Benefits Open Enrollment Guide

PRE-65 RETIREES

2018

BENEFITS SERVICE CENTER
Your Life. Your Benefits.

Benefits Open Enrollment

BENEFITS SERVICE CENTER
Your Life. Your Benefits.

BENEFITS OPEN ENROLLMENT:

November 1 - November 15, 2017

2018

It's About ...

*Your **Life.** Your **Benefits.***

Benefits Open Enrollment is Here

As a Pre-65 Retiree, your benefits are valuable and provide important protection for you and your family in the case of illness or injury. This Benefits Open Enrollment Guide covers highlights of what you need to know to help you make informed choices as you enroll in your 2018 benefits.

Don't worry! Your benefit options can be confusing. There are plenty of resources available to find out about Benefits Open Enrollment:

- Visit www.myMPCbenefits.com.
- Access the Summary Plan Descriptions (SPDs) and Summaries of Benefits and Coverage (SBCs), available at www.myMPCbenefits.com under "Notices and Plan Documents."
- Join us on Facebook at https://www.facebook.com/groups/mympcbenefits.
- Contact the Benefits Service Center at 1-888-421-2199 or send an email to benefits@marathonpetroleum.com.

Make sure you understand all your options so that you can make the best choices for you and your family. Then enroll in your 2018 benefits.
It's about … Your Life. Your Benefits.

Remember this is your only opportunity to make changes to your benefit plans, unless you have a qualifying life event.

PRINTED SUMMARY PLAN DESCRIPTIONS (SPDs) AND SUMMARIES OF BENEFITS AND COVERAGE (SBCs) AVAILABLE

We have posted the SPDs and SBCs online to help ensure you have easy access to your benefits information. If you prefer to receive a printed copy of the SPDs or SBCs, we will provide one to you at no charge. Contact the MPC Benefits Service Center at 1-888-421-2199 or benefits@marathonpetroleum.com to request a printed copy.

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The Company's policies, plans, practices and procedures may be amended, terminated or changed at any time at the sole discretion of the Company. If that should occur, the material in this document will be superseded and the provisions of the official plan documents will be followed. If there are discrepancies between this document and the official plan documents, the official plan documents will always govern.

Electing Changes — What You Need to Do

Benefits Open Enrollment is November 1 – 15, 2017. Here's how to tell if you need to do anything:

Understand Your Options

- **Read** this guide to find out what's changing for 2018.
- **Review** the enclosed Personalized Benefits Summary in your Benefits Open Enrollment packet.
- **Contact** Marathon Petroleum's Benefits Service Center with any questions.
- **Access** detailed information about all of Marathon Petroleum's benefit plans, including Summary Plan Descriptions (SPDs) and Summaries of Benefits and Coverage (SBCs) at www.myMPCbenefits.com under "Notices and Plan Documents."

Answer These Questions

- Do you want to change your Health Plan option?
- Do you need to add or remove a dependent from coverage?
- Do you want to change any of your current coverages?

YES

Enroll

- Enroll or make changes to your benefit elections. See the next two pages for enrollment instructions.
- Contact the Benefits Service Center if you have any questions during your enrollment process. Simply call 1-888-421-2199 Monday through Friday, 8 a.m. to 5 p.m., Eastern Time, or send an email to benefits@marathonpetroleum.com.

NO

You're Done

- Your current elections will roll over for 2018.

Remember!

Benefits Open Enrollment is November 1 – 15, 2017. This is your only opportunity to make changes to your benefits, unless you experience a qualifying life event.

Making Your 2018 Benefit Plan Elections

You have three ways to enroll or make changes to your benefit plan elections.

1 Email

- Scan your enclosed Personalized Benefits Summary and email it to the Benefits Service Center at benefits@marathonpetroleum.com or complete a Pre-65 Retiree Benefits Enrollment/Change Form (available at www.myMPCbenefits.com).

2 Phone

Contact the Benefits Service Center at 1-888-421-2199 and speak with a Benefits Service Center counselor Monday – Friday, 8 a.m. to 5 p.m., Eastern Time.

PHONE TIPS

Call volume is heavy during Benefits Open Enrollment. We typically return all calls within 24 hours.

If you leave a message:

- Follow the prompts to enter your callback phone number.
- Leave your name and former employee number.
- **Please allow a full 24 hours for your call to be returned.**

3 Paper

- Mark any desired changes on the Personalized Benefits Summary and return in the enclosed envelope. You can also scan and fax your summary to 419-421-3057.

