Marathon Petroleum Health Plan

Amended and Restated as of January 1, 2018

Health Plan

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Health Plan

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

I. Purpose

Medical expenses can place sizeable financial burdens on employees and their families, especially in cases of long-term or other catastrophic illnesses. The Company therefore offers this group Health Plan to provide financial assistance for most medical expenses these individuals and their families might encounter. Plan Members may elect coverage under one of the following options:

- The Saver HSA Option is a high deductible health plan with a lower monthly cost to participants. It works like a Preferred Provider Organization (PPO) with the ability to contribute to a Health Savings Account (HSA). Marathon Petroleum makes a contribution to the HSA based on coverage level. The Saver HSA Option is available to all Members.
- The Classic Option is a lower deductible PPO that provides higher levels of reimbursement for a higher monthly cost to participants and is available to all Members.

Coverage under the Medical/Surgical Program (which includes mental health and chemical dependency), Managed Prescription Drug (Prescription) Program, and the Routine Physical and Preventive Services (Preventive Services) Program are provided to Members enrolled in each of the above Options.

II. Helpful Terms

Here are some terms, as defined for purposes of the Health Plan, you may find helpful as you read through this document.

Age 65 — Throughout this document, the terms “age 65,” “post-65” and “over-age-65” mean “eligible for Medicare due to age.” The terms “pre-65,” “under-age-65” and “less than age 65” mean “not eligible for Medicare due to age.” An individual becomes Medicare eligible due to age on the first day of the month in which they turn age 65 or, if the individual turns age 65 on the first day of the month, then Medicare eligibility occurs on the first day of the month preceding the individual’s birth month. The terms are used to assist with readability and comprehension of provisions.

Coinsurance — The percentage of covered costs the Plan or the Member pays after any required deductibles are met. Examples include the 20% coinsurance the Member pays for most in-network services under the Saver HSA and Classic Options.

Copay — A fixed dollar amount (for example, $20) Member pays for a covered health care service, usually at the time you receive the service. The amount can vary by the type of covered health care service, such as an office visit or purchase of prescription drug. With an emergency room copay, coinsurance will also be applied.

Deductible — The amount each covered individual pays toward most covered charges in a Plan Year before the Plan begins paying benefits. Deductible amounts under the Medical/Surgical Program are based on the Option you select. The Medical/Surgical Program and the Managed Prescription Drug (Prescription) Program for prescription drugs purchased at retail each have separate deductibles under the Classic Option. Under the Saver HSA Option, the Medical/Surgical Program and the Prescription Program deductible is combined.

Charges under the Preventive Services Program are not subject to a deductible except for Preventive Services charges incurred out-of-network under the Classic or Saver HSA Options. Such out-of-network preventive services charges are subject to the applicable Option out-of-network medical/surgical deductible.

The deductible for the Classic Option works like this: Once the Classic Option's deductible has been met by an individual covered by the Plan, the Plan starts paying benefits for that individual. When one covered family Member or any combination of covered family Members meet the family deductible, the Plan will start paying benefits for all covered family Members.

The deductible for the Saver HSA Option works like this: For Employee Only coverage, the Plan starts paying benefits once the employee meets the individual deductible. For any Employee Plus Dependent(s) coverage, the Plan starts paying benefits once one covered family Member or any combination of family Members meets the family deductible.

Emergency Care — Emergency care is treatment required immediately for the sudden, unforeseen onset of an illness or accidental bodily injury because permanent disability or endangerment of life could result if the condition were not immediately treated. Examples of emergency situations include: unconsciousness, lacerations requiring sutures, serious burns, fractures, automobile accident, ambulance/EMS/police-initiated visits to an emergency room, electric shock, eye injury, serious breathing difficulties, poisoning and inhalation of smoke or noxious fumes.

Employee Group — Members who make up the "Employee Group" are Employee Members, Spouses of Medicare Primary Employees enrolled in OneExchange, Child(ren) Members of Medicare Primary Employees enrolled in OneExchange and Continued Members who were part of the Employee Group on the date of their initial qualifying event.

ERISA — The Employee Retirement Income Security Act of 1974, as amended.

Exchange Health Reimbursement Account (Exchange HRA) — A Company-sponsored Health Reimbursement Account, to which the Company contributes funds, that is maintained for the benefit of certain Medicare eligible Marathon Petroleum retirees and their Medicare eligible spouses, or an employee or employee's dependent who is eligible for Medicare due to disability, who enroll in an individual Medicare supplemental health care policy offered through a private Medicare marketplace known as OneExchange (see term "OneExchange" further below). *Further information regarding the Exchange HRA is available in the Marathon Petroleum Exchange Health Reimbursement Account plan document, which is separate from this Health Plan.*

Formulary — A list of preferred drugs. If no generic equivalent drug exists and you must purchase a brand name drug, your benefits will be maximized and your out-of-pocket cost minimized when you purchase a name brand drug on the formulary. Express Scripts maintains the formulary list using an independent committee that meets regularly to review the drugs on the formulary based on safety, efficacy, and cost, and to decide whether any new drug should be added. The committee also helps to ensure that Express Scripts' policies are medically sound.

Health Savings Account (HSA) — Members who enroll in the Saver HSA Option and who meet the eligibility rules for an HSA will be able to open an account with Fidelity and elect to contribute pre-tax money to their HSA up to IRS limits. In addition, MPC will contribute money to the Member's HSA. For 2018, the IRS contribution limits are $3,450 for Member Only and $6,900 for Member Plus Dependent(s), with $1,000 in additional catch-up contributions allowed for those age 55 and over. For 2018, MPC will contribute $350 for Member Only coverage and $700 for Member Plus Dependent(s) coverage. HSA funds can be used to pay deductibles and other IRS-recognized health expenditures and, unlike Health Care Flexible Spending Account (FSA) monies, can accumulate into future years. For specific information concerning HSA eligibility, benefits, and administration, refer to Fidelity's materials at www.netbenefits.com or www.401k.com.

HSA-eligible individuals who have not established an HSA with Fidelity by December 1 of the Plan Year will not receive the Company contribution for the Plan Year. Employees who separate employment (other than as a Retiree) prior to opening an HSA through Fidelity will not receive a Company contribution.

Hospital — A legally constituted and operated institution which has on-the-premises organized facilities (such as for diagnosis and major surgery) to care for and treat sick and injured persons. There must be a staff of doctors and a Registered Nurse on duty at all times. This term does not include an institution, or part of one, used mainly for rest or nursing care, convalescent care, care of the aged, care of the chronically ill, custodial care, or educational care.

Infertility — The condition of a presumably healthy Member who is unable to conceive or produce conception after a period of one year of frequent, unprotected heterosexual vaginal intercourse. This does not include conditions for men when the cause is a vasectomy or orchiectomy or for women when the cause is tubal ligation or hysterectomy.

Marathon Petroleum Company LP — In this document, this can be referred to as MPC or Company. It means Marathon Petroleum Company LP and, as appropriate, includes members of the Marathon Petroleum Company LP controlled group which have become participating employers in the Health Plan. These other members are listed in Article XXII, "Participation by Associated Companies or Organizations," and in Appendix C.

Maximum Allowed Amount — An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services (CMS). Unusual circumstances and complications are taken into consideration. The Medical/Surgical Program uses a Maximum Allowed Amount equal to 315% of the Medicare allowed rate.

Medically Necessary — Services or supplies that are provided for the diagnosis or treatment of a medical or mental health and chemical dependency condition; are appropriate for the medical or mental health and chemical dependency condition; are done within the proper setting or manner required for the medical or mental health and chemical dependency condition; and meet generally accepted health care practices.

Member — An individual who meets eligibility requirements, participates in the Health Plan, and meets the criteria as contained in Article III, "Health Plan Participation," of this document.

Negotiated Fee Schedule — The charge for a medical service or mental health and chemical dependency service or treatment that providers have agreed to accept based on a contractual relationship between the Plan and the provider network in which the provider participates. Charges under the Plan will be limited by the Negotiated Fee Schedule depending on the Option elected.

OneExchange — A private marketplace of individual Medicare supplemental, Medicare Advantage and Medicare Part D prescription drug plans, as well as vision and dental plans, offered through OneExchange, a Towers Watson company. Post-65 retirees (and their post-65 spouses) with a hire date prior to January 1, 2008, who choose to purchase an individual medical policy through OneExchange may be eligible for a Company contribution to an Exchange Health Reimbursement Account for each year that retiree/spouse is enrolled in an individual policy through OneExchange.

