772	06/12/24	S SELL 71172894	100.0000	0	757,772	757,772	0
220,586	06/13/24	S SELL 71172896	100.0000	0	220,586	220,586	0
7,753,766	06/14/24	B BUY 71172917	100.0000	0	7,753,766	7,753,766	0
207,823	06/17/24	S SELL 71172919	100.0000	0	207,823	207,823	0
1,445,754	06/18/24	S SELL 71172924	100.0000	0	1,445,754	1,445,754	0
815,151	06/20/24	S SELL 71172927	100.0000	0	815,151	815,151	0
241,850	06/21/24	B BUY 71172959	100.0000	0	241,850	241,850	0
3,037,713	06/24/24	S SELL 71172966	100.0000	0	3,037,713	3,037,713	0
1,273,408	06/25/24	S SELL 71172976	100.0000	0	1,273,408	1,273,408	0
697,990	06/26/24	S SELL 71172979	100.0000	0	697,990	697,990	0
1,286,238	06/27/24	S SELL 71172986	100.0000	0	1,286,238	1,286,238	0
4,314,648	06/28/24	B BUY 71173018	100.0000	0	4,314,648	4,314,648	0
2,773,040	07/01/24	S SELL 71173026	100.0000	0	2,773,040	2,773,040	0
626,184	07/02/24	S SELL 71173032	100.0000	0	626,184	626,184	0
355,839	07/03/24	S SELL 71173035	100.0000	0	355,839	355,839	0
3,145,919	07/05/24	B BUY 71173066	100.0000	0	3,145,919	3,145,919	0
759,025	07/08/24	S SELL 71173070	100.0000	0	759,025	759,025	0
881,908	07/09/24	S SELL 71173072	100.0000	0	881,908	881,908	0
397,276	07/10/24	S SELL 71173077	100.0000	0	397,276	397,276	0
218,901	07/11/24	S SELL 71173079	100.0000	0	218,901	218,901	0
1,313,435	07/12/24	B BUY 71173104	100.0000	0	1,313,435	1,313,435	0
371,763	07/15/24	S SELL 71173108	100.0000	0	371,763	371,763	0
499,949	07/16/24	S SELL 71173110	100.0000	0	499,949	499,949	0
664,919	07/17/24	S SELL 71173115	100.0000	0	664,919	664,919	0
328,950	07/18/24	S SELL 71173117	100.0000	0	328,950	328,950	0
4,995,600	07/19/24	B BUY 71173142	100.0000	0	4,995,600	4,995,600	0
2,004,949	07/22/24	S SELL 71173145	100.0000	0	2,004,949	2,004,949	0
610,477	07/23/24	S SELL 71173151	100.0000	0	610,477	610,477	0
1,093,318	07/24/24	B BUY 71173164	100.0000	0	1,093,318	1,093,318	0
196,559	07/25/24	S SELL 71173166	100.0000	0	196,559	196,559	0
860,749	07/26/24	S SELL 71173186	100.0000	0	860,749	860,749	0
469,220	07/29/24	S SELL 71173197	100.0000	0	469,220	469,220	0
2,705,560	07/30/24	S SELL 71173208	100.0000	0	2,705,560	2,705,560	0
6,410,385	07/31/24	B BUY 71173225	100.0000	0	6,410,385	6,410,385	0
2,143,448	08/01/24	S SELL 71173234	100.0000	0	2,143,448	2,143,448	0
1,768,287	08/02/24	B BUY 71173259	100.0000	0	1,768,287	1,768,287	0
1,275,180	08/05/24	S SELL 71173272	100.0000	0	1,275,180	1,275,180	0
3,450,109	08/06/24	S SELL 71173279	100.0000	0	3,450,109	3,450,109	0
901,360	08/07/24	S SELL 71173281	100.0000	0	901,360	901,360	0
3,311,419	08/08/24	B BUY 71173285	100.0000	0	3,311,419	3,311,419	0
JPMorgan Investor Services			J.P.Morgan				

