Marathon Petroleum
Health Care
Flexible Spending Account Plan

Restated Effective
February 15, 2018

Health Care Flexible Spending Account

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Health Care Flexible Spending Account

This document serves both as the Plan instrument and the Summary Plan Description ("SPD") for the Marathon Petroleum Health Care Flexible Spending Account Plan that the Company is required to provide to Plan Participants.

I. Purpose

The purpose of the Marathon Petroleum Health Care Flexible Spending Account Plan (the "Plan" or the "HCFSA Plan") is to permit Marathon Petroleum Company LP ("MPC") to reduce Employees' Compensation by an amount selected by the Employee, which may then be used to pay certain Qualified Medical Expenses during the Plan Year.

The HCFSA Plan allows Participants to pay for certain health care expenses with pre-tax dollars that are not covered by health, dental or other insurance plans. You can set aside pre-tax dollars from your pay to reimburse yourself for the cost of qualifying health care expenses incurred by you or your dependents. As you incur eligible expenses, you may be reimbursed for these expenses on a non-taxable basis. Any health care expenses that would otherwise qualify as a deduction from your personal income tax qualify for reimbursement. (See IRS Publication 502 or Internal Revenue Code ("Code") Section 213, which can be found at your local library or IRS office or online at www.irs.gov/uac/About-Publication-502.)

THE HEALTH CARE FLEXIBLE SPENDING ACCOUNT PLAN IS FOR REIMBURSEMENT OF HEALTH-RELATED EXPENSES FOR YOU AND YOUR DEPENDENTS.

Note: Contributions made under the Plan are, for tax purposes, excluded from gross pay and are not taxable to the Employee. The primary taxes avoided under the Plan are federal income, Social Security and Medicare taxes. In addition, certain state, county, and local income taxes may be avoided depending on an Employee's location. This reduction in gross pay lowers an Employee's income for tax purposes and may affect Social Security benefit calculations.

The Plan is established pursuant to Code Section 125 and the regulations thereunder. The Plan is also intended to qualify as a self-insured medical reimbursement plan under Code Section 105.

II. Eligibility

Regular Full-time and Regular Part-time Employees are eligible to participate in the HCFSA Plan, effective January 1 of each Plan Year.

Regular Full-time means you have a normal work schedule with the Company of at least 40 hours per week or at least 80 hours on a bi-weekly basis.

Regular Part-time employment means you are a non-supervisory Employee who is 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.

You are not eligible for this Plan if you are:

- An intern, co-op, casual or common law Employee who has not been designated by the Company as a Regular Full-time or Regular Part-time Employee; or
- An individual who has signed an agreement, or has otherwise agreed, to provide services to the Company as an independent contractor, regardless of the tax or other legal consequences of such an arrangement; or
- A leased Employee compensated through a leasing entity, whether or not you fall within the definition of "leased Employee" as defined in Code Section 414(n) of the Internal Revenue Code; or
- Enrolled in the Marathon Petroleum Health Plan Saver HSA option in the same Plan Year; or
- Ineligible for coverage under the Marathon Petroleum Health Plan.

III. Definitions

Account means the Health Care Flexible Spending Account described in Article VI.C.

Benefits Open Enrollment Period means the annual period of time designated by the Plan Administrator during which Employees may elect to participate in the Plan for the next Plan Year.

Code means the Internal Revenue Code of 1986, as amended.

Compensation includes pay for hours worked, sick pay, vacation pay, pay for allowed hours, military leave allowance, commissions, overseas premiums, temporary hardship allowances, and any other location premium approved by the Plan Administrator, while a Participant in the Plan; however, bonuses paid after a Participant retires or terminates, travel pay, and other similar special payments are excluded.

Company means Marathon Petroleum Company LP and participating subsidiaries and affiliate organizations set forth in Article XVIII.

Employee means any individual who is employed by the Company.

Grace Period means the period that begins immediately following the close of a Plan Year and ends on the day that is 2 months plus 15 days following the close of that Plan Year.

Participant means an eligible Employee as defined in Article II who makes an election to participate in the Plan for a Plan Year.

Plan Year means the period from January 1 of any calendar year through December 31 of the same year.

Qualified Medical Expenses means expenses incurred for medical care as defined in Code Section 213(d).

Spouse — The term "spouse" shall mean an individual who is legally married to a Participant and who is treated as a spouse under the Code. The term "spouse" shall also include a common law spouse established under the laws of a state in which common law marriage is legal and for which member can provide confirmation of such common law marriage as required in the Marathon Petroleum Affidavit of Common Law Marriage form.

IV. Enrollment/Effective Date of Participation

A. Initial Participation

New Employees may make an election to participate within their first 60 days of employment. You can enroll online or submit a paper enrollment form to the Benefits Service Center. If your election form is received by the Benefits Service Center or signed and dated by a Company representative on your first day of employment, you will be enrolled as of your first day of employment. Benefit enrollment elections made or received on day two through day sixty will be effective as of the date the online election was made or the date the paper enrollment form was properly signed and dated by a Company representative (Supervisor or Human Resources personnel).

