

Employee Assistance Program

# **Marathon Petroleum Employee Assistance Program**

**Effective January 1, 2018**





# Employee Assistance Program

## Table of Contents

<b>I. Introduction</b>	<b>1</b>
<b>II. Eligibility</b>	<b>1</b>
A. Employee Members	1
B. Household Members	2
C. Continued Members	2
<b>III. Program Services</b>	<b>2</b>
A. EAP Counseling Benefits	2
B. Work/Life Services	3
C. <a href="http://www.AnthemEAP.com">www.AnthemEAP.com</a>	4
<b>IV. Cost</b>	<b>4</b>
<b>V. Confidentiality</b>	<b>5</b>
<b>VI. Program Responsibilities</b>	<b>5</b>
<b>VII. Health Plan Coverage</b>	<b>5</b>
<b>VIII. Termination of EAP Coverage</b>	<b>6</b>
<b>IX. Rescission and Cancellation of Coverage</b>	<b>6</b>
<b>X. Continuation of EAP Coverage (“COBRA” Rights)</b>	<b>7</b>
<b>XI. Claims and Claims Appeal Procedures</b>	<b>7</b>
A. Pre-Service Claim Appeal	8
B. Post-Service Claim Appeal	10
C. Appointment of Authorized Representative	11
D. Finality of Decision and Legal Action	11
<b>XII. Administration</b>	<b>11</b>
<b>XIII. Modification and Termination of the EAP</b>	<b>13</b>
<b>XIV. Your Rights Under Federal Law</b>	<b>14</b>
<b>Appendix A — COBRA</b>	<b>16</b>
<b>Appendix B — Protected Health Information (PHI)</b>	<b>22</b>
<b>Appendix C — Eligible Employee Subsets of Participating Companies and Organizations</b>	<b>24</b>



# Employee Assistance Program

## **I. Introduction**

This document serves both as the plan document and the Summary Plan Description (“SPD”) for the Marathon Petroleum Employee Assistance Program (“EAP” or “the Program”). To the extent not preempted by the Employee Retirement Income Security Act of 1974 (“ERISA”), the provisions of this document shall be construed and governed by the laws of the State of Ohio.

Marathon Petroleum Company LP (“MPC”) established the Marathon Petroleum Employee Assistance Program, a program designed to offer a professional, confidential source of help for employees and their dependents who may want to seek assistance with personal problems. Since participating employers in the EAP include not only Marathon Petroleum Company LP, but also one or more other companies which have been authorized to participate in the EAP, as used in this document the word “Company” shall, as appropriate, refer to Marathon Petroleum Company LP or to a given participating employer.

## **II. Eligibility**

### **A. Employee Members**

Employees who work on a Regular “full-time” or Regular “part-time” basis are eligible for membership in the EAP (Employee Members). For purposes of benefit eligibility, Regular “full-time” basis means the employee has a normal work schedule of at least 40 hours per week or at least 80 hours on a bi-weekly basis. “Regular Part-time” means the employee is a non-supervisory employee and employed to work on a part-time basis (minimum of 20 hours but less than 35 hours per week), and not on a time, special job completion, or call when needed basis.

Employees who are covered under the Cigna International Medical and Dental Plan (“Cigna International Plans”) are also covered under the Cigna International Employee Assistance Program. As such, employees covered under the Cigna International Plans and their dependents are not eligible for coverage under this Marathon Petroleum Employee Assistance Program.

Regular employees who work on a “full-time” or “part-time” basis must be specifically designated as such by the Company to be eligible to participate in the EAP. Casual employees and common law employees who have not been designated by the Company as Regular employees who work on a “full-time” or “part-time” basis are excluded from eligibility to participate. Specifically excluded from eligibility to participate in the EAP are any individuals who have signed an agreement, or have otherwise agreed, to provide services to the Company as an independent contractor, regardless of the tax or other legal consequences of such an arrangement. Also specifically excluded are leased employees compensated through a leasing entity, whether or not the leased employee falls within the definition of “leased employee” as defined in Section 414(n) of the Internal Revenue Code.



# Employee Assistance Program

## **B. Household Members**

All Household Members of an eligible employee may participate in EAP benefits. For this purpose a Household Member covers traditional dependents and also extends to any individual whose place of residence is the same as the Employee Member.

## **C. Continued Members**

Continued Members are former Employee Members or individuals formerly covered as Household Members and who are also either the spouse or dependent child of the former Employee, and who pursuant to applicable federal law, are eligible to elect to continue coverage under the EAP beyond the date coverage would otherwise terminate if not for such federal law (Continued Members). (See “Continuation of EAP Coverage” section.)

## **III. Program Services**

The EAP provides employees and their household members with a broad range of services, including:

- Face-to-face counseling services
- Work/Life referral services and online resources, including child, elder care and legal/financial services

These services provide employees and their household members with comprehensive work/life and EAP counseling, education, and referral services. All of the resources provided by the EAP are professional and confidential, and are designed to help resolve personal problems and issues before they negatively affect one’s health, relationships with others or job performance.

### **A. EAP Counseling Benefits**

To provide the EAP service, Marathon Petroleum has retained the services of Anthem EAP. Anthem EAP counselors, who are experienced in addressing the wide variety of problems and concerns that individuals can face in everyday life, are available to help 24 hours per day, seven days per week. Some of the types of issues and concerns addressed by the EAP include:

- Family/Marital
- Parenting
- Legal
- Alcohol and Drug Abuse
- Emotional
- Stress
- Anxiety
- Depression
- Physical
- Financial
- Child Care/Elder Care



# Employee Assistance Program

The EAP will not intervene between an employee and their supervisor for work-related problems. The EAP does not supplant any established Company policies and procedures regarding work performance, behavior, or mandated compliance with the Drug and Alcohol Policy. Also, an employee's participation in the EAP does not exempt or shield them from compliance with established Company policies and procedures regarding work performance or behavior, and mandated compliance with the Drug and Alcohol Policy.