Out-of-Pocket Maximum — This is the most each covered individual would pay including deductible and coinsurance in a Plan year. Once the out-of-pocket maximum has been met, the Plan pays 100% for covered health care services and supplies for the remainder of the calendar year. The out-of-pocket maximum is combined for the Medical/Surgical Program and the Managed Prescription Drug Program.

The following **do not** count toward satisfying out-of-pocket maximum limits:

- Charges above the Maximum Allowed Amount and Negotiated Fee Schedules; and
- Non-covered charges, including charges incurred after benefit maximums (such as the benefit limit on manipulations) have been reached.

The out-of-pocket maximum works the same for the Saver HSA and Classic Options. Here's how it works: Once the individual out-of-pocket maximum has been met by an individual covered by the Plan, the Plan will pay 100% of covered benefits for that individual. (This is called an "embedded" out-of-pocket maximum.) When one covered family Member or any combination of covered family Members meet the family out-of-pocket maximum, the Plan will pay 100% of covered benefits for all covered family Members. (The Plan never pays non-covered charges or charges above the Maximum Allowed Amount, whether or not the out-of-pocket maximum has been met.)

Preferred Provider Organization or PPO — A network of health care providers (including, but not limited to physicians, hospitals, and providers of ancillary services such as diagnostics and therapy) which is managed by Anthem BC/BS, an organization with whom the Plan has contracted for Members to use their network of providers. The benefit level under the PPO depends on whether or not medical care is provided by a provider participating in the Anthem PPO Network and the Marathon Petroleum Health Plan PPO Option chosen. The two benefit levels available under the PPO Options are **in-network** benefits and **out-of-network** benefits.

Provider — A licensed physician, a hospital, or other health care professional recognized by the Health Plan.

Spouse — The term "spouse" will be interpreted to refer to any individuals who are lawfully married, including a same-sex spouse. "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.

Smart90 Walgreens — A feature of the Managed Prescription Drug Program under the Plan, managed by Express Scripts. Instead of using Express Scripts Mail Order Home Delivery, with Smart90 Walgreens, Members may fill ninety-day supplies of long-term maintenance medications (drugs you take regularly for ongoing conditions) at all Walgreens retail pharmacies and affiliates (including Duane Reade pharmacies) without incurring penalty for filling maintenance drugs at retail.

Urgent Care — Urgent care is treatment for a sudden illness or injury that demands immediate medical attention but is not life threatening. Examples or urgent situations include: sprains/strains, high fever, minor burns, vomiting, ear infections and urinary tract infections.

III. Health Plan Participation

A. Member Eligibility

You are eligible to participate in the Plan as a "Member" as follows.

1. Employee Member

An employee working on a Regular full-time basis (normal work schedule at least 40 hours per week or at least 80 hours on a bi-weekly basis) or Regular Part-time basis (non-supervisory employee as defined by MPC, with a normal work schedule of a minimum of 20 but less than 35 hours per week and not on a time, special job completion, or call when needed basis) is eligible to participate as an Employee Member.

An employee working as a Casual employee (including those hired as a co-op or intern) and who is anticipated to work at least 30 hours per week (or at least 60 hours on a bi-weekly basis) for at least three consecutive months is eligible to participate as an Employee Member.

An employee working as a Casual employee who is not anticipated to work at least 30 hours per week (or at least 60 hours on a bi-weekly basis) for at least three consecutive months will only be eligible to participate as an Employee Member after the employee meets the work hour requirements set forth in Appendix D.

In no case will coverage begin prior to the first active date of employment or, in the case of a Casual employee who becomes eligible upon meeting work hour requirements set forth in Appendix D, prior to the eligible coverage start date, provided the employee enrolls as provided in Article V, "Enrolling in the Plan," of this document.

Specifically excluded from eligibility are leased employees, independent contractors, Casual employees who do not meet the work hour requirements set forth in Appendix D or who are not hired to work a minimum of 30 hours per week for at least three consecutive months, and other employees not designated by the Company as "Regular" employees who work on a full-time or part-time basis.

Employees who are "Designated International" employees as defined by the International Medical Plan are covered under the International Medical Plan. As such, "Designated International" employees and their dependents are not eligible for coverage under this Plan.

2. Spouse of Medicare Primary Employee Who Enrolls in OneExchange

The under-age-65 spouse of an under-age-65 Medicare Primary Employee and former Member who enrolls in an individual policy through OneExchange is eligible to participate as a Spouse of a Medicare Primary Employee enrolled in OneExchange. **Note:** Could occur only when an active Employee has Medicare primary, such as after 30-month Employer-primary period under End Stage Renal Disease rules. Coverage begins:

a. on the date the Medicare Primary Employee and former Member becomes covered under an individual policy through OneExchange, as long as the spouse was eligible to participate in this Plan as a dependent on the day prior to the Medicare Primary Employee's effective date of coverage under the individual policy through OneExchange, or

b. on the date of marriage if the spouse married a Medicare Primary Employee former Member who enrolls in an individual policy through OneExchange.

3. Domestic Partner of Medicare Primary Employee Who Enrolls in OneExchange

The under-age-65 domestic partner of an under-age-65 Medicare Primary Employee and former Employee Member who enrolls in an individual policy through OneExchange is eligible to participate as a Domestic Partner of a Medicare Primary Employee enrolled in OneExchange. **Note:** Could occur only when an active Employee has Medicare primary, such as after 30-month Employer-primary period under End Stage Renal Disease rules. Coverage begins:

a. on the date the Medicare Primary Employee and former Employee Member becomes covered under an individual policy through OneExchange, as long as the domestic partner was a participant in this Plan as a domestic partner on the day prior to the Medicare Primary Employee's effective date of coverage under the individual policy through OneExchange.

4. Continued Member

An individual who has continuing coverage under COBRA is a Continued Member.

B. Dependent Eligibility

Your eligible dependents may be covered under the Plan. They include:

1. Spouse

The spouse, regardless of age, of an Employee Member is an eligible dependent under the Plan.

2. Children

Your children, through end of the month during which they turn age 26, are eligible dependents under the Plan. Children include your:

a. Natural children of the first degree;

b. Legally adopted children, and children placed with you for adoption;

c. Stepchildren;

d. 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. A child covered on December 31, 2003, as a dependent of an Employee Member under this legal custody provision and whose parents are not both deceased is allowed to remain covered under the Plan until their coverage is terminated or they otherwise cease to meet the dependent eligibility requirements of the Plan. Once coverage ends for such child they will not be permitted to be reenrolled under the Plan by a Member using this legal custody eligibility provision unless both parents are deceased and the child otherwise meets the dependent eligibility provisions of the Plan.

3. Domestic Partner

The qualified under-age-65 domestic partner of an Employee Member is an eligible dependent under the Plan. Employees must meet the requirements established in the *Marathon Petroleum Company LP Affidavit of Domestic Partner Relationship* form prior to benefit enrollment.

4. Children of Domestic Partner

Children through end of the month during which they turn age 26 of a qualified under-age-65 domestic partner, who is enrolled in the Plan, are eligible dependents under the Plan. Employees must meet the requirement established in the *Marathon Petroleum Company LP Affidavit of Domestic Partner Relationship* form prior to benefit enrollment.

5. Dependent Disabled Child

A Dependent Disabled Child who has reached end of the month during which they turn age 26 but is less than age 65 and is incapable of self-support due to a mental or physical disability may continue as an eligible dependent through the end of the month prior to the month in which Dependent Disabled Child turns age 65 if the child:

a. became disabled before reaching age 19 and was covered under the Plan when they reached age 19; or

b. became disabled between the ages of 19 and end of the month during which they turn age 26 and was covered under the Plan when they became disabled; and

c. the Disabled Dependent Child is primarily dependent on Member for support. Primarily dependent means child depends on you for more than 50% of their support, and the child qualifies as a dependent under the Internal Revenue Code as evidenced by you claiming the child as a dependent on your federal income tax return.