If you do not enroll within 60 days after your initial eligibility date, you are not eligible to participate until the following Plan Year and will have to wait until the next Benefits Open Enrollment period to enroll.

B. Benefits Open Enrollment Period

You must enroll **each** year during the Benefits Open Enrollment Period (usually held during the month of November) in order to participate in the HCFSA Plan for the following Plan Year, beginning January 1. Elections must be made on or before the specified end of the Benefits Open Enrollment Period. If you fail to make an election on or before the specified date, then you will be deemed to have waived benefit participation under this Plan for the following Plan Year. Elections under the Plan are irrevocable during the Plan Year, unless you or one of your dependents experiences a qualifying status change or event as described below.

If you are on an unpaid leave of absence during the open enrollment period, you may elect to participate in the HCFSA Plan within 60 days of your return from your leave of absence. Following your election, your participation will become effective on the date you return to active employment. If you are on a leave of absence protected by the Family and Medical Leave Act ("FMLA") during the Benefits Open Enrollment period, you may enroll to participate in the HCFSA for the following Plan Year.

C. Change in Family or Employment Status

If you experience a qualifying change in family or employment status during a Plan Year, as set forth in Article V below, you may be able to cancel or change an election under this Plan. You must make a request to change an election within 60 days of the date of the qualifying status change, and the change in election must be consistent with the status change.

However, a Participant may not make a new election mid-year to reduce the amount available in the Participant's Account if the Participant has received reimbursements from the Account during the plan year that would exceed the total salary reduction amounts for the remainder of the year under the new election.

Note: Any Employee who separates from employment and is subsequently reemployed within the same calendar year by any of the participating companies of this Plan (as set forth in Article XVIII) may elect to participate upon the first day of the next Plan Year. (Participation is not permitted in the same calendar year that both termination and re-employment occur.)

V. Making a Change in Election

Except as provided below, any election that you make under the Plan shall be irrevocable and may not be changed during the Plan Year unless you have a qualifying status change.

You may only change your election under the Plan during a Plan Year if your election is due to and consistent with a "change in family or employment status." For Plan purposes, a "change in family or employment status" includes the following events:

A. You have a change in legal marital status, including marriage, divorce, legal separation, annulment, or death of your spouse;

B. You have a change in the number of your dependents (as defined in Code Section 152), including birth, adoption, placement for adoption, or death of a dependent;

C. You, your spouse, or your dependent has a change in employment status, meaning termination or commencement of employment;

D. You, your spouse, or your dependent has a change in work schedule, including a reduction or increase in hours, a switch between part-time and full-time, or commencement of or return from an unpaid leave of absence, which affects eligibility under the HCFSA Plan;

E. Your dependent satisfies or ceases to satisfy the requirements for an eligible dependent (as defined by the IRS);

F. You, your spouse, or your dependent has a change in residence or work site which affects eligibility under the HCFSA Plan;

G. A court order requires accident or health coverage for your child;

H. You, your spouse, or your dependent gains or loses Medicare/Medicaid entitlement; or

I. Such other events as the Plan Administrator shall determine qualify in accordance with Code Section 125 and the regulations or other guidance issued thereunder.

The Plan Administrator will require Employees to submit satisfactory proof that the change in family or employment status occurred prior to permitting a change in election under the Plan.

If you have a change of status you may revoke your benefit election under the Plan for the balance of the Plan Year and make a new election, but only if both the revocation and the new election are consistent with your change in status.

A change in election made due to and consistent with a change in family or employment status must be made no later than 60 days after the change in family or employment status. If you do not make a change in election within 60 days after a change in family or employment status, you may not make a change in election until you again become eligible as a result of a subsequent change in family or employment status, or the next Benefits Open Enrollment Period, whichever occurs first.

YOU MUST CONTACT THE MARATHON PETROLEUM BENEFITS SERVICE CENTER AT 1-888-421-2199 WITHIN 60 DAYS OF A QUALIFYING STATUS CHANGE TO CHANGE YOUR CURRENT ELECTION.

VI. Plan Benefits

A. Salary Reduction Contributions

Under the Plan, you may choose to either receive your full Compensation for the Plan Year in cash (subject to such elections which you may make for any Plan Year with respect to other benefit plans and benefit programs offered by the Company) or have a portion of it applied through Salary Reduction Contributions by the Company toward the cost of benefits elected by you to be received under this Plan.

Salary Reduction Contributions are not subject to federal income taxes, Medicare tax or social security (FICA) tax. (Appendix A presents a tax savings example.) By making an election under the Plan, you authorize and agree to Salary Reduction Contributions in the amount that the Plan Administrator determines appropriate to cover the benefits elected by you for the Plan Year.

The amount you elect to receive in the form of reimbursements for Qualified Medical Expenses during the period of coverage is equal to the amount of Salary Reduction Contributions elected under this Plan.

Salary Reduction Contributions elected by you will be deducted from your Compensation on a pro rata basis over the period covered by your election based on the number of pay periods in the Plan Year to which your election applies.

If, for any pay period your Compensation to which you are entitled, absent a salary reduction election, is less than your pro rata Salary Reduction Contribution, then no Salary Reduction Contribution will be made by you for that pay period and the Plan Administrator will reduce your salary reduction for the Plan Year.