The EAP provides:

- Confidential Services
- Assessment
- Professional Counseling
- Education
- Referral Assistance (if needed)
- Follow-up

Eligible employees and household members may contact the EAP service 24 hours per day, seven days per week by calling 1-800-865-1044.

Eligible employees and household members who are located outside of the United States may contact the EAP service by calling Anthem EAP at 858-571-8222.

A counselor will speak with the caller, discuss the caller's needs, and assist in arranging an appointment with a counselor who is a part of the Anthem EAP network of EAP counselors. Anthem EAP may provide the names of more than one available EAP counselor. It is the caller's responsibility to notify Anthem of which EAP counselor is ultimately chosen. Anthem EAP will then contact the chosen EAP counselor to authorize your EAP visits or will provide you with information to use online counseling visits. Eligible employees and household members are eligible for up to eight counseling sessions per individual per problem or concern per year. Counseling options include visits conducted over the telephone, through online video using your smartphone, tablet or computer with a webcam, or one-on-one with a counselor.

## **B. Work/Life Services**

Anthem EAP consultants are available to help with a wide range of work/life issues as follows:

- Pre-natal care
- Child-care
- Health and wellness
- Summer child care
- Adoption
- Parenting
- Adult care and elder care
- Academic services
- Relocation
- Locating a service provider (such as a plumber, electrician, or pet sitter)



## Employee Assistance Program

Anthem EAP Work/Life consultants can provide counseling, education, and referral to providers and programs that meet particular service and location requirements. Anthem EAP Work/Life consultants will research specific needs and will provide the information about resources they have located.

### **C. [www.AnthemEAP.com](http://www.AnthemEAP.com)**

The Anthem EAP website provides 24 hours a day online linkage to educational information including stress, eating disorders, depression, and alcohol and drug abuse, and tip sheets on topics of interest. The link at [www.AnthemEAP.com](http://www.AnthemEAP.com) provides self-assessment tools that can be used to evaluate and create action plans based on health issues, depression, and family stress.

#### **How to Access [www.AnthemEAP.com](http://www.AnthemEAP.com)**

[www.AnthemEAP.com](http://www.AnthemEAP.com) is accessible online through MaraWeb and also from home by using <http://www.anthemeap.com>. You do not need to register to use this website. Your company name is Marathon Petroleum.

**Anthem counseling benefits and work/life services can be accessed by using the Anthem EAP toll free number, 1-800-865-1044, or online through the Anthem EAP website.**

## **IV. Cost**

Under the EAP counseling portion of the program, up to eight counseling sessions per individual per problem or concern per year with an EAP counselor are a free service and are prepaid by the Company. Sometimes, additional counseling or specialized treatment is required that is outside of the EAP benefit. In this case, you would be responsible for any cost. This additional cost may be partly covered under the Marathon Petroleum Health Plan (“Health Plan”). See the Health Plan if you are a member of that plan.

The resource, educational and referral services provided by Anthem EAP work/life services are available free of charge to employees and their household members. Organizations and services that these programs refer you to may charge a fee. The services you may select that do charge a fee are not provided free and are not a covered benefit of the EAP. These fees would be your responsibility to pay. For example, any dependent care services or adult care services you might select would be your financial responsibility.



## Employee Assistance Program

### **V. Confidentiality**

The Company recognizes that confidentiality is a cornerstone for the success and effectiveness of the EAP. The EAP was designed to benefit you and your household members. Your participation in the EAP including on line services and work life services will be treated confidentially in accordance with all state and federal laws. Local counseling offices are located away from the work site. Except in very unusual circumstances as prescribed by law (such as life threatening events), any private discussions an employee has with an Anthem EAP counselor will not be disclosed to anyone.

The Company will not be aware of an employee's participation in the EAP unless the employee requests it. Should an employee wish the Company to be aware of their participation or progress in the EAP, the employee must sign a release of information form to that effect. The Company receives only a quarterly statistical report of usage. No names or other individual identifying information are included in these reports.

In certain circumstances, an employee may have a problem that so seriously impacts work performance they may be terminated if their work performance does not improve. In these cases, the employee's supervisor may refer the employee to the EAP as a condition of continued employment. Once the initial contact is made between the employee and the EAP, the supervisor will receive no information regarding the employee's participation and progress in the program, unless the employee signs the release of information form. As with voluntary use of the EAP, any case details will be held in strict confidence and will not be provided to the supervisor or the Company, except as required by law, or as authorized by the employee.

### **VI. Program Responsibilities**

The Marathon Petroleum Employee Assistance Program is designed to offer a professional, confidential source of help for employees and household members who may want to seek assistance with personal problems and work/life issues. The Company does not determine the method of care, the services to be provided by the EAP counselors or by others to whom the EAP counselors may refer employees or their household members, nor the referrals and education provided by Anthem EAP work/life services. The Company makes no representation about the quality of the providers or the services provided. In addition, the Company does not assume any responsibility for the results of participation in the EAP.

### **VII. Health Plan Coverage**

The EAP and the benefits provided by the Marathon Petroleum Health Plan's mental health and substance abuse services and coverage complement each other. The EAP provides assessment and referral services to EAP network providers at no cost to you. For those individuals covered by both the EAP and the Health Plan, members are encouraged (but not required) to contact the EAP to assess the individual's needs. If the problem can be treated with short-term counseling (eight sessions or less), the individual will be referred to the EAP for treatment. However, if the problem requires ongoing treatment, the EAP will refer the individual to a network provider (Anthem) under the Health Plan.





# Employee Assistance Program

## **VIII. Termination of EAP Coverage**

Coverage for you and your household members terminates when you cease to meet the eligibility requirements including, but not limited to, ceasing to be a Regular full-time or part-time employee (except if your normal work schedule is reduced to 20 hours or more per week to accommodate a bona fide health problem or disability) or due to certain leaves of absence as discussed below. Coverage will also terminate if the Program is terminated by MPC or if the Company through which you have coverage ceases to be a participating employer.