6. Children Covered by Qualified Medical Child Support Order

If you become divorced or legally separated, certain court orders could require that you provide health care coverage for your child(ren), even if you do not have custody. The Plan will determine if a "medical child support order," as that term is defined under ERISA Section 609, is a "qualified medical child support order" (QMCSO), as that term is also defined under ERISA Section 609, in accordance with the Plan's QMCSO procedures. Administration of the QMCSO by the Plan will be in accordance with the terms of the Plan and the Plan's QMCSO procedures adopted by the Plan Administrator. If you would like a copy of the Plan's QMCSO procedures, please contact the Benefits Service Center at 1-888-421-2199 to request a copy. The procedures are also posted online at www.myMPCBenefits.com, under "Notices & Plan Documents," then "Legal Notices," or can be found directly at http://www.mympcbenefits.com/documents/mpc-qualified-medical-child-support-order-procedures.pdf.

From time to time you may be required to verify the eligibility of any dependent you have covered under the Plan when asked by the Plan or any claim administrator.

Note: You and your covered dependents must be covered under the same Option of the Plan.

C. Who Is Not Eligible

No individual is eligible for benefits as a Member and as a dependent, or as a dependent of more than one Member.

You are not eligible for coverage under this Plan if you are eligible for medical care benefits:

1. Under another plan maintained in the United States, toward which the Company contributes, unless your spouse is in a plan to which the Company contributes that requires you to be covered (cannot waive coverage).
2. Under another plan sponsored by a non-participating member of the controlled group which includes Marathon Petroleum Company LP.

As noted above, specifically excluded from eligibility under this Plan are leased employees, independent contractors, Casual employees who do not meet the work hour requirement set forth in Appendix D or who are not hired to work a minimum of 30 hours per week for at least three consecutive months, and other employees not designated by the Company as "Regular" employees who work on a full-time or part-time basis. Employees who are "Designated International" employees as defined by the International Medical Plan are covered under the International Medical Plan. As such, "Designated International" employees and their dependents are not eligible for coverage this Plan.

D. When Coverage Ends or May be Continued

The following are instances of when coverage under the Plan is terminated or may be continued. In most instances, if coverage may be continued, contributions are required to be paid.

1. The Employee Member resigns, is discharged, or is terminated;
    - Coverage terminates on the date employment terminates.

2. The Member fails to pay the required Member contributions on a timely basis;
    - Coverage terminates on the last date for which contributions were paid.
3. The Employee Member is transferred to a non-participating member of the controlled group to which the Company belongs;
    - Coverage terminates on the date of transfer.
4. The Employee Member loses eligibility because they become a “Designated International” employee as defined by the International Medical Plan;
    - Coverage terminates on the date of change.
5. The Employee Member is temporarily laid off;
    - Coverage may be continued for three months.
6. The Employee Member is on loan to another employer;
    - Coverage may be continued.
7. The Employee Member is on a Medical Leave;
    - Coverage may be continued for two years provided the required monthly contributions are paid.
8. The Employee Member is on Medical Leave while receiving LTD benefits or while on LTD Appeal status;
    - Coverage may be continued provided the required monthly contributions are paid.
9. The Employee Member is eligible for benefits under the Long Term Disability (LTD) Plan as a result of a disability date occurring prior to January 1, 2010;
    - Coverage may be continued through the end of the month in which employee turns age 65.
10. The Employee Member is eligible for benefits under the Long Term Disability (LTD) Plan with a disability date occurring on or after January 1, 2010, and is terminated upon reaching the maximum 24 months of Medical Leave allowed under the Marathon Petroleum Medical Leave Plan;
    - Coverage ceases as an Employee Member on the last day of employment. (Coverage as an LTD Terminated Member under the Marathon Petroleum Retiree Health Plan, if elected, begins on the first day following termination, provided the required monthly contributions are paid.)
11. If an Employee Member ceases to be eligible for benefits under the LTD Plan and does not return to work;
    - Coverage terminates when eligibility for benefits under the LTD Plan ceases.

12. The retirement eligible Employee Member on a Medical Leave is terminated under the neutral discharge practice rules as set forth in the Company's Separation Policy after the first day of the month and has elected to retire the first day of the following month;

    - Coverage terminates on the last day of employment. (Coverage as a Retiree Member under the Marathon Petroleum Retiree Health Plan, if elected, may begin on the date of retirement, provided the Retiree meets the age and service requirements and the required monthly contributions are paid.)

13. The Employee Member is on a Family Leave (including approved FMLA leave);

    - Coverage may be continued provided:

        a. the employee does not become eligible to participate in similar group plans as an employee of another employer.

        Monthly contributions may be paid in advance of the coverage period or on a monthly basis during the leave, or, if not paid in advance or during the leave, will be recouped through payroll deduction upon return from the leave.

14. The Employee Member is on a Personal Leave;

    - Coverage may be continued provided:

        a. payment of the required monthly contributions are made; and

        b. the employee does not become eligible to participate in similar group plans as an employee of another employer.

15. The Employee Member is on a Military Leave (as defined in the Marathon Petroleum Military Leave Policy);

    - Coverage for the employee and dependents will be continued while the employee is receiving Company pay offset subject to the payment of the required monthly contribution by the employee.

16. The Employee Member is granted a leave of absence for other reasons;

    - Coverage is terminated unless approval to continue coverage is granted by the Company.

17. If an Employee Member dies;

    - Coverage for the surviving spouse and other dependents terminates effective the day following the death of the employee. (Coverage as a Surviving Spouse/Dependents under the Marathon Petroleum Retiree Health Plan, if elected, may begin on the day following the date of Employee's death, provided they are eligible and pay the required Member contributions.

18. If the spouse of an Employee Member reaches age 65 before the employee;

    - Coverage for the spouse continues.

19. If Employee Member retires and is not eligible for Medicare due to age (age 65);
    - Coverage terminates on the date of retirement. (Coverage as a Retiree Member under the Marathon Petroleum Retiree Health Plan, if elected, may begin on the date of retirement, provided the Retiree meets the age and service requirements and the required monthly contributions are paid.)
20. If an Employee Member retires and is eligible for Medicare due to age (age 65);
    - Coverage terminates on the date of retirement. (An individual Medicare Supplement policy for post-65 health care coverage may be purchased through a private health care exchange, called OneExchange. Retirees hired on or before January 1, 2008, may be eligible for a Company contribution to the Exchange Health Reimbursement Account to be used toward the purchase of such individual policy.)
21. If an Employee Member and spouse die simultaneously;
    - Coverage for eligible children is continued at Company expense for 60 days following the date of death. (Children or the legal guardian may elect coverage for the children under the Marathon Petroleum Retiree Health Plan, as long as they remain eligible by paying the required contributions.)
22. If a Member becomes divorced;
    - Coverage for the spouse terminates at the effective date of the divorce. Coverage for eligible children may be continued.
23. When a child reaches first of month following month in which they turn age 26;
    - Coverage for the child terminates.
24. If a dependent becomes a regular full-time employee of the Company;
    - Coverage normally terminates since the dependent can join the Plan as an Employee Member. However, if the dependent is a spouse or child, coverage as an employee or as a dependent is optional.

IV. Cost of Coverage

The Plan is designed so the Company pays approximately 80% of the cost of the Plan and Members pay 20% of the Plan cost through contributions.

See Article II, “Helpful Terms,” of this document for the Member types that are part of the “Employee Group.”

Member contributions for the Employee Group are listed in Appendix A. Members will be advised of changes in monthly contributions prior to the start of each calendar year. Members pay for coverage through payroll deductions, or, if not receiving pay, by monthly payments in advance.

A. "Employee" Member Contributions

The total cost for the "Employee Group" is determined annually based on past claims experience for Members of that group. The Company subsidy for the group is then calculated such that the Company will be paying approximately 80% of the cost. Member contributions for the "Employee Group" are contained in Appendix A at the back of this document. Employee Members are required to make contributions on a pre-tax basis under the 125 Plan.

Contributions for eligible employees are based on receiving 100% of the full Company subsidy for the "Employee Group."

IMPORTANT NOTE: The Company reserves the right to modify the Company subsidies described above, and to make corresponding changes to the manner in which the Health Plan Member contributions are to be paid by Employee Members, as the Company may, in its sole discretion, determine to be necessary or desirable.

V. Enrolling in the Plan

A. Benefits Open Enrollment

There is a Benefits Open Enrollment each year during the fall. During Benefits Open Enrollment, a Member of the Plan will be able to change the Option they are enrolled in and, if they have not previously enrolled in the Plan as a Member, be able to late enroll in the Plan. Evidence of good health is not required. Member coverage elected and Option changes made during Benefits Open Enrollment will be effective the following January 1.

B. Member Enrollment

You may elect coverage under the Plan at the times indicated below. If you waive coverage for yourself, any spouse and/or child coverage is also waived.