B. Maximum and Minimum Contribution Amounts

The minimum Salary Reduction Contribution that you may elect is $120 per year, and the maximum amount that you may elect is $2,600 per year. If two Employees are married, each Employee may elect up to a Salary Reduction Contribution of $2,600 per year.

The maximum dollar amount elected for reimbursement of Qualified Medical Expenses incurred during a period of coverage (reduced by prior reimbursements during the period of coverage) shall be available at all times during the period of coverage, regardless of the actual amounts credited to the Participant's Account. However, no reimbursements will be made for Qualified Medical Expenses incurred after participation in the Plan has terminated, unless the Participant has elected COBRA continuation coverage as described in Article IX.

C. Health Care Flexible Spending Accounts

The Plan Administrator will establish and maintain a Health Care Flexible Spending Account ("Account") for each Participant for each Plan Year, but will not create a separate fund or otherwise segregate assets for this purpose. The Account will be a recordkeeping account for the purpose of tracking contributions, reimbursements, and forfeitures. The amount available for reimbursement of Qualified Medical Expenses is the Participant's annual contribution amount, reduced by prior reimbursements made during the Plan Year; it is not based on the amount credited to the Account through contributions at any particular time. Thus, a Participant's Account may have a negative balance during a Plan Year or other period of coverage, but the aggregate amount of reimbursement shall in no event exceed the maximum dollar amount elected by the Participant for the Plan Year.

HCFSA Account Information can be viewed at www.payflex.com or by contacting PayFlex at 844-PAYFLEX (844-729-3539).

D. Description of Benefits

If you elect to receive benefits under this Plan, you will be reimbursed for Qualified Medical Expenses incurred by you, your spouse and your dependents (children, and other qualified dependents as defined in Code Sections 152 and/or 213(d)(5)) during a Plan Year, as well as Qualified Medical Expenses incurred during the 2½ month Grace Period (January 1 through March 15) immediately following such Plan Year, subject to the maximum reimbursement limitations of this Plan and the limits elected by you for the Plan Year. The Plan will not, however, reimburse any payments for services that are paid by an insurer, claims administrator or other third party payer on your behalf.

"Qualified Medical Expenses" means expenses incurred for medical care (as defined in Code Section 213(d)), including but not limited to expenses for diagnosis, cure, mitigation or treatment of disease or injury to the body or mind, or the prevention of such disease. **If you have questions as to whether particular medical expenses qualify for reimbursement under the Plan, contact your tax advisor *prior* to enrolling in the HCFSA Plan.** You may also refer to Appendix B for a list of eligible and ineligible medical expenses.

E. Limitations to Benefits

Before the beginning of each Plan Year, the Plan Administrator will determine the maximum amount of reimbursement benefits that will be permitted for Participants under the Plan for the Plan Year. Reimbursements to you under the Plan for Qualified Medical Expenses covered for a Plan Year shall not exceed the maximum amount so determined by the Plan Administrator. You will be advised of the maximum reimbursement amount provided by the Plan for a Plan Year prior to the commencement of the Plan Year. In no event shall reimbursements to you under the Plan exceed the maximum amount elected by you for the Plan Year. In addition, your benefits may be further limited if you do not file timely claims for benefits under the Plan. For the Plan Year beginning January 1, 2018, the maximum reimbursement amount is $2,600.

F. Funding

Benefits shall be paid from the general assets for the Company. There is no trust or other fund from which benefits are paid.

G. Forfeitures

No Participant shall have any right, title or interest in any assets of the Company as the result of any Salary Reduction Contribution election made by such Participant. Any Salary Reduction Contributions which you have made during a Plan Year and which have not been applied to reimburse you for Qualified Medical Expenses incurred during such Plan Year shall be forfeited.

At the end of the Grace Period following the end of the Plan Year, amounts contributed by you to this Plan through Salary Reduction Contributions that were not reimbursed to you for such Plan Year shall be forfeited in accordance with the requirements of the Internal Revenue Code. It is, therefore, important that you plan carefully in electing your annual contribution amount. Refer to Appendix C for assistance in estimating your annual health care expenses.

VII. Continuation of Participation

Employees may be able to continue participation in the Plan during a leave of absence, as follows:

A. Participation may continue for the duration of the leave if you are on a Military Leave while receiving Company pay offset. If the leave extends into a new calendar year, an election must be made during Benefits Open Enrollment to participate in the new calendar year. Your elected contributions will continue to be deducted from your Compensation, on a pre-tax basis, while on a Military Leave and receiving Company pay offset.

B. Participation may continue for up to six months if you are on any of the following leaves of absence:

   1. Sick Leave,
   2. Family Leave of 12 workweeks or less, and
   3. “Wounded Warrior” Family Leave of 26 workweeks or less.

   Participation may be continued for no longer than six months from the commencement of your leave of absence, or until the end of the Plan Year, whichever is earlier. (You cannot elect to participate in a new Plan Year if you are on a leave of absence, other than a Military Leave, as described in VII.A. above, or FMLA protected leave.)