After You Complete Your Enrollment

Review Your Benefits Confirmation:

- Your Benefits Confirmations for 2018 elections will be printed and mailed daily, to reflect changes entered that day.
- If you make additional changes and receive multiple confirmations, be sure to keep the one with the most recent date.
- Review it carefully and if it does not reflect the changes you want to make for 2018, call the Benefits Service Center **immediately** at 1-888-421-2199 or send an email to benefits@marathonpetroleum.com.

Managing Health Care Benefits

At Marathon Petroleum, we invest considerable time and effort when determining employee premiums and benefit plan design. This process includes tabulating costs, projecting future expenses, and ensuring our benefits are market-competitive. Having members who are engaged in learning about and understanding their benefits and utilizing available plan features is an important piece in managing our health care benefits.

We work extensively with our vendor partners to strategically participate in programs that save Health Plan dollars; the Health Plan is funded 80% by Company contributions and 20% by member premiums.

Both Anthem and Express Scripts offer numerous programs designed to help provide the best value of care and save money at the same time. Marathon Petroleum chooses which programs to participate in based on a number of factors; two considerations include savings to the Health Plan (and members alike) and burden to the members. If a program would cause too large of a burden to plan members without a large enough return, the Company does not choose to participate in the program. Below are the 2016 results of some of the programs that Marathon Petroleum chose to adopt.

- In 2016, Anthem's Sleep Program conducted clinical reviews and provided for redirection to home studies where applicable. This saved approximately $195,000 in Health Plan costs.
- Best Doctors, our second opinion service, helped to confirm, modify or redirect medical care, saving the Health Plan over $826,000.
- ScreenRx, an Express Scripts program designed to improve medication adherence, reduce avoidable medical care, and address other specific behavioral, clinical and cost barriers to medication issues saved nearly $249,000 in Health Plan costs.
- Additionally, Express Scripts diligently manages prescriptions for Marathon Petroleum. This process will sometimes require obtaining extra approval from your physician for a medication or possibly trying a generic or another similar medication. Express Scripts pharmacists also look for harmful drug interactions of medication combinations. While these programs may sometimes be individually challenging, they saved the Health Plan over $8.2 million in 2016.
- Another way we save money on prescriptions is with a Specialty Pharmacy. Many of our members utilize what are called "Specialty Drugs" which, in general, are very expensive or rare prescriptions. Express Scripts' Specialty Pharmacy, Accredo, manages these prescriptions for our members and saved over $3 million in 2016.

Doing Your Part to Manage Costs

The following four easy action items can help all of us work together toward being healthier, knowledgeable health care consumers.

Getting preventive health care. Ensure that you are living well by utilizing the Health Plan for preventive services covered at 100%, including vaccinations and screening tests. Taking care of yourself and utilizing these services are the best defense against more costly treatment resulting from illness or injuries left untreated.

Knowing what Levels of Care are available to you. Being enrolled in the Health Plan provides you a number of options if you or a covered dependent aren't feeling well. Understanding your options can save you time and money when you need care.

Medical Action	Classic co-pays	Saver (before/after deductible is met)
Anthem's 24/7 Nurseline	$0	$0
Anthem's LiveHealth Online	$10	$49/$9.80
Doctor's Office	$20	$125*/$25
Urgent Care	$50	$190*/$38
Emergency Room**	$200 then deductible + 20%	Deductible then $200 + 20%

*average cost of doctor's/urgent care visit
**average cost of ER visit is $1,200

LEVELS OF CARE

This chart represents the choices available to you and the associated costs, depending on your Health Plan option. The Anthem Nurseline is 1-888-596-9473 and can be found on the back of your Anthem card; you can download the LiveHealth Online app to use the service on your phone or computer.

Staying on track with medications. Not adhering to recommended dosages and medication schedules for chronic conditions (such as coronary heart disease, diabetes, high blood pressure, etc.) can negatively impact your health. This can also cause the Health Plan and its members to incur unnecessary expenses when a condition is exacerbated and needs extra medical care.

Shopping for health care. Most health care services are shoppable, meaning that just as you shop for better pricing on other large expenses, you can shop for better pricing for your health care needs as well. Marathon Petroleum has participated in Anthem's AIM program since 2015. This is a cost and quality program that helps you find low-cost providers for certain diagnostic services, such as CT scans, MRI scans and sleep apnea testing.

Here's how it works:

- The doctor lets Anthem know you will have a diagnostic procedure.
- Anthem will check to see if the provider who will perform the procedure offers a low cost for the service in your area. Anthem will also check other area providers.
- If the provider doesn't offer a low cost, Anthem will contact you to alert you to lower-cost providers nearby.
- You choose the provider that best meets your needs, whether it's the one recommended by your doctor or suggested by Anthem. There is no penalty if you choose not to take advantage of Anthem's suggestion.
- Members can also contact AIM at the High Tech Imaging Pre Cert number on the back of your card: 1-888-953-6703.