FD495 SCHEDULE H (FORM 5500 - 4J-3) SCHEDULE OF REPORTABLE TRANSACTIONS SERIES OF TRANSACTIONS IN SAME SECURITY			BP CONSOLIDATED WELFARE PLAN 504			PAGE 40 P 47376 MARCH 31, 2024 MARCH 31, 2025	
			THROUGH				
				1,751,901	5% VALUE OF	87,595	
				COST OF ASSET	CURRENT VALUE	NET GAIN	
						OR (LOSS)	
DESCRIPTION OF ASSET			BASED ON MARKET	VALUE OF			
IDENTITY OF PARTY INVOLVED			PURCHASE PRICE	EXPENSES			
			SELLING PRICE				
1,339,715	08/09/24	S SELL 71173307	100.0000	0	1,339,715	1,339,715	0
264,165	08/12/24	S SELL 71173313	100.0000	0	264,165	264,165	0
1,064,650	08/13/24	S SELL 71173315	100.0000	0	1,064,650	1,064,650	0
533,161	08/14/24	S SELL 71173318	100.0000	0	533,161	533,161	0
812,924	08/15/24	S SELL 71173320	100.0000	0	812,924	812,924	0
5,030,309	08/16/24	B BUY 71173348	100.0000	0	5,030,309	5,030,309	0
546,714	08/19/24	S SELL 71173353	100.0000	0	546,714	546,714	0
756,913	08/20/24	S SELL 71173356	100.0000	0	756,913	756,913	0
608,341	08/21/24	S SELL 71173358	100.0000	0	608,341	608,341	0
267,756	08/22/24	S SELL 71173361	100.0000	0	267,756	267,756	0
2,476,274	08/23/24	B BUY 71173388	100.0000	0	2,476,274	2,476,274	0
435,685	08/26/24	S SELL 71173397	100.0000	0	435,685	435,685	0
1,893,229	08/27/24	S SELL 71173414	100.0000	0	1,893,229	1,893,229	0
558,643	08/28/24	S SELL 71173417	100.0000	0	558,643	558,643	0
1,638,066	08/29/24	S SELL 71173424	100.0000	0	1,638,066	1,638,066	0
3,993,740	08/30/24	B BUY 71173449	100.0000	0	3,993,740	3,993,740	0
2,490,902	09/03/24	S SELL 71173461	100.0000	0	2,490,902	2,490,902	0
2,991,218	09/04/24	S SELL 71173467	100.0000	0	2,991,218	2,991,218	0
7,147,316	09/05/24	B BUY 71173473	100.0000	0	7,147,316	7,147,316	0
2,734,283	09/06/24	S SELL 71173498	100.0000	0	2,734,283	2,734,283	0
414,133	09/09/24	S SELL 71173502	100.0000	0	414,133	414,133	0
689,201	09/10/24	S SELL 71173506	100.0000	0	689,201	689,201	0
480,568	09/11/24	S SELL 71173508	100.0000	0	480,568	480,568	0
866,733	09/12/24	S SELL 71173516	100.0000	0	866,733	866,733	0
3,130,751	09/13/24	B BUY 71173536	100.0000	0	3,130,751	3,130,751	0
760,684	09/16/24	S SELL 71173540	100.0000	0	760,684	760,684	0
705,905	09/17/24	S SELL 71173543	100.0000	0	705,905	705,905	0
563,377	09/18/24	S SELL 71173546	100.0000	0	563,377	563,377	0
323,557	09/19/24	S SELL 71173548	100.0000	0	323,557	323,557	0
4,780,844	09/20/24	B BUY 71173576	100.0000	0	4,780,844	4,780,844	0
223,460	09/23/24	S SELL 71173579	100.0000	0	223,460	223,460	0
3,876,902	09/24/24	S SELL 71173585	100.0000	0	3,876,902	3,876,902	0
588,381	09/25/24	S SELL 71173588	100.0000	0	588,381	588,381	0
774,009	09/26/24	S SELL 71173595	100.0000	0	774,009	774,009	0
438,807	09/27/24	B BUY 71173635	100.0000	0	438,807	438,807	0
4,561,307	09/30/24	B BUY 71173652	100.0000	0	4,561,307	4,561,307	0
2,374,180	10/01/24	S SELL 71173659	100.0000	0	2,374,180	2,374,180	0
546,897	10/02/24	S SELL 71173665	100.0000	0	546,897	546,897	0
312,887	10/03/24	S SELL 71173667	100.0000	0	312,887	312,887	0
2,102,830	10/04/24	B BUY 71173694	100.0000	0	2,102,830	2,102,830	0
403,365	10/07/24	S SELL 71173697	100.0000	0	403,365	403,365	0
3,542,796	10/08/24	S SELL 71173704	100.0000	0	3,542,796	3,542,796	0
717,753	10/09/24	S SELL 71173707	100.0000	0	717,753	717,753	0
3,964,873	10/10/24	B BUY 71173716	100.0000	0	3,964,873	3,964,873	0
770,184	10/11/24	S SELL 71173739	100.0000	0	770,184	770,184	0
1,487,329	10/15/24	S SELL 71173743	100.0000	0	1,487,329	1,487,329	0
363,552	10/16/24	S SELL 71173746	100.0000	0	363,552	363,552	0
JPMorgan Investor Services			J.P.Morgan				