Coverage for you and your household members will be continued for three months if you are temporarily laid off. If you are granted a leave of absence (other than a Military Leave), coverage for you and your dependents continues for up to two years to the extent you are eligible for Company contributions to a Company-provided health plan. If you are granted a Military Leave, coverage for you and your dependents is continued.

## **IX. Rescission and Cancellation of Coverage**

The Plan may rescind your coverage or a covered dependent's coverage based upon a fraudulent act or omission, or intentional misrepresentation of a material fact, by you or your dependent after the Plan provides you with 30 days' advance written notice of that rescission of coverage. Examples of fraud or intentional misrepresentation include a member claiming a non-spouse as a spouse, or an ineligible individual as an eligible dependent, or not notifying the Plan of changes that render a covered dependent no longer eligible for coverage. A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, meaning that it will be effective back to the time that you or your dependent should not have been covered by the Plan. However, the following situations will not be considered rescissions of coverage and do not require the Plan to give written notice 30 days in advance:

- The Plan terminates coverage back to the date of an employee's loss of employment when there is a delay in administrative recordkeeping between the employee's loss of employment and notification to the Plan of the termination.
- The Plan retroactively terminates coverage because of a failure to timely pay required premiums or contributions for coverage.
- The Plan retroactively terminates a former spouse's coverage back to the date of divorce when full COBRA premiums are not paid.

In all other circumstances under which you and your dependents were covered by the Plan and should not have been covered, the Plan will cancel coverage prospectively — going forward — once the mistake is identified. Such cancellation will not be considered a rescission and does not require the Plan to give you 30 days' advance written notice.





## Employee Assistance Program

### **X. Continuation of EAP Coverage (“COBRA” Rights)**

Federal law requires that you and your dependents (which includes your spouse and dependent children) be permitted to elect to continue coverage under the EAP when coverage terminates due to certain qualifying events. Such qualifying events include your death, termination of employment, reduction in hours, divorce or legal separation, or due to one of your dependents ceasing to meet the requirements of an eligible dependent. In the case of divorce, legal separation, or a dependent ceasing to meet the requirements of an eligible dependent, you or your dependent must notify the Plan Administrator within sixty (60) days after such event (this notification can be made by contacting the Company’s local Human Resources office or Benefits Administration in Findlay) in order to be eligible to elect to continue coverage from the EAP. For purposes of COBRA, your eligible dependents include your legal spouse and children through end of the month in which they turn age 26, including natural children of the first degree, legally adopted children and children placed with you for adoption, stepchildren, and children whose parents are both deceased and who permanently reside with you and for whom you have legal custody as determined by a court of competent jurisdiction. For further information, please refer to the detailed continuation provisions included in the EAP as Appendix A.

### **XI. Claims and Claims Appeal Procedures**

The Company anticipates that EAP services will be provided to eligible employees and their dependents automatically. If, however, an individual believes that a request for EAP services has been denied, in whole or in part, the individual is entitled to appeal the decision and the appeal must be made by following the appeal procedures outlined below:

The Plan Administrator, or others delegated authority to hear final appeals by the Plan Administrator, has the authority to render decisions on all appeals submitted under the Plan and the determination made by the Plan Administrator, or others delegated authority to hear final appeals by the Plan Administrator, to an appeal concerning benefits shall be final.

Appeals to the Plan Administrator must contain all of the required information in order to be regarded as an appeal under the Plan. If required information is missing the request will not be regarded by the Plan as an appeal and it will be returned to the covered individual, or their designated representative, with no determination made. The covered individual, or their duly authorized representative, should contact Anthem EAP prior to filing the appeal in order to clarify any questions they may have on the reason for the denial by the claim payer. All appeals must contain the following information:

- a. A statement that a formal appeal under the Plan is being made and the type of appeal (Urgent Pre-Service Claim Appeal, Non-Urgent Pre-Service Claim Appeal or Post-Service Claim Appeal.)
- b. The name of the individual for whom the claim was denied.
- c. The Social Security number of the employee and, if the individual for whom the claim was denied is not the employee, the name of the employee.
- d. Name of Plan the individual is covered under. (For example, the Employee Assistance Program.)



## Employee Assistance Program

- e. Identify the claim denied for which the appeal is being made. Include the date of service, name of the provider and/or facility.
- f. Any and all information necessary for a complete and thorough review of the claim appeal. Provide the complete name and phone number of any mental health professionals to contact for additional information supporting the approval of the appeal.
- g. Address and telephone number of the individual or duly authorized representative, making the appeal.
- h. Authorization for release of personal health information if appropriate and necessary.

How an appeal is made and the time frames for requesting an appeal vary depending on the type of health service claim denied. The following explains the three types of appeal for the three types of claims and the procedures for making an appeal for each of the three types of appeals: Urgent Pre-Service Claim Appeal, Non-Urgent Pre-Service Claim Appeal, and Post-Service Claim Appeal.

For those claim appeal procedures that require that the appeal be sent in writing to the Plan Administrator, the address for the Plan Administrator of the Marathon Petroleum Employee Assistance Program is as follows. A form for you to use to submit the appeal can be found at [www.myMPCBenefits.com](http://www.myMPCBenefits.com) under “Your Health Forms” and is titled “Claim Denial Appeal Form.” The form can also be obtained by requesting a copy from the Benefits Service Center at 1-888-421-2199 or by mail at:

Marathon Petroleum EAP Appeals  
The Plan Administrator  
539 South Main Street  
Findlay, OH 45840

For those claim appeal procedures that require that the appeal be sent in writing to Anthem EAP, the address for sending appeals to Anthem EAP is as follows:

Anthem EAP  
700 Broadway  
Denver, CO 80273

### A. Pre-Service Claim Appeal

If a request for healthcare was denied before the health care is rendered (such as a result of a prior authorization, precertification, or preapproval) by Anthem EAP under the Plan, the claim is a pre-service claim and the covered individual may appeal following the pre-service claim appeal procedures. In addition, the pre-service claim appeal procedures depend on if it is an urgent or a non-urgent claim. **An urgent claim appeal is a claim for medical care or treatment where withholding immediate treatment could seriously jeopardize the life or health of a patient or a patient’s unborn child, or could affect the ability of the patient to regain maximum functions.**

# Employee Assistance Program

## 1. Urgent Pre-Service Claim Appeal

A covered individual, or their designated representative, may appeal a denial decision of an urgent pre-service claim by phone or in writing (by mail or facsimile). There is no time limit for the covered individual to make such an appeal.