1. Enrollment When First Eligible for Coverage

a. Prospective Employee Members (other than Casual employees who meet work hour requirements set forth in Appendix D) must enroll online or complete, sign, and submit the proper enrollment form as follows in order to be covered as an Employee Member under the Plan:

   i. Benefit enrollment elections made online on date of hire or via paper enrollment forms signed and dated by a Company representative (Supervisor or Human Resources personnel) or received by the Benefits Service Center on or before the hire date will be considered to have enrolled on their hire date.

   ii. Benefit enrollment elections made online or via paper enrollment forms signed by a Company representative or received by the Benefits Service Center on any day following the hire date will be enrolled in benefits as of the later date.

   iii. Benefit enrollment elections will not be accepted after 60 days from hire date.

iv. Enrollment elections received prior to date of hire will become effective not earlier than the employee's effective date of hire. In the event a prospective Employee Member does not begin his or her employment with the Company on the original scheduled date of hire, the effective date of coverage will be moved to a later date that coincides with the date of the employee's actual date of hire. (New hires and rehires cannot commence benefits under the Plan before they are employed by the Company.)

b. Prospective Employee Members who are Casual employees who meet work hour requirements set forth in Appendix D must complete, sign, and submit the proper enrollment form as follows in order to be covered as an Employee Member under the Plan:

i. Benefit enrollment elections made via paper enrollment forms signed and dated by a Company representative (Supervisor or Human Resources personnel) or received by the Benefits Service Center on or before the first eligible coverage start date will be considered to have enrolled on their first eligible coverage start date.

ii. Benefit enrollment elections made via paper enrollment forms signed by a Company representative or received by the Benefits Service Center on any day following the first eligible coverage start date will be enrolled in benefits as of the later date.

iii Benefit enrollment elections will not be accepted after 60 days from eligible coverage start date.

iv. Enrollment elections received prior to eligible coverage start date will become effective not earlier than the employee's first eligible coverage start date.

Speedway employees who transfer to MPC and Speedway employees who are promoted into a Salary Grade 12 and Above position will maintain the same Health Plan election as in effect under the corresponding Speedway Health Plan for the remainder of the plan year.

2. Late Enrollment

If you have previously waived coverage under the Health Plan, you are able to late enroll in the Plan during Benefits Open Enrollment and your coverage will be effective the following January 1. If you late enroll during Benefits Open Enrollment you may also elect to cover your eligible dependents and the coverage for your eligible dependents will also be effective the following January 1.

In addition to Benefits Open Enrollment, you may late enroll in the Plan due to any of the following four events:

a. your marriage;

b. you acquire an eligible dependent due to birth, adoption, or placement for adoption;

c. your and/or your eligible dependent's loss of eligibility for coverage under another group health benefit plan or other health insurance coverage obtained either through another employer or through self-employment; or

d. the exhaustion of COBRA continuation of coverage by either you or your eligible dependent, under another employer plan.

If the enrollment form is received on or before the date of any of the above events, participation is effective on the date of the event. If the event is due to birth, adoption, or placement for adoption and the enrollment form is received no later than 60 days following the event, then your coverage will begin retroactive to the date of the event. For all other events, if the enrollment form is not received on or before the date of the event and is received no later than 60 days following the event, then coverage will be effective the date the enrollment form is received by the Benefits Service Center or the date employee notifies the Benefits Service Center of such event.

For purposes of this section, the phrase "loss of eligibility for coverage" includes any loss of health coverage which results from a legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, and the termination of employer contributions toward that coverage. Loss of eligibility for coverage does not include a loss of coverage due to any individual's failure to make timely premium payments (or other required contributions) for any reason.

In addition, under the Children's Health Insurance Program (CHIP) Reauthorization Act of 2009, effective April 1, 2009, you may enroll in the Plan within 60 days of either (1) termination of Medicaid or CHIP coverage due to loss of eligibility or (2) becoming eligible for a state premium assistance program under Medicaid or CHIP coverage.

3. Enrollment for Continued Member Coverage

See Article XIX, "Your Legal Right to Continue Coverage Under COBRA."

C. Dependent Enrollment

1. If the enrollment form for an eligible dependent or dependents is received by the Company on or before an event described below, participation is effective on the date of the event. If the enrollment form for an eligible dependent or dependents is received by the Company after the date of an event described below, but no later than 60 days following the event, then coverage will be effective the date the enrollment form is received by the Benefits Service Center or the date employee notifies the Benefits Service Center of such event.

   a. the first date of eligibility of the Member;

   b. the first date of eligibility of the dependent;

   c. the loss of eligibility for coverage by an eligible dependent of a Member under another group health benefit plan or other health insurance coverage obtained either through another employer or through self-employment;

   d. exhaustion of COBRA continuation of coverage under another employer's group health benefit plan by you or your dependent.

   For purposes of this section, the phrase "loss of eligibility for coverage" does not include a loss of coverage due to any individual's failure to make timely premium payments (or other required contributions) for any reason.

Under the Children's Health Insurance Program (CHIP) Reauthorization Act of 2009, effective April 1, 2009, dependents may be enrolled in the Plan within 60 days of either (1) termination of Medicaid or CHIP coverage due to loss of eligibility or (2) becoming eligible for a state premium assistance program under Medicaid or CHIP coverage.

2. If the enrollment form for a child Member is received at any other time than those listed above (which are qualifying events), the child Member can be enrolled at other times — but ONLY if employee Member is already enrolled in the Employee and Children or Employee and Family coverage — and further, the child Member's late enrollment date cannot become effective until 90 days after the later of (a) the effective date of the Member's coverage, or (b) the date an enrollment form is received by the Company.

   Note: An eligible dependent may only be enrolled in the Plan if the Member to which the dependent is related is also enrolled in the Plan.

D. 125 Plan Restrictions

If an Employee Member is making contributions to the Plan through the 125 Plan, coverage types (e.g., Member Only, Member and Spouse, Member and Child(ren) and Member and Family coverage) may not be changed except:

1. when the change is due to and consistent with the events defined in the 125 Plan, including a "change in family or employment status" or a loss of eligibility for coverage under another group health benefit plan (provided employee notifies the Benefits Service Center within 60 days of such change); or

2. during the Health Plan Benefits Open Enrollment at which time the election would be effective January 1 of the year following the election.

In any of the situations described in this Section D, the effective date of changing the type of Health Plan coverage will coincide with the date the change can be made under the terms of the 125 Plan. In addition, failure to provide timely notification (within 60 days of a change in status) of a dependent's ineligibility will mean that Employee Member must continue making Employee Contributions for the coverage level in which Employee was enrolled prior to the status change, even though a dependent is no longer covered under the Plan. (For example, an employee who gets divorced, but fails to make timely notification, would have to continue contributing at the Employee & Spouse coverage cost for the remainder of the Plan year, but will have Employee Only coverage effective the date of the divorce.)

VI. Changing Coverage Options While Enrolled

If a current Plan Member wishes to make a change between the available Options of coverage under the Health Plan, the change may be made during the Benefits Open Enrollment Period designated by the Plan Administrator each year, by using the procedures set up by the Plan Administrator to make such changes. See Article I, "Purpose," of this document for an explanation of available Options. Such a change will be effective for both the Member and any covered dependents on January 1 of the following year.

When an Option change is made other than during Benefits Open Enrollment as described above, see Article XV, "Coordination of Coverage Due to Transfer of Employment or Change of Option" for information on recognition of medical expenses incurred under the previous Option.

VII. Waiver of Coverage

A Member may waive coverage under the Health Plan for the Member and/or dependents at any time, unless the Member is making contributions to the Plan through the 125 Plan as described in Section A immediately below. The waiver is effective the day the proper form is received by the Company. Subject only to the exception described in Section B below, if Member coverage is waived, all dependent coverage must also be waived.

A. If a Member is making contributions to the Plan through the 125 Plan, coverage may not be waived except:

   1. when the waiver is due to a "change in family or employment status" as outlined in the 125 Plan text;

   2. when the waiver is due to an Employee Member who has a change in employment status such that Employee is reasonably expected to average less than 30 hours per week (even if hours reduction does not result in loss of eligibility under this Plan), the Employee may prospectively revoke their election under this Plan provided the revocation corresponds to the Employee's intended enrollment (along with any related individuals who cease coverage due to the revocation) in another plan that provides minimum essential coverage that is effective no later than the first day of the second month following the month that includes the date the Plan coverage is revoked;

   3. when the waiver is due to an Employee Member who becomes eligible for a special enrollment period (i.e., due to marriage, birth, adoption or placement for adoption) to enroll in a qualified health plan under the Health Insurance Marketplace, the Employee may prospectively revoke their election under this Plan provided the revocation corresponds to the Employee's intended enrollment (along with any related individuals who cease coverage due to the revocation) in a qualified health plan in the Health Insurance Marketplace that must be effective beginning no later than the day immediately following the last day of this Plan coverage; or

   4. during Benefits Open Enrollment for the Health Plan, at which time the waiver election would be effective January 1 of the year following the election.