FD495			BP CONSOLIDATED WELFARE PLAN 504			PAGE 41	
SCHEDULE H (FORM 5500 - 4J-3)						P 47376	
SCHEDULE OF REPORTABLE TRANSACTIONS						MARCH 31, 2024	
SERIES OF TRANSACTIONS IN SAME SECURITY			THROUGH			MARCH 31, 2025	

FD495 SCHEDULE H (FORM 5500 - 4J-3) SCHEDULE OF REPORTABLE TRANSACTIONS SERIES OF TRANSACTIONS IN SAME SECURITY					BP CONSOLIDATED WELFARE PLAN 504		PAGE 42 P 47376 MARCH 31, 2024 MARCH 31, 2025		
					THROUGH				
					BASED ON MARKET VALUE OF	1,751,901	5% VALUE OF	87,595	
					PURCHASE PRICE	COST OF ASSET	CURRENT VALUE	NET GAIN	
IDENTITY OF PARTY INVOLVED					SELLING PRICE			OR (LOSS)	
1,763,091	12/26/24	B	BUY	71174217	100.0000	0	1,763,091	1,763,091	0
585,222	12/27/24	S	SELL	71174237	100.0000	0	585,222	585,222	0
1,320,446	12/30/24	S	SELL	71174245	100.0000	0	1,320,446	1,320,446	0
27,167	12/31/24	S	SELL	71174252	100.0000	0	27,167	27,167	0
2,078,863	01/02/25	S	SELL	71174295	100.0000	0	2,078,863	2,078,863	0
49,481	01/03/25	S	SELL	71174319	100.0000	0	49,481	49,481	0
1,747,348	01/06/25	S	SELL	71174329	100.0000	0	1,747,348	1,747,348	0
4,599,941	01/07/25	B	BUY	71174338	100.0000	0	4,599,941	4,599,941	0
676,541	01/08/25	S	SELL	71174347	100.0000	0	676,541	676,541	0
422,579	01/09/25	S	SELL	71174348	100.0000	0	422,579	422,579	0
1,283,798	01/10/25	S	SELL	71174374	100.0000	0	1,283,798	1,283,798	0
542,741	01/13/25	S	SELL	71174379	100.0000	0	542,741	542,741	0
912,792	01/14/25	S	SELL	71174382	100.0000	0	912,792	912,792	0
795,904	01/15/25	S	SELL	71174384	100.0000	0	795,904	795,904	0
201,710	01/16/25	S	SELL	71174386	100.0000	0	201,710	201,710	0
6,385,658	01/17/25	B	BUY	71174419	100.0000	0	6,385,658	6,385,658	0
427,139	01/21/25	S	SELL	71174423	100.0000	0	427,139	427,139	0
1,184,551	01/22/25	S	SELL	71174426	100.0000	0	1,184,551	1,184,551	0
357,384	01/23/25	S	SELL	71174429	100.0000	0	357,384	357,384	0
770,085	01/24/25	B	BUY	71174452	100.0000	0	770,085	770,085	0
1,195,162	01/27/25	S	SELL	71174458	100.0000	0	1,195,162	1,195,162	0
695,971	01/28/25	S	SELL	71174462	100.0000	0	695,971	695,971	0
981,679	01/29/25	S	SELL	71174470	100.0000	0	981,679	981,679	0
623,566	01/30/25	S	SELL	71174481	100.0000	0	623,566	623,566	0
1,888,334	01/31/25	B	BUY	71174516	100.0000	0	1,888,334	1,888,334	0
1,939,015	02/03/25	S	SELL	71174526	100.0000	0	1,939,015	1,939,015	0
1,635,182	02/04/25	S	SELL	71174539	100.0000	0	1,635,182	1,635,182	0
522,879	02/05/25	S	SELL	71174541	100.0000	0	522,879	522,879	0
517,458	02/06/25	S	SELL	71174544	100.0000	0	517,458	517,458	0
1,513,772	02/07/25	B	BUY	71174569	100.0000	0	1,513,772	1,513,772	0
518,760	02/10/25	S	SELL	71174576	100.0000	0	518,760	518,760	0
1,164,179	02/11/25	S	SELL	71174579	100.0000	0	1,164,179	1,164,179	0
1,224,805	02/12/25	B	BUY	71174583	100.0000	0	1,224,805	1,224,805	0
795,535	02/13/25	S	SELL	71174586	100.0000	0	795,535	795,535	0
6,023,310	02/14/25	B	BUY	71174616	100.0000	0	6,023,310	6,023,310	0
2,087,008	02/18/25	S	SELL	71174620	100.0000	0	2,087,008	2,087,008	0
1,171,269	02/19/25	S	SELL	71174625	100.0000	0	1,171,269	1,171,269	0
376,336	02/20/25	S	SELL	71174628	100.0000	0	376,336	376,336	0
5,461,726	02/21/25	B	BUY	71174652	100.0000	0	5,461,726	5,461,726	0
852,994	02/24/25	S	SELL	71174656	100.0000	0	852,994	852,994	0
3,695,269	02/25/25	S	SELL	71174663	100.0000	0	3,695,269	3,695,269	0
743,426	02/26/25	S	SELL	71174666	100.0000	0	743,426	743,426	0
946,872	02/27/25	S	SELL	71174682	100.0000	0	946,872	946,872	0
2,853,881	02/28/25	B	BUY	71174715	100.0000	0	2,853,881	2,853,881	0
1,884,173	03/03/25	S	SELL	71174724	100.0000	0	1,884,173	1,884,173	0
873,741	03/04/25	S	SELL	71174731	100.0000	0	873,741	873,741	0
456,895	03/05/25	S	SELL	71174733	100.0000	0	456,895	456,895	0
JPMorgan Investor Services					J.P.Morgan				