   While on an unpaid leave of absence of more than 30 days, you may make an election change during the Plan Year, as described in Article V above. Therefore, you may choose to terminate participation upon commencement of any of an unpaid leaves of absence.

If you continue participation, your Salary Reduction Contributions will continue to be deducted on a non-taxable basis from your Compensation, including sick benefits while on Medical Leave, or military pay while on Military Leave. For periods of unpaid leave, you may elect Participant, to the extent possible, to pre-fund your elected contributions from your last paycheck for the payroll period immediately prior to your unpaid status. Upon return to work in a Plan Year, your elected contributions to the HCFSA Plan will resume and additional contributions to the extent possible will be deducted from your pay on a pre-tax basis to cover elected contributions not made for periods while you were on an unpaid leave during the Plan Year.

C. Participation terminates if you are on a leave of absence other than described in A. and B., above, such as those listed below. You may elect to continue your coverage through COBRA (Appendix E). Information on COBRA will be mailed to you by PayFlex.

1. Sick Leave while receiving LTD benefits,
2. Educational Leave, and
3. Personal Leave.

> Employees on an unpaid leave of absence during the enrollment period may elect to participate in the HCFSA within 60 days of their return from a leave of absence.

VIII. Transfer of Employment

If you are transferred to another employer within the controlled group to which MPC belongs (Appendix D), you will remain a Participant for the remainder of the Plan Year. Your annual Salary Reduction contributions must remain at the same level as your initial election amount, unless you incur a qualifying status change during the Plan Year.

IX. Termination of Participation

Your participation in the Plan shall cease on:

A. the end of a Plan Year (December 31) for which you have elected to participate; or

B. the date you cease to be eligible to participate (including due to a leave of absence as described in Article VII.C. above); or

C. the date on which your employment with the Company terminates; or

D. the date on which your employer discontinues participation; or

E. the date on which Marathon Petroleum Company LP terminates the Plan itself.

Note: *You may not terminate participation in the Plan during the Plan Year unless the change is due to and consistent with a change in family or employment status, and your request is made within 60 days of the qualifying status change.*

Upon your termination of participation in the Plan, any remaining Salary Reduction Contributions that you have elected for the balance of the Plan Year and your period of coverage shall cease with the date of termination. You shall have the right to submit a claim for reimbursement at any time prior to the expiration of the period for filing claims for any Qualified Medical Expenses incurred during the period of coverage for which contributions have been paid.

Under the terms of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), your HCFSA may be continued by choosing to continue making monthly after-tax contributions to the HCFSA. If an Employee elects COBRA continuation coverage, participation may be continued through the end of the Plan Year (plus the 2½ month Grace Period), provided claims reimbursement does not exceed employee contributions as of the date of the qualifying event. Contact PayFlex at 1-844-PAYFLEX (1-844-729-3539) to elect COBRA coverage under this Plan or to request additional information.

X. Limitation of Benefits for Highly Compensated and Key Employees

It is the intent of the Company that the election made by a Participant under the Plan shall not result in taxable income merely due to the available election and that all benefits provided under any election under the Plan be nontaxable to the extent permitted under Code Section 125, other Sections of the Code that are applicable to the Group Plans, and any applicable regulations. To the extent that it is necessary to preserve the nontaxable nature of elections made by Participants who are Highly Compensated Members, Highly Compensated Employees, or Key Employees (as defined under Code Sections 125(e)(1), 414(q), and 416(i), and the regulations thereunder), the Company reserves the right to: (1) limit benefits provided to Key Employees to no more than 25 percent of the aggregate of such benefits provided to all Employees under the Plan; (2) provide the Plan to a group or classification of Employees which the Internal Revenue Service shall not find discriminatory in favor of Highly Compensated Employees or Highly Compensated Members; (3) limit the contributions or benefits provided to Highly Compensated Employees so as to avoid discrimination in favor of that group; and (4) convert and/or recharacterize salary reduction elections of Highly Compensated Employees from pre-tax to after tax elections so as to avoid discrimination in favor of that group.

XI. Claim Procedures

There are two ways to obtain reimbursement for Qualified Medical Expenses under the Plan:

A. Debit Card

A debit card will be sent to you containing the value of your annual HCFSA election amount. If you choose to activate the PayFlex debit card, you can use the debit card to pay for eligible out-of-pocket expenses such as copays, coinsurance, deductibles, eligible over-the-counter items, etc. If you do not or cannot use the debit card to pay for an eligible health care expense, you can pay for it with another form of payment, and then submit a manual claim for reimbursement to PayFlex.

In order to be eligible for the debit card, you must agree to abide by the terms and conditions of the debit card program as set forth in the electronic payment cardholder agreement administered by PayFlex including limitations as to card usage and the Plan's right to withhold and offset for ineligible claims.