What's Changing

Benefit Updates for 2018

The following benefit changes will be effective January 1, 2018. Changes are highlighted in blue.

Update on **Pre-65 Retiree Premiums**

Premiums will **increase** for both Health Plan options. Premiums for the Dental and Vision Plans will **remain the same** for 2018.

	PRE-65 RETIREE HEALTH PLAN *CLASSIC OPTION*		PRE-65 RETIREE HEALTH PLAN *SAVER HSA OPTION*	
	2017	2018	2017	2018
Employee Only	$162	$170	$111	$116
Employee + Spouse	$325	$339	$220	$230
Employee + Children	$325	$339	$220	$230
Employee + Family	$487	$509	$331	$346

Update on **Health Plan Design**

There are a few changes for 2018. The deductible is **increasing** for both options and the out-of-pocket maximum is **increasing** for the Classic option. The ER copay is also **increasing** for both options.

	HEALTH PLAN-CLASSIC OPTION *IN-NETWORK BENEFITS*		HEALTH PLAN-SAVER HSA OPTION *IN-NETWORK BENEFITS*	
	2017	2018	2017	2018
Deductible	$500 Individual	$600 Individual	$1,350 Retiree Only	$1,400 Retiree Only
	$1,000 Family	$1,200 Family	$2,700 Retiree + Dependents**	$2,800 Retiree + Dependents**
Out-of-Pocket (OOP Maximum)*	$3,000 Individual	$3,500 Individual	$5,000 Individual	$5,000 Individual
	$6,000 Family	$7,000 Family	$10,000 Family	$10,000 Family
Coinsurance	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible
Office Visit	$20 for primary care; $50 for specialist and urgent care	$20 for primary care; $50 for specialist and urgent care	You pay 20% after deductible	You pay 20% after deductible
Preventive Services	Plan covers at 100% (no deductible)	Plan covers at 100% (no deductible)	Plan covers at 100% (no deductible)	Plan covers at 100% (no deductible)
ER Charge	$150 charge, then deductible plus 20% coinsurance	$200 charge, then deductible plus 20% coinsurance	Deductible, then $150 charge, then 20% coinsurance	Deductible, then $200 charge, then 20% coinsurance

*Medical and prescription drug expenses will apply toward meeting the out-of-pocket maximum.

**Retiree + Dependents covers Retiree + Spouse, Retiree + Child(ren) and Retiree + Family.

(continued)

	HEALTH PLAN-CLASSIC OPTION *OUT-OF-NETWORK BENEFITS*		HEALTH PLAN-SAVER HSA OPTION *OUT-OF-NETWORK BENEFITS*	
	2017	**2018**	**2017**	**2018**
Deductible	$1,000 Individual	$1,200 Individual	$2,700 Employee Only	$2,800 Employee Only
	$2,000 Family	$2,400 Family	$5,400 Employee + Dependents**	$5,600 Employee + Dependents**
Out-of-Pocket (OOP Maximum)*	$6,000 Individual	$7,000 Individual	$10,000 Individual	$10,000 Individual
	$12,000 Family	$14,000 Family	$20,000 Family	$20,000 Family
Coinsurance	You pay 40% after deductible	You pay 40% after deductible	You pay 40% after deductible	You pay 40% after deductible
Office Visit	You pay 40% after deductible	You pay 40% after deductible	You pay 40% after deductible	You pay 40% after deductible
Preventive Services	You pay 40% after deductible	You pay 40% after deductible	You pay 40% after deductible	You pay 40% after deductible
ER Charge	$150 charge, then deductible plus 20% coinsurance	$200 charge, then deductible plus 20% coinsurance	Deductible, then $150 charge, then 20% coinsurance	Deductible, then $200 charge, then 20% coinsurance

*Medical and prescription drug expenses apply toward meeting the out-of-pocket maximum.
**Employee + Dependents covers Employee + Spouse, Employee + Child(ren) and Employee + Family.

Update on **Health Plan Benefits**

Smart90 - Walgreens

Members may now obtain 90-day supplies at a Walgreens pharmacy via the Smart90-Walgreens program. Walgreens is now an in-network pharmacy for Marathon Petroleum prescription coverage. Members may continue to utilize the Express Scripts mail order pharmacy.