A prospective Member and dependents may rejoin the Plan, subject to the procedures listed under "Late Enrollment" in Article V.

VIII. Special Provisions for Under-Age-65 Disabled/ESRD Individuals

If you or your covered spouse are under age 65, covered by Medicare due to disability or End Stage Renal Disease (ESRD) and have Medicare as the primary payer of benefits, you or they may choose to change your or their coverage from the Health Plan to an individual Medicare supplemental policy through OneExchange.

(Children are not eligible for coverage under an individual policy through OneExchange.) If you make this choice, you may continue to cover your eligible under-age-65 dependents under the Health Plan.

You or your covered spouse may elect to change coverage to an individual Medicare supplemental policy through OneExchange to be effective on the first date of coverage by Federal Medicare, where Medicare is the primary payer of benefits, provided your change election is received by the Company within 60 days after the first date of coverage by Medicare (where Medicare is the primary payer of benefits). In addition, you may change your or their coverage back to the Health Plan or elect an individual Medicare supplemental policy through OneExchange during Benefits Open Enrollment with the change taking effect the following January 1.

For information on making changes from the Health Plan to an individual Medicare Supplemental policy through OneExchange, contact the Benefits Service Center at 1-888-421-2199. For information on Medicare eligibility and your rights to Social Security benefits, contact your local Social Security office.

A. Offset Provision

The offset provision applies to you if you or a covered dependent are disabled/end stage renal disease (ESRD) and "eligible for Medicare Benefits" and have (or would have if Medicare were elected) Medicare as your primary payer of benefits (with the Health Plan as the secondary payer of benefits). Under the offset provision, your benefits under the Health Plan will be reduced (offset) by the benefits payable under Medicare Parts A and B (or that would have been payable had Medicare been elected). "Eligible for Medicare Benefits" means the individual is or could be covered under Medicare Part A, or Part A and B, because of 1) the entitlement to Social Security benefits for themselves or for one of their parents (in the case of a child) or 2) end stage renal disease (ESRD.)

IX. Overview of How the Plan Works

A. Plan Options

If you are eligible to enroll for Health Plan coverage, you and any eligible dependents can enroll in the following options as indicated below:

- **Classic or Saver HSA (Options)** — Both Options are available to all Members and are subject to in-network and out-of-network benefit levels, depending upon the Option chosen.

The PPO (Preferred Provider Organization) network offered will be:

- the Anthem BC/BS BlueCard PPO Network

Prescription drug benefit levels differ based on the Option in which the employee is enrolled. The Managed Prescription Drug Program is administered by Express Scripts.

B. Types of Programs

Benefits under the Plan are provided by the following programs:

1. **Medical/Surgical Program** — Covers services and supplies relating to a medical diagnosis, mental health and chemical dependency, and other services which are not covered by the Managed Prescription Drug Program or the Routine Physical and Preventive Services Program.

2. **Managed Prescription Drug (Prescription) Program** — Covers "outpatient prescription drugs." For a definition of "outpatient prescription drugs," see Article XIII, "Managed Prescription Drug Program." of this document.

3. **Routine Physical Examination and Preventive Services (Preventive Services) Program** — Covers a routine physical examination, and designated preventive screening tests and designated preventive immunizations. Coverage is limited to one covered service each calendar year or as recommended by the U.S. Preventive Services Task Force pursuant to provisions of the Patient Protection and Affordable Care Act (PPACA). See Article XI, "Physical Examination and Preventive Services (Preventive Services)," of this document.

4. **Best Doctors** — Members are eligible to voluntarily utilize this third-party service to gain access to expert physicians to help with making medical decisions and to locate specialists. Members can contact Best Doctors at 1-866-904-0910 or visit www.bestdoctors.com/members. Best Doctors provides the services summarized below.

   In-Depth Medical Review — A leading physician expert reviews a member's diagnosis and/or treatment plan and provides a detailed recommendation. The Best Doctors expert reviews everything in great detail and creates a comprehensive report, either confirming what the member has been told or recommending a change. Members can share the report with their treating physician as a basis for further discussion of treatment options. (Note: As with other medical/surgical treatments, procedures or prescriptions drugs which may be recommended by a health care provider for a member, coverage under the Plan is governed by the terms of the Plan and a recommendation by Best Doctors is not a decision regarding coverage under the Plan.)

   Ask the Expert — Members can get answers to basic questions about a diagnosis, treatment options or a health condition from an expert. Best Doctors will discuss your concerns with you and deliver your questions to the most appropriate specialist. Best Doctors will also help you determine what questions to ask.

   Find A Doctor — If you need to find a specialist in your local area who is approved by the Plan, Best Doctors has a database of more than 53,000 medical experts in over 450 specialties and subspecialties to help find the doctor who's right for you.

C. Comparing the Plan's Options

See Appendix A at the back of this document for the chart comparing the Plan's Options, deductibles and out-of-pocket maximum amounts.

X. Medical/Surgical Program

A. Plan Deductible

The Medical/Surgical Program has a deductible amount that must be met each calendar year before the Plan pays for any medical/surgical covered expenses.

1. **In-Network:** Once the in-network medical/surgical deductible is met, in-network benefits are paid under the Medical/Surgical Program of the Plan. Only in-network covered charges and eligible out-of-network emergency room coinsurance apply toward the in-network deductible. Out-of-network covered charges do not apply toward the in-network deductible, with the exception of eligible out-of-network emergency room coinsurance.
2. **Out-of-Network:** Once the out-of-network medical/surgical deductible is met, out-of-network benefits are paid under the Medical/Surgical Program of the Plan. Out-of-network covered charges apply toward the out-of-network deductible. In-network covered charges **do not** apply toward the out-of-network deductible.

Charges under the Routine Physical Examination and Preventive Services (Preventive Services) Program are not subject to the medical/surgical deductible except for preventive services obtained out-of-network.

Under the Classic Option, charges under the Managed Prescription Drug (Prescription) Program cannot be applied toward the Medical/Surgical Program deductible. Under the Saver HSA Option, the deductible is combined for the Medical/Surgical Program and the Prescription Program.

You can refer to Article II, "Helpful Terms," of this document for more information about how the Plan deductible works under the Classic and Saver HSA Options.

Speedway employees who transfer to MPC and Speedway employees who are promoted into Salary Grade 12 and Above position will have deductibles transferred to the Plan.

B. Out-of-Pocket Maximum Limit

The medical/surgical out-of-pocket maximum is the most each covered individual would pay in the form of deductible, coinsurance and copays each calendar year, subject to the Maximum Allowed Amount and other plan limitations as further described in Article II, "Helpful Terms," of this document. Once the appropriate out-of-pocket maximum has been met, the Plan pays 100% of all medical/surgical covered expenses for the remainder of the calendar year.

Once the in-network medical/surgical out-of-pocket maximum is met, most covered charges under the in-network level of benefits of the Medical/Surgical Program are paid at 100% for the rest of the calendar year. Once the out-of-network medical/surgical out-of-pocket maximum is met, most covered charges under the out-of-network level of benefits of the Medical/Surgical Program and the Preventive Services Program are paid at 100% for the rest of the calendar year. Any copays or coinsurances you pay by obtaining preventive services out-of-network (under the Preventive Services Program) are applied toward the out-of-network medical/surgical out-of-pocket maximum.

In-network and exception benefit level coinsurances apply toward meeting the in-network out-of-pocket maximum limit. Out-of-network coinsurances apply only toward meeting the out-of-network out-of-pocket maximum. However, out-of-network emergency room copays apply toward meeting the in-network out-of-pocket maximum. In-network emergency room copays do not apply toward the out-of-network out-of-pocket maximum. See Article XII, "Classic & Saver HSA Options," Section G for more information on exception benefit levels.