Every debit card transaction must be validated as an eligible expense. You must keep your itemized receipts and/or EOB's for all expenses paid for with your debit card and provide them to PayFlex when requested. PayFlex may require substantiation to verify any qualifying expenses. If you fail to provide the requested documentation and receipts in a timely manner, or if the Plan or PayFlex determines the payment to have been for a non-qualified expense, the transaction will be deemed ineligible. PayFlex may allow you to either offset the ineligible expense amount with another qualifying expense or request that you reimburse PayFlex the amount of the ineligible expense. Your failure to respond promptly to these requests will result in your debit card being suspended or terminated. If you fail to make the required reimbursement either to PayFlex or the Company, the Company may, in accordance with applicable law, withhold the amount from your paycheck. If, despite these efforts, non-qualified expenses are not reimbursed, the amount may be treated as taxable income and reported as such on your IRS Form W-2, Wage and Tax Statement.

B. Manual Reimbursement

If you prefer to file your own claims or have expenses that were not previously paid with the PayFlex debit card process, you can always file manual claims for reimbursement of eligible expenses:

Mailed claims: PayFlex
P.O. Box 4000
Richmond, KY 40476-4000

Faxed claims: 1-855-703-5305

Customer Service: 1-844-PAYFLEX (1-844-729-3539)

Claim forms can be obtained on the web at www.payflex.com after you register, or by calling PayFlex Customer Service.

All claims (including those expenses incurred during the 2½ month Grace Period) must be postmarked by May 31 following the end of the Plan Year for which Qualified Medical Expenses were incurred and for which reimbursement is sought. Any claims submitted after such date shall be automatically denied. All claims must be made by you or your authorized representative in writing and delivered to PayFlex.

If you have questions or want to check the status of your HCFSA, you should go to www.payflex.com or contact PayFlex at 1-844-PAYFLEX (1-844-729-3539).

First time users should follow the online registration process.

XII. Benefit Claims

If a claim for a Plan benefit is wholly or partially denied by the Plan, notice of the decision shall be furnished to the Participant by the Plan or Third Party Administrator within a reasonable period of time, but not later than 30 days after receiving the claim. If more time is needed to review the claim, the Plan may extend the time period up to an additional 15 days, explaining the reason for the extension and will notify the Participant of the extension before the end of the first 30-day period and reasons for the extension and date by which a decision is expected to be made. If a claim is rejected, the Plan will provide a written notification which shall include the following information:

- The specific reason or reasons for the denial;
- Specific reference to the Plan provisions on which the denial is based;
- A description of any additional material or information necessary to complete the claim and an explanation of why this material or information is necessary; and
- An explanation of the steps to be taken to submit the claim for review.

If a claim is incomplete, the extension notice will also specifically describe the required information or will allow a Participant 45 days to submit any requested information, which will suspect the time for a decision until the information is provided.

Appeals of Denied Claims

A Participant or their duly authorized representative may appeal a denial of a claim by requesting a review by written application to the Plan Administrator or designee no later than 180 days after receipt by the Participant of written notification of denial of a claim. The Participant or his or her duly authorized representative:

- May review pertinent documents; and
- May submit issues and comments in writing. Failure to make written request for appeal within the 180-day period after the receipt of the Plan Administrator's notice of denial of the claim shall render the Administrator's decision regarding the claim final, binding and conclusive on all parties.

A decision on review of a denied claim shall be made by the Plan Administrator not later than sixty (60) days after the Plan Administrator's receipt of a request for review.

Written notice will be provided to the Participant, advising if the appeal was granted or denied. If the appeal is denied, the notice will describe the specific reason(s) for the denial; the specific Plan provision(s) upon which the decision is based; a statement of your right to review (upon request and at no charge) relevant documents and other information; a description of an internal rule, guideline, or other similar criteria relied upon in making the decision, if any; and any additional appeal levels, including the right to seek judicial review of the Plan's decision.

Questions regarding any of the procedures discussed above may be directed to the Plan Administrator.

XIII. 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.mympcbenefits.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.

XIV. Unclaimed Payments

If within 5 years after any amount becomes payable hereunder to a Participant, the same shall not have been claimed, provided due and proper care have been exercised by the claims administrator and the Corporation in attempting to make such payments by providing notice at the Participant's last known address, the amount thereof shall be forfeited and shall cease to be a liability of the Plan. In such case, the amount thereof shall be retained by the Corporation in its general assets. Provided that the claimant initially made a timely claim, the claimant shall have the right and responsibility to re-establish their claim for payment with the Corporation by providing due proof that such amount is owed to the Participant.

XV. Statute of Limitations

A claimant must follow and fully exhaust the applicable claims and appeals procedures described in this Plan before taking action in any other forum regarding a claim for benefits under the Plan. 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.

XVI. 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, as required by HIPAA, the Company has agreed to:

- Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law, including the HIPAA Privacy Standards;
- Implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information ("EPHI") (EPHI means PHI that is transmitted by or maintained in electronic media) that the Company creates, maintains or transmits on behalf of the Plan;
- Ensure that any agent or subcontractor, to whom it provides PHI received from the Plan, agrees to the same restrictions and conditions that apply to the Company with respect to such information;
- 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 Administrator any use or disclosure of the PHI of which it becomes aware that is inconsistent with the uses or disclosures permitted by this section, or required by law;
- Report to the Plan Administrator any security incident of which it becomes aware;
- Make available PHI to individual Plan members as required by Code Section 164.524 of the HIPAA Privacy Standards;
- Make available PHI for amendment by individual Plan Participants and incorporate any amendments to PHI requested by individual Plan Participants, as required by Code Section 164.526 of the HIPAA Privacy Standards;
- Make available the PHI required to provide an accounting of disclosures to individual Plan Participants as required by Code Section 164.528 of the Privacy Standards;
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan and Company with the HIPAA Privacy Standards;
- 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 information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- 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 can be obtained from the Notice of Privacy Practices available at http://www.mympcbenefits.com/documents/mpc-privacy-notice.pdf.