Maintenance Medications

To encourage the use of mail order or Smart90-Walgreens and to mitigate plan costs, 30-day supplies of maintenance medications will be limited to **TWO** fills at any in-network retail pharmacy. Members who continue to use retail pharmacies to obtain 30-day supplies will pay 100% of the prescription cost; the amount paid will not count toward the member's coinsurance or out-of-pocket maximum.

THAT'S ALL THE CHANGES FOR 2018

You've now read about all the benefit updates and changes for 2018. The rest of this booklet contains details of the benefits plans, useful contacts, dependent eligibility rules and important notices, which will assist you as you review your benefits coverage to identify any changes you may want to make in 2018.

Benefit Plans

Health Plan Options

Marathon Petroleum's Health Plan, administered by **Anthem BlueCross BlueShield** (for medical expenses) and **Express Scripts** (for prescription drug coverage), offers two options: Classic and Saver HSA. Both options:

- Offer the same Anthem preferred provider network.
- Cover the same services.
- Cover in-network preventive care at 100%, with no deductible.

The primary difference between the two options is how you pay for your health care expenses, so the Classic and Saver HSA options will have different premiums, deductibles and out-of-pocket maximum limits, as shown on page 12. The following chart offers a side-by-side comparison of the Classic and Saver HSA options.

Key Health Plan Option Features	Classic *"Pay up-front"*	Saver HSA *"Pay as you go"*
Premiums and Deductibles	• Higher monthly premiums, but lower deductibles and out-of-pocket maximums. • With Family coverage, until the family deductible is met, each covered family member must meet the individual deductible before the Health Plan starts paying coinsurance.	• Lower monthly premiums, but higher deductibles and out-of-pocket maximums. • With Retiree + Dependents* coverage, once any combination of covered family members reaches the annual deductible, the Health Plan starts paying coinsurance for all family members. • Qualifies as a High Deductible Health Plan (HDHP).
Copays and Coinsurance	Includes copays instead of coinsurance for office visits and prescription drugs. Coinsurance applies for all other services.	No copays; only coinsurance.
Prescription Drug Coverage	• Separate deductibles for medical and retail prescription drugs. • Prescription drugs have copays (retail drugs are subject to a smaller, separate deductible that must be met before copays apply).	• Annual deductible includes both medical and prescription drug expenses. • Certain generic preventive drugs covered at 100%. (The list of these drugs can be found on www.myMPCbenefits.com.) • You pay all your medical and prescription drug costs in full until you reach your deductible (with the exception of preventive care and certain generic preventive medications). • You pay 20% after deductible for retail and mail-order drugs.

*Retiree + Dependents covers Retiree + Spouse, Retiree + Child(ren) and Retiree + Family.

(continued)

Key Health Plan Option Features	Classic *"Pay up-front"*	Saver HSA *"Pay as you go"*
Health Savings Account	Not available.	• Offers a portable Health Savings Account (HSA) that includes triple-tax advantages. • Company contributes $350 for Retiree Only coverage or $700 for Retiree + Dependents coverage*.
Out-of-Pocket Maximums	**Both Health Plan options** have in-network out-of-pocket maximums. So whichever option you choose, the most you'll pay for covered in-network medical (including prescription drug) expenses out of your own pocket in a calendar year is the out-of-pocket maximum for your selected Health Plan option. With Family coverage, until the family out-of-pocket maximum is met, each covered family member must meet the individual out-of-pocket maximum for the Plan to begin paying at 100% for that individual.	

*Retiree + Dependents covers Retiree + Spouse, Retiree + Child(ren) and Retiree + Family.

QUALIFYING LIFE EVENTS

If you have a qualifying life event (e.g., change in other coverage, divorce or your spouse's retirement), you have **60 days** to notify the Marathon Petroleum Benefits Service Center of the event, change your benefit elections, provide appropriate documentation, and have your premiums adjusted accordingly. The change in benefits elections must be due to, and consistent with, the qualifying life event. To ensure you have the right coverage and are paying the appropriate premiums for your needs, be sure to notify the Benefits Service Center of any qualifying life event within 60 days.

2018 Health Plan Monthly Retiree Contributions

Monthly contribution amounts for the Classic and Saver HSA Health Plan options shown below are for retirees with 100% of the Company subsidy. Your specific rates, based on your earned percentage of the Company subsidy, can be found on your "Personalized Benefits Summary." You can find a complete list of the accrual rates on www.myMPCbenefits.com.