If the appeal is made by telephone or facsimile, the covered individual is to make the appeal by contacting the Benefits Service Center at 1-888-421-2199. Listen for the prompt in the opening message for filing an urgent pre-service claim appeal. Information for filing an appeal by phone or facsimile will be provided. If the appeal is made by facsimile, the covered individual is to make the appeal by sending the appeal to the Plan Administrator, Attention: Marathon Petroleum EAP Claim Appeals, The Plan Administrator of the Marathon Petroleum EAP.

If the appeal is made in writing the appeal is to be sent to the Plan Administrator at the address stated at the beginning of this section on “Claims and Claim Appeal Procedures.”

A determination by the Plan Administrator, or others delegated authority to hear final appeals by the Plan Administrator, will be made within 72 hours of the claim payer receiving the appeal request. The appeal determination will be sent to the individual making the appeal at the telephone number and address provided in the appeal.

**Note:** A pre-service claim that is “urgent” when it is initially filed and the determination is made by the respective claim payer, will cease to be an “urgent” pre-service claim and will become a non-urgent pre-service claim if between the date of the claim denial and the date the appeal is made, the health care services are actually rendered and the only decision to be made is who will pay for the services.

It is not anticipated that there will be any Urgent Pre-Service Claim Appeals under the EAP due to the nature of the benefits provided by the EAP. These Urgent Pre-Service Claim Appeal provisions are provided to meet federal regulations.

## 2. Non-Urgent Pre-Service Claim Appeal

A covered individual, or their designated representative, is to first telephone Anthem EAP at 1-800-865-1044 and ask that their claim be reviewed.

If, after the claim has been reviewed in response to the telephone call, the covered individual continues to disagree with the handling and disposition of the claim, they are entitled to submit a written appeal to Anthem EAP at the address found at the beginning of this section on “Claims and Claim Appeal Procedures” (it is suggested that you send a copy of your written appeal to Anthem EAP to the Plan Administrator at the address also stated at the beginning of this section). That written appeal will be reviewed in accordance with Anthem EAP’ internal appeal procedures. The written appeal must be received by Anthem EAP within 180 days of the initial denial. Anthem EAP must respond to your written appeal within 15 days for a Non-Urgent Pre-Service claim.

If after receiving the response to a written appeal from Anthem EAP you continue to disagree with the handling and disposition of the claim, you are entitled to submit a written appeal to the Plan Administrator as detailed below.



## Employee Assistance Program

The covered individual, or their designated representative, may appeal a denial decision of a non-urgent pre-service claim in writing. (Such appeal must be in writing. Non-urgent pre-service claim appeals cannot be submitted by telephone, facsimile or e-mail.) The appeal to the Plan Administrator must be received by the Plan Administrator within 30 days of the date of the denial of the first appeal by Anthem EAP.

The covered individual, or their designated representative, is to send the appeal to the Plan Administrator at the address stated at the beginning of this section “Claim and Claim Appeal Procedures.” A determination by the Plan Administrator, or others delegated authority to hear final appeals by the Plan Administrator, will be made within 15 days of the Plan Administrator receiving the appeal request. The appeal determination will be sent to the individual making the appeal at the address provided in the appeal.

### **B. Post-Service Claim Appeal**

A covered individual, or their designated representative, is to first telephone Anthem EAP at 1-800-865-1044 and ask that their claim be reviewed.

If after the claim has been reviewed in response to the telephone call, the covered individual continues to disagree with the handling and disposition of the claim, they are entitled to submit a written appeal to Anthem EAP at the address found at the beginning of this section on “Claims and Claim Appeal Procedures” (it is suggested that you send a copy of your written appeal to Anthem EAP to the Plan Administrator at the address also stated at the beginning of this section.) That written appeal will be reviewed in accordance with the claim administrator’s internal appeal procedures. The written appeal must be received by Anthem EAP within 180 days of the initial denial. Anthem EAP must respond to your written appeal within 30 days for a Post-Service Claim Appeal.

If after receiving the response to a written appeal from Anthem EAP you continue to disagree with the handling and disposition of the claim, you are entitled to submit a written appeal to the Plan Administrator as detailed below.

A covered individual, or their designated representative, may appeal a denial decision of a post-service claim in writing by sending the appeal to the Plan Administrator at the address stated at the beginning of this Section “Claims and Claim Appeal Procedures.” (Such appeal must be in writing and cannot be submitted by telephone, facsimile or e-mail.) The appeal must be received by the Plan Administrator within 30 days of the date of the denial of the first appeal by Anthem EAP.

A determination by the Plan Administrator, or others delegated authority to hear final appeals by the Plan Administrator, will be made within 30 days of the Plan Administrator receiving the appeal request. The appeal determination will be sent to the individual making the appeal at the address provided in the appeal.



## Employee Assistance Program

### **C. Appointment of Authorized Representative**

An authorized representative may act on behalf of a claimant with respect to a benefit claim or appeal under the Plan's claim and appeal procedures. No person will be recognized as an authorized representative until the Plan receives an *Appointment of Authorized Representative* form signed by the claimant, except that for urgent care claims the Plan shall, even in the absence of a signed Appointment of Authorized Representative form, recognize a health care professional with knowledge of the claimant's medical condition (e.g., the treating physician) as the claimant's authorized representative unless the claimant provides specific written direction otherwise.