Under both the Classic Option and the Saver HSA Option, covered charges under the Prescription Program are paid at 100% after the combined Medical/Surgical Program and Prescription Program out-of-pocket maximum is reached.

You can refer to Article II, "Helpful Terms," of this document for more information about how the out-of-pocket maximum limit works.

Speedway employees who transfer to MPC and Speedway employees who are promoted into Salary Grade 12 and Above position will have out-of-pocket maximums transferred to the Plan.

C. Covered Expenses

Expenses must be medically necessary in order to be covered by the Plan. They are also limited to the Maximum Allowed Amount, negotiated fee schedules, and other Plan limitations. **See the Article XIV, "Expenses Not Covered Under the Plan," in this document for a list of specific types of expenses which are not covered,** even though they may otherwise be considered medically necessary.

The Health Plan includes (but is not limited to) coverage for the following services at the coinsurance amounts indicated on the chart in Article X, "Medical/Surgical Program, " Section F. Please refer to the separate sections for further requirements which may affect the level of coinsurance (in-network vs. out-of-network).

See Article X, "Medical/Surgical Program," Section D, for specific pre-certification requirements which may apply.

There may be significant penalties applied to the Member for not following the pre-certification requirements.

Required Notice Under the Women's Health and Cancer Rights Act of 1998 (Women's Health Act): If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the deductibles and coinsurance as shown in Appendix A will apply.

If you would like more information on WHCRA benefits, call Anthem at 1-855-698-5676.

1. Hospital Inpatient Charges

Covered hospital charges include:

a. Room and board charges.

b. Intensive care unit charges.

c. Ancillary charges which include charges for diagnostic expenses (laboratory tests and X-rays); medicines; use of operating and recovery rooms; private nursing fees; and other items prescribed as medically necessary by a doctor.

2. Physician and Surgeon Charges

Covered physician and surgeon charges include physician, surgeon, physician specialists, anesthetist and other physician fees for services performed in the hospital. (For physician charges in the emergency room, see "3. Emergency Room Charges" below.)

Classic and Saver HSA Options. If a covered individual uses an in-network facility and the facility uses an out-of-network Radiologist, Anesthesiologist, Pathologist, and/or Assistant Surgeon, coverage for the provider will be at the in-network level (80% under both Options) and the charges will be subject to the Maximum Allowed Amount (which means the Member will be responsible for both the coinsurance of 20% as well as any charges in excess of the Maximum Allowed Amount).

Independent Medical Evaluations/Second Surgical Opinions. You may be required to obtain an Independent Medical Evaluation (IME)/Second Surgical Opinion by the pre-certification review agency if there are any questions as to medical necessity, appropriateness, and cost effectiveness of a hospital admission, surgery, or diagnostic procedure. You will be advised if you are required to obtain an IME/Second Surgical Opinion and the charges for the approved evaluation will be covered by the Plan without being subject to the medical/surgical deductible or coinsurance provisions.

3. Office Visits — Primary Care

Standard Primary Care Physicians include:

- Advance Registered Nurse Practitioners
- Nurse Practitioners
- Nurse Practitioner Pilot Program
- Obstetricians
- Gynecologists
- General Practice
- Family Practice
- Internal Medicine
- Physician Assistants
- Pediatricians
- Clinical/Multi Specialty Groups

Classic Option. The Member copay for covered physician office visits is $20 if an in-network provider is used. If Member uses an out-of-network provider, Member cost is 40% coinsurance after meeting the out-of-network deductible, as well as any charges in excess of the Maximum Allowed Amount.

Saver HSA Option. The Member pays 100% of charges until the deductible is met. If an in-network provider is used, once the in-network deductible has been met, Member cost is 20% coinsurance. If Member uses an out-of-network provider, once the out-of-network deductible is met, Member cost is 40% coinsurance, as well as any charges in excess of the Maximum Allowed Amount.

4. Office Visits — Specialist Care

Specialist Physicians include cardiologists, oncologists, chiropractors, pulmonologists, urologists, rheumatologists and neurologists. In general, specialists are those who provide medical care in a specialized medical field and who are not listed above as a standard primary care physician.

Classic Option. The Member copay for all covered physician office visits is $50 if an in-network provider is used. If Member uses an out-of-network provider, Member cost is 40% coinsurance after meeting the out-of-network deductible, as well as any charges in excess of the Maximum Allowed Amount.

Saver HSA Option. The Members pays 100% of charges until the deductible is met. If an in-network provider is used, once the in network deductible has been met, Member cost is 20% coinsurance. If Member uses an out of network provider, once the out-of-network deductible is met, Member cost is 40% coinsurance, as well as any charges in excess of the Maximum Allowed Amount.

5. Office Visits — LiveHealth Online

Using LiveHealth Online, Members have access to board-certified doctors 24 hours a day, seven days a week, via an online video visit with a doctor or therapist by using a smartphone, tablet or computer with a webcam. LiveHealth Online physicians can provide medical care for common conditions including the flu, colds, pink eye, sinus infections, bronchitis and more and can send prescriptions to the pharmacy of your choice, if needed. For more information on how to use or sign up, Members should go to www.livehealthonline.com. LiveHealth Online is not for emergencies.

Classic Option. The Member copay for a LiveHealth Online visit is $10, and the copay is applied to your in-network out-of-pocket maximum.

Saver HSA Option. Member cost for a LiveHealth Online visit is $49, and the cost is applied to your in-network deductible and out-of-pocket maximum.

6. Urgent Care Facility

Urgent Care facilities are not emergency rooms and not meant to provide treatment of life threatening or serious conditions. Urgent care facilities are often open for extended hours in the evenings and on weekends, and can provide treatment for common conditions such as upper respiratory infection, ear ache, fever, and minor injuries, cuts and burns.

Classic Option. The Member copay for a visit to an urgent care facility is $50 if an in-network provider is used. If Member uses an out-of-network provider, Member cost is 40% coinsurance after meeting the out-of-network deductible, as well as any charges in excess of the Maximum Allowed Amount.

Saver HSA Option. The Members pays 100% of charges until the deductible is met. If an in-network provider is used, once the in-network deductible has been met, Member cost is 20% coinsurance. If Member uses an out-of-network provider, once the out-of-network deductible is met, Member cost is 40% coinsurance, as well as any charges in excess of the Maximum Allowed Amount.

7. Emergency Room Charges

Covered emergency room charges include emergency room facility charges, physician charges, and ancillary charges.

Under the Classic Option, all emergency room visits that do not result in a hospital admission will be subject to a $200 copay. Additionally, the Member pays any amount remaining toward meeting the deductible and then 20% coinsurance. The emergency room copay does not apply toward the deductible, but it does apply toward the out-of-pocket maximum.

Under the Saver HSA Option, the Member pays 100% of charges until the deductible is met. Once the deductible has been met, the Member is subject to a $200 copay (copay waived if member is admitted to the hospital) and then 20% coinsurance. The emergency room copay applies toward the out-of-pocket maximum.

8. Ambulance Services

Covered ambulance services include emergency local ambulance service or public carrier, to and from the residence or place of disability and nearest adequate facility for treatment, as prescribed by a doctor. Ambulance services to or from the patient's home or other location for convalescence care are generally not covered. Refer to Article XIV, "Expenses Not Covered Under the Plan," for further information.

9. Diagnostic Tests

Diagnostic tests must be recommended by a doctor for the diagnosis of an illness or injury. Covered diagnostic tests include X-rays or tests performed in a doctor's office, laboratory, or at a hospital as an outpatient. Hearing tests are covered if medically necessary and performed for diagnostic purposes in connection with an illness or injury.

10. Therapeutic Treatment

The following therapeutic treatments are covered. Periodic reports at the individual's expense stating the ongoing nature of the treatments may be required before benefits will be paid.

a. Physical therapy, occupational therapy, and non-educational speech therapy. Physical therapy, occupational therapy and non-educational speech therapy are limited to 30 visits per each therapy per diagnosis, with in-network and out-of-network visits combined and with facility and professional services combined. Additional therapy will require medical necessity review and approval.

b. Manipulations, regardless of provider type or specialty, are limited to 20 visits per person per year, while the individual is not confined to a hospital or other covered institution as an admitted inpatient.

11. Immunizations, Injections, and Allergy Shots

Expenses for immunizations, allergy shots, and other injectable drugs which are not covered under any other provision of the Plan, are covered by the Plan under this provision if they are prescribed by a physician for treatment of an illness or injury. (Please note, insulin and certain specialty medications — injectable medications administered either by the Member or a health care professional — are covered under the Managed Prescription Drug Program of the Plan.)