	Monthly Contributions	
	Classic Option	**Saver HSA Option**
Retiree Only	$170	$116
Retiree + Spouse	$339	$230
Retiree + Children	$339	$230
Family	$509	$346

Company Contribution to Health Savings Account

	Classic Option	**Saver HSA Option**
HSA Funding	None	$350 Retiree Only/ $700 Retiree + Dependents**

2018 Health Plan Options Comparison

Health Plan (includes Medical, Surgical, Mental Health and Substance Use Disorder)

	Classic Option ***In-network benefits***	**Saver HSA Option** ***In-network benefits***
Deductible	$600 Individual	$1,400 Retiree Only
	$1,200 Family	$2,800 Retiree + Dependents**
Out-of-Pocket (OOP) Maximum*	$3,500 Individual	$5,000 Individual
	$7,000 Family	$10,000 Family
Coinsurance	You pay 20% after deductible	You pay 20% after deductible
Office Visit	$20 for primary care; $50 for specialist and urgent care	You pay 20% after deductible
Preventive Services	Plan covers at 100% (no deductible)	Plan covers at 100% (no deductible)
ER Charge	$200 charge, then deductible plus 20% coinsurance	Deductible, then $200 charge, then 20% coinsurance

*Medical and prescription drug expenses will apply toward meeting the out-of-pocket maximum.
**Retiree + Dependents covers Retiree + Spouse, Retiree + Child(ren) and Retiree + Family.

	Classic Option *Out-of-network benefits*	Saver HSA Option *Out-of-network benefits*
Deductible	$1,200 Individual	$2,800 Retiree Only
	$2,400 Family	$5,600 Retiree + Dependents**
Out-of-Pocket (OOP) Maximum*	$7,000 Individual	$5,000 Individual
	$14,000 Family	$10,000 Family
Coinsurance	You pay 40% after deductible	You pay 40% after deductible
Office Visit	You pay 40% after deductible	You pay 40% after deductible
Preventive Services	You pay 40% after deductible	You pay 40% after deductible
ER Charge	$200 charge, then deductible plus 20% coinsurance	Deductible, then $200 charge, then 20% coinsurance

*Medical and prescription drug expenses will apply toward meeting the out-of-pocket maximum.
**Retiree + Dependents covers Retiree + Spouse, Retiree + Child(ren) and Retiree + Family.

Prescription Drugs (Rx)

Marathon Petroleum's prescription drug coverage for both Health Plan options is administered by **Express Scripts**. You will automatically receive prescription drug coverage if you enroll in either Health Plan option. Your prescription drug costs will depend on the Health Plan option you elect, whether you purchase at a retail pharmacy or through mail order, and the type of prescription drugs you buy (i.e., generic or brand name).

All prescription and specialty drugs **MUST** be purchased through Express Scripts Mail Order or at a Participating Network Pharmacy, or there will be no coverage from the Plan.

Members may now receive 90-day supplies through a Walgreens pharmacy or the Express Scripts mail order pharmacy. Walgreens is now an in-network pharmacy for the Marathon Petroleum prescription plan.

	Classic Option	Saver HSA Option
Out-of-Pocket Maximum	Combined with medical	
Prescription Annual Deductible	Retail Only — $100 Individual; $200 Family	Combined with medical
Retail (30-day supply) • **Generic Drugs** • **Preferred Brand Drugs** • **Non-Preferred Brand Drugs**	 $10 after deductible $30 after deductible $60 after deductible	You pay 20% after deductible*
Mail Order or Smart90 (90-day supply): • **Generic Drugs*** • **Preferred Brand Drugs (includes Specialty Drugs)** • **Non-Preferred Brand Drugs**	 $25 $75 $150	You pay 20% after deductible*

* Certain generic preventive drugs under the Saver HSA option are covered at 100%. A list of these drugs can be found at www.myMPCbenefits.com.

** To encourage the use of Mail Order or Smart90 - Walgreens, there will be no coverage for the third and subsequent fills of a "maintenance drug" purchased at other participating retail pharmacies. You will pay 100% of the cost of the medication.

Health Savings Account (HSA)

A Health Savings Account, administered by **Fidelity**, is a triple-tax-advantaged account that you can use to pay for qualified health-related expenses, including copays, coinsurance and deductibles for medical, prescription drug, dental and vision expenses. You are eligible to participate in an HSA only if you enroll in the **Saver HSA option** of the Health Plan.

If you have a Fidelity HSA through MPC, Marathon Petroleum contributes $350 for Retiree Only coverage or $700 for Retiree + Dependents coverage to your HSA, and the Company contributes to your HSA each year that you enroll in the Saver HSA Option. You can also make pre-tax contributions to your HSA, up to the IRS limits. For 2018, the IRS limits are:

- $3,450 for Retiree Only coverage ($350 MPC contribution + $3,100 retiree contribution).
- $6,900 for Retiree + Dependents coverage ($700 MPC contribution + $6,200 retiree contribution).
- Plus an additional $1,000 in catch-up contributions if you're over age 55.