XVII. Administration of the Plan

Important Plan Administration Information	
Plan Name	Marathon Petroleum Health Care Flexible Spending Account Plan
Plan Administrator (Agent for service of legal process)	David R. Sauber P.O. Box 1 539 South Main Street Findlay, OH 45839-0001 Phone: 1-419-422-2121
Employer Identification Number	31-1537655
Type of Plan	Welfare Plan
Plan Sponsor	Marathon Petroleum Company LP 539 South Main Street Findlay, OH 45840
Plan Number	571
Inspection of Plan Documents	Plan documents may be inspected by making a request at any Company Human Resources office or by writing: Marathon Petroleum Company LP Benefits Administration 539 South Main Street Findlay, OH 45840
Plan Year	The Plan Year is January 1 through December 31. Records are kept on a calendar year basis.
Recordkeeper/ Claims Processing	PayFlex Systems USA, Inc P.O. Box 4000 Richmond, KY 40476-4000 1-844-PAYFLEX (1-844-729-3539)

The Plan Administrator shall be responsible for the administration and interpretation of the Plan.

In determining the eligibility of Employees and in construing the Plan's terms, the Plan Administrator has the power to exercise discretion in the construction of doubtful, disputed or ambiguous terms or provisions of the Plan in cases where the Plan instrument is silent, or in the application of Plan terms or provisions to situations not clearly or specifically addressed in the Plan text 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 he or she may make with respect to the Plan, in the form of a written administrative ruling 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.

The records of PayFlex, the Plan Administrator and the Company shall be conclusive in respect to all matters involved in the administration of the Plan except as otherwise provided herein or by law.

The Company shall pay all costs and expenses incurred in administering the Plan.

Any discretionary acts taken under the Plan by PayFlex, the Plan Administrator, or the Company shall be uniform in nature and shall be applicable to all members similarly situated, and shall be administered in a nondiscriminatory manner in accordance with the provisions of the Code. It is intended that the standard of judicial review applied to any determination made by PayFlex or the Plan Administrator shall be the "arbitrary and capricious" standard of review.

The Plan shall be construed, whenever possible, to be in conformity with the requirements of the Code. To the extent not in conflict with the preceding sentence, or preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), the construction of the Plan shall be governed by the laws of the State of Ohio. Decisions of the Plan Administrator made on all matters within the scope of that authority shall be final and binding upon all persons, including the Company, all Participants and beneficiaries, their heirs and personal representatives, and all labor unions or other similar organizations representing members.

In the event that a benefit provided under the Plan does not satisfy the requirements of Code sections 105 and 106, and therefore becomes taxable to the Participant, any reimbursement or benefit will be paid no later than the last day of the taxable year following the taxable year in which the expense was incurred.

XVIII. Further Information

A. Limitation Regarding Employment

Neither the existence of the Plan nor the fact that an Employee has become a member of the Plan shall give any person any right to continued employment. Further, the Company may make decisions relating to an Employee's employment without regard to the effect that such decisions may have on the Employee's rights under the Plan.

B. No Interest or Earnings

No interest or earnings of any type shall accrue, be credited to, or be payable on any amounts that are credited on behalf of a member under the Plan or any supplement thereto.

C. Severability

In case any Plan provisions shall be held illegal or invalid for any reason, such illegality or invalidity shall not affect the remaining provisions, and the Plan shall be construed and enforced as if such illegal and invalid provisions had never been set forth in the Plan.

D. Forfeitures

Any unused amounts from the end of a Plan Year to which the Grace Period relates that are not used to reimburse eligible expenses incurred either during the Plan Year to which the Grace Period relates or during the Grace Period will be forfeited and restored to the Employer. Amounts so forfeited shall be applied by the Employer to reduce future costs.

E. Internal Revenue Service (IRS) Regulations

You are responsible for ensuring the expenses submitted for reimbursement under this program meet all of the eligibility requirements set forth under the Internal Revenue Service regulations. Deliberately providing false information could result in penalties imposed by the Internal Revenue Service.

F. Non-Assignability

No benefit under this Plan may be voluntarily or involuntarily assigned or alienated and any attempt to do so shall be void and unenforceable.

XIX. Participation by Associated Companies and Organizations

Upon specific authorization and subject to any terms and conditions it may wish to establish, Marathon Petroleum Company LP may permit eligible Employees of subsidiaries and affiliated organizations to participate in this Plan. Currently, these participating companies include, but are not limited to, Marathon Petroleum Company LP, Marathon Petroleum Corporation, Marathon Petroleum Service Company, Marathon Petroleum Logistics Services LLC, Marathon Refining Logistics Services 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 D. In addition, eligible subsets of employees must satisfy all eligibility provisions otherwise provide by this Plan.