12. Treatment for TMJ

Charges for the treatment of Temporomandibular Joint Dysfunction (TMJ) are covered by the Plan.

13. Hearing Aids

Coverage for hearing aids and certain related charges are covered, subject to deductible and coinsurance, only if services are obtained through an in-network provider. Coverage is limited to one hearing aid per ear every 36 months (three years). Covered expenses include conformity exam, placement exam and hearing aid assessment exam, each limited to one per 36 months, not included with any other exam. Hearing exams/testing are covered with no visit limit, batteries, repairs and additional charges are not covered.

14. Coverage for Autism Spectrum Disorder and Rett Syndrome

Treatment includes Applied Behavior Analysis (ABA) therapy, as well as speech and occupational therapy within the limits of the Plan.

Applied Behavior Analysis (ABA) Therapy:

- Precertification is required prior to services being rendered.
- A diagnosis of Autism Spectrum Disorder or Rett Syndrome is required. Evaluation and diagnosis must have been completed by a psychiatrist, developmental behavior pediatrician, psychologist or neurologist.
- Ongoing reviews for medical necessity take place at specific intervals throughout the child's treatment. These typically occur every six months. However internals may vary based on the child's needs and the target behaviors that are being addressed through therapy.
- ABA providers must be independently licensed professional such as clinical social workers, clinical psychologists or masters level therapists; or they must be behavior analysts certified by the Behavior Analyst Certification Board.
- ABA may be provided in an office setting, in the home or in another community setting outside of the classroom. Services provided in the classroom setting are not covered.

Members or their ABA provider must contact Anthem's Autism Spectrum Disorders (ASD) Program at 1-844-269-0538 prior to engaging in ABA services to request pre-certification and to ensure services are covered. The ASD Program provides clinical review of ABA assessment and treatment requests to insure that appropriate and medically necessary care is being delivered. The Program also offers autism-focused case management services to support members with coordination of care, resource referrals and educational information.

15. Infertility Treatment

With a diagnosis of infertility, covered treatment includes one attempt (or cycle) per member per lifetime, at an in-network provider, for in vitro fertilization ("IVF") and artificial insemination ("AI"). IVF includes gamete intrafallopian transfer ("GIFT) and zygote intrafallopian transfer ("ZIFT"). Labs, X-rays, ultrasounds or diagnostic procedures do not count toward the one attempt (or cycle), but will be covered as well. Although not required, the provider should submit a pre-determination to Anthem to verify the treatment sought is a covered procedure at an in-network provider or facility, as well as to provide member with an estimate of covered expenses. Treatment provided by an out-of-network provider is not covered.

16. Mental Health Parity and Substance Abuse Equity

The Plan has been designed to be in compliance with the Mental Health Parity and Addiction Equity Act of 2008 (the MHPAEA) and will provide inpatient and outpatient benefits, including emergency care and prescription drug coverage, for mental health conditions and substance use disorders without quantitative or non-quantitative treatment limitations more restrictive than those applied to equivalent medical/surgical benefits for other conditions covered by the Plan. To the extent that the Plan does not otherwise satisfy the requirements of the MHPAEA, the Plan will be interpreted under this paragraph in the manner which complies with the requirements of the MHPAEA.

Charges for the following expenses are covered by the Plan:

Substance Abuse Disorders

a. Inpatient institutions and ancillaries and residential treatment centers, including detoxification. Methadone clinics are covered.

b. Outpatient institutions and outpatient therapy. Methadone clinics are covered.

c. Outpatient office visits.

Mental Health and Eating Disorders

a. Inpatient institutions and ancillaries and residential treatment centers.

b. Outpatient institutions and outpatient therapy.

c. Outpatient office visits.

In order for treatment to be eligible for coverage at a residential treatment center ("RTC") or facility, the RTC must be licensed and operated as required by law, which includes:

a. Room, board, and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight hours daily with 24 hour availability;

b. A staff with one or more doctors available at all times;

c. Residential treatment takes place in a structured facility-based setting;

d. The resources and programming to adequately diagnose, care and treat a psychiatric and/or substance use disorder;

e. Facility is designated residential, subacute, or intermediate care and may occur in care systems that provide multiple levels of care; and

f. Is fully accredited by The Joint Commission ("TJC"), the Commission on Accreditation of Rehabilitation Facilities ("CARF"), the National Integrated Accreditation for Healthcare Organizations ("NIAHO"), or the Council on Accreditation ("COA").

The term residential treatment center/facility does not include a provider, or that part of a provider, used mainly for:

a. Nursing care

b. Rest care

c. Convalescent care

d. Care of the aged

e. Custodial care

f. Educational care

17. Other Covered Expenses

Charges for the following expenses are covered by the Plan:

a. Charges made by a registered nurse when recommended by a doctor to perform skilled nursing procedures on an intermittent basis.

b. Charges for radiation therapy and chemotherapy whether performed as a hospital inpatient or an outpatient.

c. Charges for intravenous (IV) and intramuscular injectable drugs. (Please note, certain specialty medications — injectable medications administered either by the Member or a health care professional — are covered under the Managed Prescription Drug Program of the Plan.)

d. Charges for durable medical equipment and prosthetic/orthopedic devices. These charges include plastic molds, splints, trusses, crutches, braces, artificial limbs or eyes, insulin pump (as well as tubing and needles for the pump) and rental of respirator, wheelchair, hospital-type bed, or special mechanical equipment for treatment of an illness.

e. Charges for acupuncture provided by a licensed or certified physician, chiropractor, or acupuncturist acting within the scope of that license or certification. (Does not include acupuncture coverage for smoking cessation treatment.)

f. Contraceptive diaphragms and IUDs.

g. Weight Reduction surgery is covered under the Health Plan under the "Centers of Excellence" concept. Qualifying Health Plan Members will receive coverage for the procedure if they have the procedure done at a facility that has been identified as a Center of Excellence by Anthem BC/BS. Reimbursement will be at the 80% level under both Options. ***If the procedure is done at a facility that has not been designated as a Center of Excellence, there will be no reimbursement.***

   In order to qualify for this surgery, you must have a Body Mass Index of at least 40, or a BMI of 35 or greater with complicating morbidities, directly related to or exacerbated by obesity. There are other requirements that you may have to meet. In order to see if you qualify, you will need to contact Anthem. They will also be able to provide you with the list of Centers of Excellence.

18. Hospitalization Alternatives

a. Skilled Nursing Facility

Skilled nursing facility means an institution that provides room, board and skilled nursing services for medical care around-the-clock. It must comply with legal requirements and keep daily medical records of all patients. The term does not include institutions used mainly for substance abuse, rest care, educational care, custodial care or care of the aged.

Coverage for skilled nursing facility is subject to the following restrictions:

If confinement begins after:

- discharge from a hospital confinement of at least three days; or
- discharge from an extended care facility where confinement began as described immediately above;

then payment will be made up to the 180th day of confinement for covered charges made by the facility.

If member is readmitted to a skilled nursing facility within 72 hours, no new hospital stay is required.

Payments for all skilled nursing facility confinements are limited to 365 days in each covered person's lifetime.

b. Home Health Care

Home Health Care Agency means a public or private agency or organization, or part of one, which provides skilled nursing and other therapeutic services. It must keep clinical records of all patients. The services must be supervised by a doctor or Registered Nurse and they must be based on policies set by associated professionals, which include at least one doctor and one Registered Nurse.

Charges made by a qualified home health care agency for home health services that have been prescribed by a doctor in place of hospital services are covered by the Plan. Covered services include:

- Part-time nursing care given in the covered person's home by a Registered Nurse, a Licensed Practical Nurse, a Licensed Public Health Nurse, or Licensed Vocational Nurse, if under the supervision of a Registered Nurse;
- Part-time home health aide visits for personal care of the patient and light household tasks (four hours allowed per visit);
- Physical, occupational, or non-educational speech therapy provided in the covered person's home; and
- Physical, occupational, or non-educational speech therapy, or the use of medical equipment and prescription drugs provided on an outpatient basis by a home health agency, or if arranged with a home health agency, a hospital or other facility.

Services performed by a Member of the covered person's immediate family or by a person who normally lives in the home are excluded. Also excluded are services not needed for the treatment of an injury or illness.

c. Hospice Care

Hospice care is a coordinated system of medical, psychological and nursing care for terminally ill patients given at an approved hospice facility or at home.