You manage this account. You can choose to save and invest the money with tax-free earnings or use it to pay eligible expenses during the year, up to your current balance. If you have had an HSA with a previous health plan, you can transfer it to your Fidelity HSA.

Your HSA has a triple-tax advantage because:

- The contributions you make are pre-tax.
- Any investment earnings are tax-free.
- Payments from the account for qualified health care expenses are tax-free.

At any time, you may make an after-tax contribution to your Fidelity HSA, by transferring money online into your HSA from another Fidelity account or from an outside bank using electronic funds transfer (EFT), or by check. You may also call a Fidelity Representative to transfer money. You then report all contributions to your HSA on Form 8889 and file it with your Form 1040 or Form 1040NR.

HSA funds roll over from year to year and belong to you, so you will always have access to these funds. You do not need to submit receipts for reimbursement. However, it's recommended you save receipts and records in case the IRS requests proof that these funds were used for qualified health care expenses.

If you or your spouse will be 65 and/or Medicare eligible in the next year, special rules apply for the HSA. Please consult a tax advisor.

The HSA account is used to reimburse eligible health care expenses. To view a list of eligible HSA expenses for this account, refer to IRS Publication 502, which you can obtain through your local IRS office or from the IRS's website at www.irs.gov. Please be aware that the rules governing IRS-qualified health care expenses are subject to change from year to year.

Pre-65 Retiree Dental Plan

Marathon Petroleum's Pre-65 Retiree Dental Plan is administered by **Cigna Dental**. Under this Plan, you can save more when you receive care from a dentist in the Cigna Dental Preferred Provider Organization (DPPO) Advantage Network, since these dentists have agreed to give Plan members the largest discounts. To find a Cigna Advantage Network provider, call Cigna at 1-800-244-6224 or go to www.cigna.com. **This Plan is not open to new enrollment.**

2018 Pre-65 Retiree Dental Plan Monthly Contributions

Contribution amounts for the Pre-65 Retiree Dental Plan will **remain the same** for 2018.

	Retiree Only	Retiree + Spouse	Retiree + Children	Retiree + Family
Cigna Dental PPO	$23	$46	$50	$79

Pre-65 Retiree Dental Plan Overview

There are **no** Plan changes for 2018.

	In-Network	Out-of-Network
Calendar Year Maximum (Individual)	$1,000	
Calendar Year Deductible • Individual Maximum • Family Maximum	$50 per person N/A	
Preventive & Diagnostic Care: • Oral Exams • Cleanings • Routine and Non-Routine X-Rays • Sealants • Space Maintainers (limited to non-orthodontic treatments) • Emergency Care to Relieve Pain	Based on reduced contracted fees	Based on maximum allowable charge (in-network fee level)
Basic Restorative Care: • Fillings • Oral Surgery • Surgical Extraction of Impacted Teeth • Anesthetics • Major and Minor Periodontics • Root Canal Therapy/Endodontics • Relines, Rebases and Adjustments • Repairs: Bridges, Crowns and Inlays • Repairs: Dentures	You pay 20% after deductible is met	You pay 20% after deductible is met
Major Restorative Care: • Crowns/Inlays/Onlays • Dentures • Bridges	You pay 50% after deductible is met	You pay 50% after deductible is met
Orthodontic Care	Not covered	Not covered
Claims	ID cards are not issued for the Pre-65 Retiree Dental Plan. You or your provider files a claim form for reimbursement.	

The Pre-65 Retiree Dental Plan details and claim form can be found at www.myMPCbenefits.com.

*Out-of-network reimbursement amounts are limited to the amount that the Plan would reimburse for in-network care. As a result, individuals who use out-of-network dentists will be required to pay the balance of the charges not paid by the Plan. This is known as "balance billing."

**Coverage levels are not the same as in the active employee Dental Plan. Covered amounts are based on reduced contracted fees, referred to as "maximum allowable charges," and are generally lower than paid under the active employee Dental Plan.

Pre-65 Retiree Vision Plan

The Marathon Petroleum Vision Plan is administered by **Anthem Blue View Vision**. Vision coverage includes regular eye exams and the opportunity to purchase glasses and contact lenses at discounted rates. You can receive care from any licensed eye care professional, but if you see an Anthem in-network provider, you receive a higher level of benefits and there are no claim forms to file.

If you see an out-of-network provider, you receive a lesser discount on services and must file a claim for reimbursement. For a list of in-network providers, call Anthem at 1-866-723-0515 or visit www.Anthem.com. **This Plan is not open to new enrollment.**

2018 Pre-65 Retiree Vision Plan Monthly Contributions

Contribution amounts for the Pre-65 Retiree Vision Plan will **remain the same** for 2018.