An *Appointment of Authorized Representative* form may be obtained from, and completed forms must be submitted to, the Marathon Petroleum Benefits Service Center, 539 S. Main Street, Findlay, OH 45840, 1-888-421-2199, or the appropriate claims administrator. The form is also available on <http://www.mympcbenefts.com>. Once an authorized representative is appointed, the Plan shall direct all information, notification, etc. regarding the claim to the authorized representative. The claimant shall be copied on all notification regarding decisions, unless the claimant provides specific written direction otherwise.

A representative who is appointed by a court or who is acting pursuant to a document recognized under applicable state law as granting the representative such authority to act, can act as a claimant's authorized representative without the need to complete the form, provided the Plan is provided with the legal documentation granting such authority.

A claimant may also need to sign an authorization form for the release of protected health information to the authorized representative.

### **D. Finality of Decision and Legal Action**

A claimant must follow and fully exhaust the applicable claims and appeals procedures described in this Program before taking action in any other forum regarding a claim for benefits under the Program. Any suit or legal action initiated by a claimant under the Plan must be brought by the claimant no later than one year following a final decision on the claim for benefits under these claims and appeals procedures. The one-year statute of limitations on suits for benefits applies in any forum where a claimant initiated such suit or legal action. If a civil action is not filed within this period, the claimant's benefit claim is deemed permanently waived and abandoned, and the claimant will be precluded from reasserting it.

## **XII. Administration**

### **Plan Name and Plan Identification Number**

The formal name of the plan is the Marathon Petroleum Employee Assistance Program. MPC's employer identification number is 31-1537655 and the plan number is 554. Plan documents may be inspected by submitting a request to your local Human Resources office or to Marathon Petroleum Company LP, Benefits Administration, 539 South Main Street, Findlay, OH 45840.





# Employee Assistance Program

## **Plan Sponsor and Administrator**

The plan is sponsored by Marathon Petroleum Company LP, 539 South Main Street, Findlay, OH 45840. The Plan Administrator and Named Fiduciary of the plan is David R. Sauber, 539 South Main Street, Findlay, OH 45840, (419) 422-2121. The Plan Administrator shall appoint such Assistant Plan Administrators as may be deemed necessary.

In determining the eligibility of participants and others for benefits and in construing the EAP's terms, the Plan Administrator has the power to exercise their discretion in the construction of doubtful, disputed or ambiguous terms or provisions of the EAP, in cases where the EAP plan instrument is silent, or in the application of terms or provisions to situations not clearly or specifically addressed in the EAP plan instrument itself. In situations in which the Plan Administrator deems it to be appropriate, the Plan Administrator may evidence (i) the exercise of such discretion, or (ii) any other type of decision, directive or determination they may make with respect to the Plan, in the form of written administrative rulings which, until revoked or until superseded by plan amendment or by a different administrative ruling, shall thereafter be followed in the administration of the Plan. All decisions of the Plan Administrator made on all matters within the scope of their authority shall be final and binding upon all persons, including the Company, all participants and beneficiaries, and their heirs and personal representatives. It is intended that the standard of judicial review to be applied to any determination made by the Plan Administrator shall be the "arbitrary and capricious" standard of review.

## **Participating Employers**

Upon specific authorization and subject to such terms and conditions as it may establish, Marathon Petroleum Company LP may permit subsidiaries and affiliated organizations to participate in this plan. Currently, these participating companies include Marathon Petroleum Company LP, Marathon Petroleum Corporation, Marathon Petroleum Service Company, Catlettsburg Refining LLC, Marathon Petroleum Logistics Services LLC, Blanchard Refining Company LLC, Speedway LLC, Speedway Prepaid Card LLC, and MW Logistics Services LLC. Employee eligibility within these participating companies may be limited to certain employee subsets, as identified in Appendix C. In addition, eligible subsets of employees must satisfy all eligibility provisions otherwise provided by this plan.

The term "Company" and other similar words shall include Marathon Petroleum Company LP and such affiliated organizations. The term "employee" and other similar words shall include any eligible employee of these companies.

## **Type of Plan and Administration**

The plan provides employee assistance and is administered in part by the plan sponsor, Marathon Petroleum Company LP, and in part under a contract with Anthem EAP, 700 Broadway, Denver, CO 80273.

## **Plan Year**

The plan year ends on December 31, and the plan's records are kept on a calendar year basis.

## **Agent for Service of Legal Process**

The agent for service of legal process on the Plan is the Plan Administrator and process may be served on the Plan Administrator at 539 South Main Street, Findlay, OH 45840.

# Employee Assistance Program

## **XIII. Modification and Termination of the EAP**

The Company reserves the right to modify or terminate this Plan, in whole or in part, in such manner, as it shall determine.

Marathon Petroleum Company LP (“the Company”) may exercise its reserved rights of amendment, modification or termination:

- (i) By written resolution by the Board of Directors of Marathon Petroleum Corporation;
- (ii) By written resolution by the General Partner of Marathon Petroleum Company LP;
- (iii) By written resolution by the Executive Committee;
- (iv) By written actions exercised by any other committee, for example the Marathon Petroleum Corporation Salary and Benefits Committee (the Salary and Benefits Committee”), to which the Board of Directors of Marathon Petroleum Corporation or the Executive Committee has specifically delegated rights of amendment, modification or termination; or
- (v) By written actions exercised by any other entity or person to which or to whom the Board of Directors of Marathon Petroleum Corporation or the Executive Committee has specifically delegated rights of amendment, modification, or termination.

In addition to the other methods of amending the Company’s employee benefit plans, policies, and practices (hereinafter referred to as “MPC Employee Benefit Plans”) which have been authorized, or may in the future be authorized, by the Marathon Petroleum Corporation Board of Directors, the Marathon Petroleum Corporation Vice President of Human Resources and Administrative Services may approve the following types of amendments to MPC Employee Benefit Plans:

- (i) With the opinion of counsel, technical amendments required by applicable laws and regulations;
- (ii) With the opinion of counsel, amendments that are clarifications of Plan provisions;
- (iii) Amendments in connection with a signed definitive agreement governing a merger, acquisition or divestiture such that, for MPC Employee Benefit Plans, needed changes are specifically described in the definitive agreement, or if not specifically described in the definitive agreement, the needed changes are in keeping with the intent of the definitive agreement;
- (iv) Amendments in connection with changes that have a minimal cost impact (as defined below) to the Company; and
- (v) With the opinion of counsel, amendments in connection with changes resulting from state or federal legislative actions that have a minimal cost impact (as defined below) to the Company.