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

XX. Modification and Termination of the Plan

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 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, the Executive Committee or the Salary and Benefits 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 Senior 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.

XXI. Your Rights Under Federal Law

As a Participant in the Marathon Petroleum Health Care Flexible Spending Account Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all plan Participants shall be entitled to:

Receive Information About Your Plan 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 plan 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 plan. 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.

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 plans 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

Tax Savings Example

You will want to estimate how much money your Health Care Flexible Spending Account might help you save. To do this, make a list of the appropriate health, dental, vision and hearing expenses that you expect to incur during the Plan Year. It will help to review your insurance claims and checkbook over the last year or two to establish an idea of your typical out-of-pocket expenses. Estimate these expenses and multiply the total by your overall tax rates for federal, state, city and Social Security taxes to estimate your savings.

Here's an example of what a family situation might look like:

Eligible Expenses	Without the HCFSA	With the HCFSA
Health and dental plan deductibles and coinsurance	$ 300	$ 300
+ Dental expenses	200	200
+ Eyeglasses/contact lens expenses	200	200
+ Prescription coinsurance/copays	50	50
= Total out-of-pocket expenses	$ 750	$ 750
Taxes on income earned to pay expenses (30%)	$ 225	0
Actual employee cost	**$ 975**	**$ 750**

By paying for medical-related expenses through the HCFSA, this family could save $225 a year in taxes.

Note: Keep in mind; you cannot have an HCFSA if you are enrolled in the Marathon Petroleum Health Plan Saver HSA option.

Appendix B

Qualifying and Non-Qualifying Medical Expenses

The following is not intended to be a complete list of Internal Revenue Service Qualifying Medical Expenses and non-Qualifying Medical Expenses. It is the Company's intention to allow such expenses according to IRS guidelines and as interpreted by PayFlex. If you have questions concerning eligibility of medical expenses, contact your tax advisor and/or PayFlex prior to enrolling in the Health Care Flexible Spending Account.

Expenses Allowed by the IRS

- Acupuncture
- Alcoholism or drug addiction treatment center, including meals and lodging
- Allergy shots
- Ambulance
- Artificial limbs
- Birth control/family planning (male and female)
- Breast pumps and supplies
- Chiropractic expenses
- Christian Science practitioner expenses
- Contact lenses and contact lens solutions
- Cost of medically necessary operations and related treatments
- Crutches
- Deductibles, coinsurance, copayments and amounts exceeding medical, dental and vision plan limits
- Dental expenses, including preventive, diagnostic, restorative, orthodontic and therapeutic care
- Dentures
- Diagnostic fees
- Eyeglasses, eye exams, prescription sunglasses, artificial eye and polish
- Facility fees (hospital, nursing home, rehabilitation facility, home for mentally or physically disabled)
- Fertility treatments
- Health screenings (cholesterol, diabetes glucose, blood pressure, etc.)
- Hearing expenses (including examinations, hearing aids and batteries, TV or phone adapter)
- Home improvements (capital modification of personal residence ramps/doorways/railings/lifts)
- Hospital services/fees
- Insulin
- Insurance plan co-pays and deductibles
- Laboratory fees

- Lodging while receiving medical care away from home (stipulations apply)
- Medical information plan fees
- Medical supplies
- Nursing services (including wages and fees, extra rent or utility expenses)
- Obstetrical expenses
- Orthopedic shoes
- Over-the-counter products that **do not** *require a doctor's statement* or prescription may include wound care products such as bandages and gauze, thermometer, heating pad and contact lenses solution
- Over-the-counter medications and products, which **do** require a doctor's prescription for treatment of a medical condition **and** which must be filled at a pharmacy may include allergy prevention and treatment, antacids, antifungals, antihistamines, cough medicines, decongestants, eye drops, pain relievers, smoking cessation aids, topical antibiotics and topical steroids
- Over-the-counter products, which **do** require a doctor's prescription **and** a doctor's statement stating the diagnosis or medical condition **and** must be filled at a pharmacy may include acne products, dietary/nutritional/herbal supplements, hair loss treatments and lactose intolerance supplements
- Oxygen
- Physician fees
- Prescription drugs/medicines
- Psychiatric fees and psychiatric care, including the cost of supporting a mentally ill dependent at a specially equipped medical center
- Psychologist fees
- Service animals for disabled persons (cost and care of the animal)
- Special modification devices of a telephone or television for the hearing-impaired
- Special education for the blind
- Special plumbing for the handicapped
- Speech therapy to treat a medical condition (or is restorative or rehabilitative in nature)
- Sterilization/sterilization reversal fees
- Surgical fees
- Therapy received as medical treatments
- Transplants, organ or tissue
- Transportation essential to obtain medical care (ambulance, mileage, tolls, parking, taxi, bus, etc.)
- Tuition at special school for disabled person
- Tuition fees (part), if college or private school furnishes breakdown of medical charges
- Vaccines
- Vision correction surgery (doctor's statement may be required)
- Vision expenses — examinations, eyeglasses, contact lenses, and seeing-eye dogs (and their upkeep)
- Weight-loss or stop-smoking program prescribed by a doctor
- Wheelchair and maintenance
- X-rays