	Retiree Only	Retiree + Spouse	Retiree + Children	Retiree + Family
Vision Plan	$7	$12	$13	$20

Pre-65 Retiree Vision Plan Overview

There are **no** Plan changes for 2018.

Plan Features	In-Network	Out-of-Network
Frequency of Service		
• Exams	Once every calendar year	Once every calendar year
• Lenses/Contacts	Once every calendar year	Once every calendar year
• Frames	Once every other calendar year	Once every other calendar year
Exams	No copay	Up to a maximum allowance of $35
Frames	No copay (Up to $130 retail)	Up to a maximum allowance of $45
Lenses		
• Single Vision	$10 copay	Up to a maximum allowance of $25
• Bifocal	$10 copay	Up to a maximum allowance of $40
• Trifocal	$10 copay	Up to a maximum allowance of $55
Contact Lenses (in lieu of prescription eyeglass lenses)	Up to a maximum allowance of $130 This benefit applies to one order of contact lenses per calendar year	Up to a maximum allowance of $105 This benefit applies to one order of contact lenses per calendar year

The Pre-65 Retiree Vision Plan details and the out-of-network claim form can be found at www.myMPCbenefits.com.

Useful Contacts

Plan or Service	Online	Phone
Marathon Petroleum Benefits Service Center Online access to Plan documents, forms and updates	Email: benefits@marathonpetroleum.com http://www.myMPCbenefits.com	1-888-421-2199
Health Care		
Classic and Saver HSA Health Plan Options **Anthem BlueCross BlueShield** *Find Providers, Claims and ID Cards* *Pre-Certification*	http://www.anthem.com Group #: 003329993	1-855-698-5676 1-866-776-4793
Prescription Drug Program **Express Scripts**	http://www.express-scripts.com Group #: MARAPET	1-877-207-1357
Billing/Premiums PayFlex	http://www.payflex.com	1-844-PAYFLEX (1-844-729-3539)
Pre-65 Retiree Dental Plan **Cigna Dental PPO**	http://www.cigna.com Group #: 2499499	1-800-244-6224
Pre-65 Retiree Vision Plan **Anthem Blue View Vision**	http://www.anthem.com	1-866-723-0515
Health Savings Account (HSA)		
Fidelity	http://www.netbenefits.com/marathonpetroleum	1-800-544-3716

CHANGES THROUGHOUT THE YEAR

Keep in mind that if you have any dependent changes during the year, such as marriage or divorce, you have only **60 days** to notify the Benefits Service Center in order to effectively make the change. This could potentially have an effect on premiums, eligibility and offering of benefits through COBRA provisions.

Important Notices

PLEASE NOTE:

The following notices are current as of September 1, 2017.

Marathon Petroleum is required by law to provide you with certain notices that inform you about your rights regarding eligibility, enrollment and coverage of health care plans.

Women's Health and Cancer Rights Act of 1998 Notice

The Women's Health Act requires the publication of the following notice annually:

The Plan provides mastectomy coverage and also provides for reconstructive surgery in a manner determined in a consultation with the attending physician and the patient. Coverage includes reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

This notice is made solely to satisfy the Act's requirements. The Health Plan has always covered such procedures and in no way does this reflect a change in plan provisions.

Special Enrollment Notice

Special enrollment events allow you and your eligible dependents to enroll for health coverage outside of the Benefits Open Enrollment period under certain circumstances if you lose eligibility for other coverage, become eligible for state premium assistance under Medicaid or the State Children's Health Insurance Program (CHIP), or acquire newly eligible dependents. This is required under the Health Insurance Portability and Accountability Act (HIPAA).

If you decline enrollment in a medical plan for you or your dependents (including your spouse/domestic partner) because of other health insurance coverage, you or your dependents may be able to enroll in a medical plan without waiting for the next Benefits Open Enrollment period if you:

- Lose other coverage. You must request enrollment within 60 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption or placement for adoption. You must request enrollment within 60 days after the marriage, birth, adoption or placement for adoption.
- Lose Medicaid or CHIP coverage because you are no longer eligible. You must request enrollment within 60 days after the loss of such coverage.