For purposes of the above, “minimal cost impact” is defined as an annual cost impact to the Company per MPC Employee Benefit Plan case that does not exceed the greater of:

- (i) An amount that is less than one-half of one percent of its documented total cost (including administrative costs) for the previous calendar year; or
- (ii) \$500,000.

The Board of Directors of Marathon Petroleum Corporation or the Executive Committee has delegated to the Salary and Benefits Committee the authority to amend, modify, or terminate this Plan at any time. This authority delegated to the Salary and Benefits Committee shall be exercised in writing.





# Employee Assistance Program

## **XIV. Your Rights Under Federal Law**

As a Participant in the Marathon Petroleum Employee Assistance Program, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA provides that all plan Participants shall be entitled to:

### **Receive Information About Your Plans and Benefits**

Examine, without charge, at the plan administrator’s office and at other specified locations, such as worksites, all plan documents governing the plan, including insurance contracts, and a copy of the latest annual reports (Form 5500 Series) filed by the plans with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, and copies of the latest annual reports (Form 5500 Series) and updated summary plan descriptions. The administrator may make a reasonable charge for the copies.

Receive, as required by law, a summary of a plan’s annual financial reports.

### **Continue Group Health Plan Coverage**

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

### **Prudent Actions by Plan Fiduciaries**

In addition to creating rights for plan Participants ERISA imposes duties upon the people who are responsible for the operation of the plans. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan Participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

### **Enforce Your Rights**

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



## Employee Assistance Program

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual reports from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### **Assistance With Your Questions**

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

## Appendix A

### COBRA

*Required Notice: Participants of the Marathon Petroleum Employee Assistance Program, are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to continue health care coverage for themselves, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. Participants and their dependents may have to pay for such coverage.*

*The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, (COBRA) requires that most employers sponsoring group health plans offer plan members and their covered dependents the opportunity for a temporary extension of health coverage (continuation of coverage) at group rates in certain instances where plan coverage would otherwise end. This Appendix A explains how the provisions of COBRA affect the members of the Marathon Petroleum Employee Assistance Program (the "Plan").*

#### I. Group Covered

All Employee Members of the Plan (other than nonresident aliens with no U.S.-source earned income), including their covered eligible dependents (i.e., spouse and dependent children), are subject to these COBRA provisions.

#### II. Qualifying Events and Maximum Length of Continuation Periods

A. If an **Employee Member** of the Plan loses coverage:

1. because of termination of employment (including retirement), either voluntary or involuntary, for reasons other than gross misconduct,
2. because of a reduction of work hours (e.g., change from regular to casual status), or
3. because of layoff;

then the Member and the currently covered eligible dependents who lose coverage due to the event may be entitled to elect continuation of coverage.

B. If the covered **Spouse** of an Employee Member of the Plan loses coverage:

1. because of the death of an Employee Member,
2. because of the divorce or legal separation from an Employee Member, or
3. because the Employee Member's employment with the Company ends for any reason other than gross misconduct, or because of a reduction of work hours (e.g., change from regular to Casual status or layoff); or
4. because the Employee Member becomes entitled to benefits under Medicare;

then the Spouse, and any other currently covered eligible dependents who lose coverage due to the event may be entitled to elect continuation of coverage.



## Employee Assistance Program

- C. If an eligible **Child** of an Employee Member of the Plan loses coverage:
1. because of the death of an Employee Member,
  2. because the dependent no longer meets the Plan's definition of an eligible Child, or
  3. because the Employee Member's employment with the Company ends for any reason other than gross misconduct, or because of a reduction of work hours (e.g., change from regular to Casual status or layoff); or
  4. because the Employee Member becomes entitled to benefits under Medicare;
- then the eligible Child may be entitled to elect continuation of coverage.

### III. Maximum Length of Continuation Periods

COBRA continuation coverage is a temporary continuation of health coverage. When the qualifying event is the employee's termination of employment (other than for gross misconduct) or reduction of work hours, COBRA continuation coverage for the employee and the employee's covered spouse and dependent children generally lasts for only up to a total of 18 months from the date of the qualifying event.

When the qualifying event is the death of the employee, your divorce [or legal separation], or the employee's Medicare entitlement, COBRA continuation coverage for the employee's spouse and/or dependent children (but not the employee) lasts for up to a total of 36 months from the date of the qualifying event. Also, the employee's dependent children are entitled to COBRA continuation coverage for up to 36 months after losing eligibility as a dependent child under the terms of the plan.

### IV. Extension of Maximum Length of Continuation Periods

**Disability Extension:** In the case of a loss of coverage due to termination of employment or reduction of hours, the maximum 18-month COBRA continuation coverage period may be extended to a maximum of 29 months from the date of the initial qualifying event for an individual (employee or eligible dependent) if that individual is determined to have been disabled for Social Security purposes on the date of the qualifying event or at any time during the first 60 days of continuation coverage. In addition, the extension from 18 months to 29 months will apply not only to the particular disabled individual but also to all of the individuals in the same family who elected continuation of coverage due to the termination of employment or reduction in hours of employment. In order for this extension to apply, however, the disabled individual must notify the Plan Administrator of the Social Security determination before the end of the 18-month period and within 60 days of the date of the determination. The disabled individual must also notify the Plan Administrator within 30 days of any final determination that the individual is no longer disabled. (Refer to the section called "Cost" below for the cost of continued coverage during the 19th through 29th month.)