FD495 SCHEDULE H (FORM 5500 - 4J-3) SCHEDULE OF REPORTABLE TRANSACTIONS SERIES OF TRANSACTIONS IN SAME SECURITY				BP CONSOLIDATED WELFARE PLAN 504		THROUGH		PAGE 43 P 47376 MARCH 31, 2024 MARCH 31, 2025
DESCRIPTION OF ASSET IDENTITY OF PARTY INVOLVED				BASED ON MARKET PURCHASE PRICE SELLING PRICE	VALUE OF EXPENSES	1,751,901 COST OF ASSET	5% VALUE OF CURRENT VALUE	87,595 NET GAIN OR (LOSS)
359,328	03/06/25	S SELL	71174736	100.0000	0	359,328	359,328	0
2,533,989	03/07/25	B BUY	71174766	100.0000	0	2,533,989	2,533,989	0
1,066,242	03/10/25	S SELL	71174772	100.0000	0	1,066,242	1,066,242	0
1,171,129	03/11/25	S SELL	71174775	100.0000	0	1,171,129	1,171,129	0
658,914	03/12/25	S SELL	71174778	100.0000	0	658,914	658,914	0
257,029	03/13/25	S SELL	71174781	100.0000	0	257,029	257,029	0
7,997,541	03/14/25	B BUY	71174813	100.0000	0	7,997,541	7,997,541	0
463,844	03/17/25	S SELL	71174817	100.0000	0	463,844	463,844	0
905,095	03/18/25	S SELL	71174820	100.0000	0	905,095	905,095	0
792,625	03/19/25	S SELL	71174823	100.0000	0	792,625	792,625	0
776,925	03/20/25	S SELL	71174827	100.0000	0	776,925	776,925	0
280,932	03/21/25	S SELL	71174861	100.0000	0	280,932	280,932	0
465,069	03/24/25	S SELL	71174864	100.0000	0	465,069	465,069	0
797,846	03/25/25	S SELL	71174867	100.0000	0	797,846	797,846	0
532,821	03/26/25	S SELL	71174877	100.0000	0	532,821	532,821	0
276,112	03/27/25	S SELL	71174880	100.0000	0	276,112	276,112	0
262,772	03/28/25	S SELL	71174907	100.0000	0	262,772	262,772	0
399,411	03/31/25	S SELL	71174916	100.0000	0	399,411	399,411	0
192,119,343	55	TOTAL BUYS			0	192,119,343	192,119,343	0
190,307,658	195	TOTAL SELLS			0	190,307,658	190,307,658	0
382,427,001		SECURITY TOTAL			0	382,427,001	382,427,001	0
JPMorgan Investor Services				J.P.Morgan				

BP CONSOLIDATED WELFARE BENEFIT PLAN

SCHEDULE H, LINE 4i – SCHEDULE OF ASSETS (HELD AT END OF YEAR)

March 31, 2025

Identity of Issue, Borrower, Lessor or Similar Party	Description of Investment, including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value	Cost	Current Value
* JPMorgan Chase Bank	JPMorgan U.S. Government Money Market Fund - Capital Shares	\$4,143,950	\$4,143,950

* Indicates party-in-interest.