To request special enrollment or obtain more information, contact the Benefits Service Center at 1-888-421-2199.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the states on the following list, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of August 10, 2017. Contact your State for more information on eligibility:

ALABAMA — Medicaid

Website: http://myalhipp.com

Phone: 1-855-692-5447

ALASKA — Medicaid

The AK Health Insurance Premium Payment Program

Website: http://myakhipp.com

Phone: 1-866-251-4861

Email: CustomerService@MyAKHIPP.com

Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS — Medicaid

Website: http://myarhipp.com

Phone: 1-855-MyARHIPP (855-692-7447)

COLORADO — Medicaid

Health First Colorado

Website: https://www.healthfirstcolorado.com/

Health First Colorado Member Contact Center:

Phone: 1-800-221-3943/ State Relay 711

CHP+ Website: Colorado.gov/HCPF/Child-Health-Plan-Plus

FLORIDA — Medicaid

Website: http://flmedicaidtplrecovery.com/hipp

Phone: 1-877-357-3268

GEORGIA — Medicaid

Website: http://dch.georgia.gov/medicaid

– Click on Health Insurance Premium Payment (HIPP)

Phone: 404-656-4507

INDIANA — Medicaid

Healthy Indiana Plan for low-income adults 19-64

Website: http://www.in.gov/fssa/hip/

Phone: 1-877-438-4479

All other Medicaid

Website: http://www.indianamedicaid.com

Phone 1-800-403-0864

IOWA — Medicaid

Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp

Phone: 1-888-346-9562

KANSAS — Medicaid

Website: http://www.kdheks.gov/hcf/

Phone: 1-785-296-3512

KENTUCKY — Medicaid

Website: http://chfs.ky.gov/dms/default.htm

Phone: 1-800-635-2570

LOUISIANA — Medicaid

Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331

Phone: 1-888-695-2447

MAINE — Medicaid

Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html

Phone: 1-800-442-6003

TTY: Maine relay 711

MASSACHUSETTS — Medicaid and CHIP

Website: http://www.mass.gov/eohhs/gov/departments/masshe alth/

Phone: 1-800-462-1120

MINNESOTA — Medicaid

Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp

Phone: 1-800-657-3739

MISSOURI — Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm

Phone: 573-751-2005

MONTANA — Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP

Phone: 1-800-694-3084

NEBRASKA — Medicaid

Website: http://www.ACCESSNebraska.ne.gov

Phone: (855) 632-7633

Lincoln: (402) 473-7000

Omaha: (402) 595-1178

NEVADA — Medicaid

Website: http://dwss.nv.gov

Phone: 1-800-992-0900

NEW HAMPSHIRE — Medicaid

Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf

Phone: 603-271-5218

NEW JERSEY — Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid

Medicaid Phone: 609-631-2392

CHIP Website: http://www.njfamilycare.org/index.html

CHIP Phone: 1-800-701-0710

NEW YORK — Medicaid

Website: http://www.nyhealth.gov/health_care/medicaid

Phone: 1-800-541-2831

NORTH CAROLINA — Medicaid

Website: https://dma.ncdhhs.gov/

Phone: 919-855-4100

NORTH DAKOTA — Medicaid

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid

Phone: 1-844-854-4825

OKLAHOMA — Medicaid and CHIP

Website: http://www.insureoklahoma.org

Phone: 1-888-365-3742

OREGON — Medicaid

Website: http://healthcare.oregon.gov/Pages/index.aspx

http://www.oregonhealthcare.gov/index-es.html

Phone: 1-800-699-9075

PENNSYLVANIA — Medicaid

Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm

Phone: 1-800-692-7462

RHODE ISLAND — Medicaid

Website: http://www.eohhs.ri.gov

Phone: 855-697-4347

SOUTH CAROLINA — Medicaid

Website: http://www.scdhhs.gov

Phone: 1-888-549-0820

SOUTH DAKOTA — Medicaid

Website: http://dss.sd.gov

Phone: 1-888-828-0059

TEXAS — Medicaid
Website: http://gethipptexas.com
Phone: 1-800-440-0493
UTAH — Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669
VERMONT— Medicaid
Website: http://www.greenmountaincare.org
Phone: 1-800-250-8427
VIRGINIA — Medicaid and CHIP
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282
WASHINGTON — Medicaid
Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program
Phone: 1-800-562-3022 ext. 15473
WEST VIRGINIA — Medicaid
Website: http://mywvhipp.com/
Phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN — Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002
WYOMING — Medicaid
Website: https://wyequalitycare.acs-inc.com
Phone: 307-777-7531

To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

- U.S. Department of Labor
  Employee Benefits Security Administration
  www.dol.gov/ebsa
  1-866-444-EBSA (3272)
- U.S. Department of Health and Human Services
  Centers for Medicare & Medicaid Services
  www.cms.hhs.gov
  1-877-267-2323, Menu Option 4, Ext. 61565

Pre-65 Retirees