**Second Qualifying Event Extension:** Eligible dependents of the Employee Member who are entitled to a maximum 18-month COBRA continuation coverage period will have that period extended to a maximum of 36 months from the date of the first qualifying event if any of the following subsequent qualifying events occur during the maximum 18-month period (or during the maximum 29-month period, if applicable) and results in a loss of coverage:



## Employee Assistance Program

1. the death of the Employee Member,
2. the divorce or legal separation of the Employee Member,
3. the Child no longer meets the Plan's definition of an eligible dependent,
4. the Employee becomes entitled to benefits under Medicare.

In the case of events (2) and (3) above, however, the period will be extended only if notice of the event is provided to the Plan Administrator by the Member or dependent in accordance with "Notification Procedure" below.

**Employee Member's Medicare Entitlement Occurs Before a Qualifying Event That Is Member's Termination of Employment or Reduction of Work Hours:** In addition, if an Employee Member becomes entitled to benefits under Medicare and the Member's covered eligible dependents properly elect continuation coverage due to a qualifying event which occurs on or after the date of such entitlement to Medicare, the Eligible Dependents will be eligible for a minimum of 36 months of continuation of coverage measured from date of entitlement to benefits under Medicare.

### V. Termination of Continued Coverage

The Continued Member's (or continued dependent's) coverage will end on the earliest of the following dates:

1. the date the Continued Member (or continued dependent) first becomes covered, after the date of their COBRA election, under another group health plan which does not contain any exclusion or limitation with respect to any preexisting condition of that individual, either as an employee, retiree, dependent or otherwise;
2. the date the Continued Member (or continued dependent) first becomes entitled after the date of their COBRA election, to benefits under Medicare;
3. the last date of coverage for which timely premiums have been paid;
4. the date on which the applicable 18-, 29-, or 36-month period ends;
5. for an individual (employee or eligible dependent) who has had their maximum period of continued coverage extended from 18 months to 29 months due to a determination of disability for Social Security purposes, and who later receives a final determination that they are no longer disabled for Social Security purposes, the later of a) the first day of the month that begins more than 30 days after the date of the final determination, and b) the end of the 18-month period;
6. the first date on which no member of the controlled group which includes Marathon Petroleum Company LP provides any group health plan to any of its employees.

### VI. Notification Procedure

- A. If coverage terminates due to the Employee Member's layoff, the Employee Member's reduction in work hours, the Employee Member's termination of employment (for reasons other than gross misconduct), the Employee Member's death, or the Employee Member becoming entitled to benefits under Medicare:

# Employee Assistance Program

1. MPC will notify the Plan Administrator of such event within 30 days; and
  2. The Plan Administrator will notify the employee/dependent of their rights under COBRA within 14 days after receiving notice from MPC.
- B. In the event of the divorce or legal separation of the Employee Member and spouse, or in the event that a Dependent Child no longer meets the Plan's definition of eligible dependent:
1. The Employee Member or dependent must notify the Plan Administrator in writing of the effective date of that event within 60 days after that date. (This notification can be submitted to the Plan Administrator through the Company's local Human Resources office or Benefits Administration in Houston, Texas); and
  2. The Plan Administrator or representative will inform the Employee Member/dependent of their rights under COBRA at the time of such notification, or mail the information within 14 days. Notification to the spouse will serve as notification for all dependents residing with the spouse.
- C. The Employee Member/dependent must elect to continue coverage within a specified election period. This period ends on the later of 60 days from:
1. the date of the notice from the Plan Administrator, if applicable, or
  2. the date of termination of coverage.
- D. If an election is not made within the election period described above, coverage ceases at the time of the qualifying event. If you initially waive COBRA continuation coverage, but revoke that waiver within the 60-day election period, coverage will only be effective from the date of the waiver.

## VII. Special COBRA Election Period Under the Trade Act of 2002

In addition to the regular 60-day election period indicated in the "Notification Procedure" section immediately above, the Trade Act of 2002 provides for an additional "special" election period for individuals deemed eligible for trade adjustment assistance (TAA) benefits and a health COBRA tax credit. This "special" election period is 60 days in length and applies to those who had not previously elected COBRA coverage during the election period indicated in the "Notification Procedure" section immediately above, and are deemed eligible for the tax credit provisions, but only if the tax credit eligibility determination occurs within six months of the loss of group health coverage (qualifying event date.) If COBRA coverage is elected under this special COBRA election period, it begins on the first day of that special period and continues for the applicable 18, 29 or 36 months (depending on the circumstances) from the date of the initial loss of group health coverage. There is no coverage for the period between the initial loss of group health coverage and the beginning of the additional special election period. Information on the right to an additional "special" election period, together with other information on trade adjustment assistance, including an explanation of provisions of the Trade Act of 2002 under the American Recovery and Reinvestment Act of 2009, is available to potentially eligible individuals through the State Workforce Agencies in connection with the certification process for trade adjustment assistance.





## Employee Assistance Program

### VIII. Type of Coverage

The coverage offered must be a continuation of the benefits currently being provided under the Plan to other members and dependents, with respect to whom a qualifying event has not occurred. Subject only to the exception stated below, the right to elect continuation of coverage is offered only to those members and covered eligible dependents who on the day before the loss of coverage due to the qualifying event were covered under the Plan.

#### Change in Coverage Category

A. A Continued Member may elect to decrease their coverage.

B. Addition of Eligible Dependents

1. Eligible Dependents at Time of Qualifying Event

A Continued Member may elect, subject to the late enrollment provisions of the Plan, to cover any eligible dependents whom the Member did not cover at the time the Member lost their coverage due to the qualifying event.

2. Eligible Dependents Acquired After Qualifying Event

a) A Continued Member or a covered eligible dependent who elected continuation coverage may add any eligible dependents whom they acquire after their qualifying event, subject to the late enrollment provisions of the Plan.

b) Effective January 1, 1997, eligible dependent children who are added for continuation of coverage pursuant to the late enrollment provisions of the Plan by a Continued Member who was formerly an Employee Member of the Plan, and who are either:

i. child that is a blood descendent of the first degree of the covered employee who is born during a period of COBRA continuation of coverage, or

ii. child that has been “placed for adoption” with the covered employee during a period of COBRA continuation of coverage,

shall be treated for COBRA continuation of coverage purposes as if they were covered eligible dependent children of the Continued Member at the time of the qualifying event except they will not be eligible to begin COBRA continuation of coverage until the date of their birth or the date of their placement for adoption with the covered employee, whichever is applicable.