Expenses NOT Allowed by the IRS

- Adoption fees
- Church of Scientology practitioners
- Cosmetic surgery-related expenses including doctor, surgical, hospital, supplies, etc.
- Diaper service
- Expenses claimed as a deduction or credit for federal or state income tax purposes
- Expenses reimbursed under another flexible spending account program
- Expenses reimbursed through another benefit program or another employer
- Expenses reimbursed through Medicare or another government program
- Funerals and burials
- General counseling (e.g., family, marital or couple)
- Hair transplants and hair removal
- Health club dues/memberships
- Household and domestic help expenses (even though recommended by a physician due to an employee's or dependent's inability to perform physical housework)
- Insurance premiums, including health, dental, vision, COBRA, life insurance, long-term care insurance, disability insurance, Medicare)
- Lessons (swimming, dancing, gymnastics, aerobics, etc.)
- Liposuction
- Maternity clothes
- Over-the-counter medications (unless prescribed by a doctor and filled at a pharmacy — see "Expenses Allowed by the IRS" section above)
- Personal hygiene products, including toothpaste, toothbrush, floss, deodorant, shampoo, soap and shaving cream
- Physical therapy treatments for general well-being
- Teeth whitening
- Vitamins (without doctor's statement)

Contact PayFlex at 1-844-PAYFLEX (1-844-729-3539) if you have any questions.

Appendix C

Annual Health Care Expenses Worksheet (for determining annual contributions to the HCFSA*)

Expenses that will be paid by you with no reimbursement from other plans**

	Expenses for Self	Expenses for Dependents
Health expenses:		
Health deductibles/coinsurance	$	$
Immunizations	$	$
Routine physical exams	$	$
Well baby care	$	$
Prescription drug deductibles/coinsurance	$	$
Other expenses	$	$
Dental expenses:		
Dental deductibles/coinsurance	$	$
Dental expenses not covered in full	$	$
Orthodontia expenses not covered in full	$	$
Other expenses	$	$
Vision expenses:		
Exams	$	$
Eyeglasses or contact lenses	$	$
Other expenses	$	$
Hearing expenses:		
Exams	$	$
Hearing aids, batteries	$	$
Other expenses	$	$
Other expenses:	$	$
TOTALS	**$**	**$**

Important Information

* This worksheet is not intended to be applicable in whole or in part to every employee situation. If you have questions about whether an anticipated expense will be eligible, contact your tax advisor prior to enrolling in the HCFSA.

** All eligible expenses must have been incurred (have a date of service) during the Plan Year for which they are reimbursed. Eligibility for reimbursement is based on date of service, not date of payment.

If you currently itemize deductions on your federal income tax return and you deduct health-related expenses, you should consult your tax advisor to determine if you should participate in the HCFSA.

Appendix D

Eligible Employee Subsets of Participating Companies and Organizations

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

Appendix E

Continuation of Coverage Rights Under COBRA

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 plan coverage in certain circumstances where plan coverage would otherwise end. This Appendix explains how the provisions of COBRA affect Participants of the HCFSA Plan.

COBRA continuation coverage under the HCFSA Plan will be offered only to Participants and other qualified beneficiaries losing coverage due to a qualifying event who have underspent accounts. A Participant has an underspent account if the annual limit elected by the Participant, reduced by the reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the premiums for HCFSA coverage that will be charged for the remainder of the Plan Year.

HCFSA COBRA coverage will consist of the HCFSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by the reimbursable claims submitted up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the Plan Year, and COBRA coverage will terminate at the end of the Plan Year.

Qualifying Events

COBRA continuation coverage is available to employee Participants who lose coverage due to:

- termination for any reason other than gross misconduct; or
- a reduction in hours.

Spouses of Participants may elect COBRA continuation coverage if the spouse loses coverage due to:

- The employee Participant's death; or
- The employee Participant's reduction of hours; or
- The employee Participant's termination for any reason other than gross misconduct; or
- Divorce or legal separation from the employee Participant.

A dependent child of a Participant may elect COBRA continuation coverage if the dependent child loses coverage under the HCFSA Plan due to:

- The employee Participant's death; or
- The employee Participant's reduction in hours; or
- The employee Participant's termination for any reason other than gross misconduct; or
- The dependent's ineligibility for coverage as a "dependent child."

When the qualifying event is termination, reduction in hours, or death of the Participant, the Plan will offer coverage to qualified beneficiaries. For the other qualifying events (divorce, legal separation, losing eligibility for coverage as a dependent) you must notify the Company in writing within 60 days of the event. Please keep the Company apprised of any changes of address for the Participant and any spouse or dependent children.

If you elect COBRA continuation coverage, you will be required to pay a monthly premium, equal to 102% of your Salary Reduction Contributions, for the remainder of the Plan Year. COBRA coverage will terminate if you fail to pay the required monthly premium, and your Account will be forfeited.

For additional information concerning your COBRA rights, contact PayFlex at 800-PAYFLEX (844-729-3539).