Any amendments to the Plan applicable to similarly situated non-continued members will be applicable to Continued Members as well. Such amendments include, but are not limited to, changes in coverage or elimination of coverage.

### IX. Cost

There is no cost for Continued Member coverage. MPC will cover the cost of any COBRA continuation of coverage elected under this Plan.





## Employee Assistance Program

### **X. Administration**

The continuation coverage under the Marathon Petroleum Employee Assistance Program is administered by PayFlex, P.O. Box 3039, Omaha, NE 68103-3039, 844-PAYFLEX (844-729-3539). Information is also available at [www.payflex.com](http://www.payflex.com).

### **XI. Special Continuing Circumstances**

#### A. General

When coverage would have ceased because of a qualifying event, except for the fact that the Company, through the operation of the Plan or otherwise, has at its discretion extended coverage for a specific period of time after the qualifying event under conditions more beneficial than COBRA requires, then COBRA coverage elected after such period expires will not extend longer than the applicable 18, 29, or 36 months from the date of the original qualifying event.

#### B. Change in Control

Employees who are eligible for a cash severance benefit under the Marathon Petroleum Change in Control Severance Benefits Plan and who satisfy all the requirements for Change in Control benefits will be eligible to receive extended coverage for 18 months as follows:

Eligible terminated employees (including those eligible to retire at the time of termination) and their eligible dependents who immediately prior to termination were Members of the Employee Assistance Program (EAP) have the opportunity to continue coverage under the terms and conditions of the EAP as applied to active employees for a period of 18 months provided the terminated employee is eligible for and timely elects continuation of such coverage in accordance with COBRA. The terminated employee shall pay the active employee rate (if applicable) with respect to coverage during the eighteen (18) months following the termination date and, thereafter (if applicable), the full COBRA rate with respect to such coverage.

If coverage is elected under this Change in Control provision and the eligible terminated employee should die during the 18 months of extended active employee coverage the survivor continuation provisions otherwise provided to active employees will apply.

The period of coverage provided under this section shall constitute continuation coverage required by COBRA. The eligibility of the terminated employee to continue such coverage at both the active employee rate (if applicable) and full COBRA rate shall not exceed a period of eighteen (18) months unless a longer period is required by COBRA. Such benefits shall be governed by and subject to (i) the terms and conditions of the plan documents providing such benefits, including the reservation of the right to amend or terminate such benefits under those plan documents at any time provided that for a period of two (2) years following a Change in Control, the Plan may not be amended in an adverse manner solely for employees eligible for benefits under this section, and (ii) the provisions of COBRA.

## **Appendix B**

### **Protected Health Information (PHI)**

#### **A. Use and Disclosure of Protected Health Information (PHI)**

The Plan will use protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations. The Plan will disclose PHI only to the Plan Administrator and other members of the Company's workforce who are authorized to receive such PHI, and only to the extent and in the minimum amount necessary for that person to perform Plan administrative functions. "Members of the Company's workforce" generally include certain employees who work in the Company's employee benefits department, human resources department, payroll department, legal department, and information technology department. The Plan Administrator keeps an updated list of those members of the Company's workforce who are authorized to receive PHI.

In the event that any member of the Company's workforce uses or discloses PHI other than as permitted by the terms of the Plan regarding PHI and 45 C.F.R. parts 160 and 164 ("HIPAA Privacy Standards"), the incident shall be reported to the Plan's privacy officer. The privacy officer shall take appropriate action, including:

- Investigation of the incident to determine whether the breach occurred inadvertently, through negligence or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;
- Appropriate sanctions against the persons causing the breach which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment;
- Mitigation of any harm caused by the breach, to the extent practicable; and
- Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

In order to protect the privacy and ensure adequate security of PHI and EPHI (EPHI means PHI that is transmitted by or maintained in electronic media), as required by HIPAA, the Company has agreed to:

- Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law, including HIPAA privacy standards;
- Implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of EPHI that the Company creates, receives, maintains or transmits on behalf of the Plan;
- Ensure that the adequate separation between the Plan and the Company described above is supported by reasonable and appropriate security measures;



## Employee Assistance Program

- Ensure that any agents, including a subcontractor, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Company with respect to such PHI;
- Ensure that any agent to whom it provides EPHI shall agree, in writing, to implement reasonable and appropriate security measures to protect the EPHI;
- Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Company;
- Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Report to the Plan Administrator any security incident of which it becomes aware;
- Make PHI available to an individual in accordance with HIPAA's access requirements;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make available the information required to provide an accounting of disclosures;
- Make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA;
- If feasible, return or destroy all PHI received from the Plan that the Company still maintains in any form, and retain no copies of such PHI when no longer needed for the purposes for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible);
- To use reasonable and appropriate security measures to protect the security of all PHI, including EPHI, and to support the separation between the Plan and the Company, as needed to comply with the HIPAA Security Standards.

More information can be obtained regarding the use of PHI under HIPAA and the establishment of a security officer from the Notice of Privacy Practices available at <http://www.mympcbenefts.com/documents/mpc-hipaa-notice-of-privacy-practices.pdf>.

## **Appendix C**

### **Eligible Employee Subsets of Participating Companies and Organizations**

- Marathon Petroleum Corporation
  - Regular employees
- Marathon Petroleum Company LP
  - Regular employees
- Marathon Petroleum Service Company
  - Regular employees
- Marathon Petroleum Logistics Services LLC
  - Regular employees
- Marathon Refining Logistics Services LLC
  - Regular employees
- MW Logistics Services LLC
  - Regular Employees
- Speedway LLC
  - Regular employees in Salary Grades 12 and Above
- Speedway Prepaid Card LLC
  - Regular employees in Salary Grades 12 and Above