Covered hospice care expenses include inpatient hospice care services, physician services, pain control, prescription drugs, home health care services, physical therapy, use of medical equipment, homemaker services, emotional support services, and bereavement counseling.

Hospice covered expenses are in place of all other benefits under any other provision of the Plan for the same charges.

19. Case Management

If you or a covered dependent suffer a catastrophic illness or injury, you'll likely have many decisions to make regarding medical care. Case Management is designed to help manage the care of patients who suffer a catastrophic illness or injury while covered under the Plan.

The primary objective of Case Management is to identify and coordinate alternative medical treatments that are cost effective and meet accepted standards of medical practice. Case Management also monitors the care of the patients, and coordinates communication among the health care providers, patients, and others.

You or your covered dependent may be offered the chance to participate in Case Management after the Case Management team reviews your medical status, talks to the attending physician, and determines that an alternative treatment program or other special assistance would be in your best interest and is cost effective to the Plan.

If you accept the offer to participate in Case Management, the Plan pays after the deductible 100% of expenses which are not covered expenses under any other provisions of the Plan. All of these expenses must be incurred while you are covered under the Plan and are participating in Case Management. Custodial care (except for respite care) is not covered under the Case Management provision.

The patient may terminate participation in Case Management, or the Plan may terminate the patient's participation in Case Management at any time. Expenses incurred after such a termination are not covered under these Case Management provisions.

Anthem BC/BS is the third party administrator of the Plan who makes the Case Management decisions on behalf of the Plan.

20. Transplant Management Program

The Transplant Management Program is administered by Anthem BC/BS. Your coverage is higher if you participate in the Transplant Management Program.

You must agree to have the procedure performed at one of the designated Transplant Centers of Excellence facilities offered by Anthem BC/BS, and they must have a center of excellence that is for the required transplant.

If the above requirements are met, coverage will be at 100% for health care expenses related to the specialized procedure performed at the designated Transplant Centers of Excellence facility. The hospital expenses of a donor or prospective donor which are related to the covered individual's organ or tissue transplant are covered at 100%. The Transplant Management Program covered expenses are in place of all other benefits under any other provision of the Plan for the same charges. There is a maximum benefit allowance of $30,000 per occurrence for the National Bone Marrow Donor Search. In addition, the approved transportation and approved lodging for one accompanying individual (two individuals if patient is minor child) will be reimbursed at 100%. Lodging is limited to $50/day; maximum travel reimbursement is $10,000 per transplant.

a. If you choose not to participate in the Transplant Management Program

The designated facilities under the Transplant Management Program are considered participating providers/in-network providers. If you choose not to participate in the Program and choose not to use a designated facility, your procedure will be subject to the out-of-network provisions of the Classic and Saver HSA Options. You will also be subject to the out-of-network provisions if you use an otherwise participating provider. Eligible donor or prospective donor expenses will be covered at the out-of-network level of benefit.

b. Other Transplant Information

Please note that the choice of physician and facility under this Plan is that of the patient. "Transplant Centers of Excellence" is a term of Anthem BC/BS and its use does not constitute an endorsement by MPC or the Plan. The Plan offers these "Transplant Centers of Excellence" in an effort to broaden Member choices, but does not endorse any provider over another.

21. Clinical Trials

The Plan pays for routine care costs incurred during your participation in a qualifying clinical trial. Benefits include coverage for services given to a participant in an approved clinical trial if the services are covered services under this Plan. Covered expenses will be covered at the in-network level if provided by an in-network provider or at the out-of-network level if provided by an out-of-network provider.

An "approved clinical trial" means a phase I, phase II, phase III or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

a. Federally funded trials approved or funded by one of the following:
   - The National Institutes of Health
   - The Centers for Disease Control and Prevention
   - The Agency for Health Care Research and Quality
   - The Centers for Medicare & Medicaid Services
   - Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs
   - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
   - Any of the below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
     - The Department of Veterans Affairs
     - The Department of Defense
     - The Department of Energy

b. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;

c. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

When a requested service is part of an approved clinical trial, it is a covered service even though it might otherwise be Investigational as defined by this Plan. All other requests for clinical trials services that are not part of approved clinical trials will be reviewed according to Anthem Clinical Coverage Guidelines, related policies and procedures.

The Plan is not required to provide benefits for the following services and reserves its right to exclude any of the following services:

- The experimental/investigative item, device, or service, itself; or
- Items and services that are given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; or
- Any item or service that is paid for, or should have been paid for, by the sponsor of the clinical trial.

D. Pre-Certification Requirements

Pre-certification is required for certain services. All inpatient admissions (including observation care), almost all outpatient surgeries, and certain diagnostic procedures must be pre-certified. Your provider will work with you to obtain pre-certification. However, you or the covered Member is ultimately responsible for making sure that pre-certification is received. **Any care that is not certified as medically necessary by the appropriate pre-certification review agency is not covered by the Plan.**

1. Pre-Certification Review Unit and Contact Information

To receive pre-certification or if you have questions about pre-certification, call the number below. You are required to call the pre-certification review unit for all in-network and out-of-network care.

- Pre-certification Review Unit: Telephone number 1-866-776-4793

2. Inpatient Admissions and Outpatient Services Requiring Certification

See Appendix B for list of inpatient admissions and outpatient services that require pre-certification with the pre-certification review unit.

3. Time Frame for Making the Certification

You are required to call the pre-certification review unit prior to an admission or procedure under the time frames stated below.

a. Hospital inpatient admissions, including observation care

i. **Elective Admissions** — You are required to notify the pre-certification review unit at least seven days prior to an elective admission. In cases where this is not possible, notify them as soon as you know about the intended hospital admission.

ii. **Maternity Admissions** — Although pre-certification is not required for maternity admissions, you are encouraged to notify Anthem BC/BS of such admissions since it is helpful for Anthem BC/BS to monitor treatment for both the mother and newborn.

Required Notice Under the Newborns' and Mothers' Health Protection Act (Newborn's Act): Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

iii. **Emergency Admissions** — Call the pre-certification review agency within two working days following an emergency admission. An emergency admission is defined as a condition which, unless treated at once on a hospital inpatient or observation basis would either jeopardize the patient's life, or cause serious impairment to the patient's body functions.

b. Outpatient Services

You are required to call the pre-certification review agency at least seven days before the scheduled surgery or diagnostic procedure. In cases where this is not possible, notify them as soon as you know about the surgery or procedure.

E. Assistance from 24/7 NurseLine and ConditionCare

1. All Plan Members have access to a registered nurse 24 hours a day, 7 days a week. 24/7 NurseLine is available to offer reliable and timely information to:

   - Assess and understand symptoms.
   - Find additional help to make informed healthcare decisions.
   - Locate a doctor, hospital or other practitioner.
   - Get information about an illness, medication or prescription.
   - Find information about a personal health issue such as diet, exercise or high blood pressure.

   The Program is administered by Anthem and can be reached by calling **1-888-596-9473**. Bilingual nurses are also available.

2. Anthem BC/BS has also been engaged to provide ConditionCare for employees who have chronic conditions involving asthma, chronic heart failure (CHF), chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD) or diabetes. If you have a chronic condition, you may be contacted by a nurse specifically qualified to help you: learn to recognize your symptoms and lessen their affect, understand which treatments and medications may work best for you, help to follow your doctor's plan of care, and live healthier and feel your best every day.

The ConditionCare Program is voluntary. Plan Members can get more information on the ConditionCare Program by calling **1-866-387-8827**.

F. Medical/Surgical Program — Member Coinsurance and Copay Chart

(Chart information is subject to limitations described in other parts of this document.)

Expense Type	Saver HSA (After Deductible, Member Pays)		Classic (After Deductible, Member Pays)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
1. Hospital Inpatient Charges				
a. Room and board (semi-private room)	20%	40%	20%	40%
b. Ancillary charges	20%	40%	20%	40%
2. Physician and Surgeon Charges				
a. Physician charges for inpatient surgery, maternity, and medical consultation	20%	40%	20%	40%
b. Physician charges for outpatient surgery:				
– In physician's office	20%	40%	20%	40%
– Other than physician's office	20%	40%	20%	40%
c. Office visits to primary care physicians	20%	40%	$20 copay*	40%
d. Office visits to specialists	20%	40%	$50 copay*	40%
e. Virtual office visit via LiveHealth Online	$49	Not covered	$10 copay*	Not covered
f. Office visit at urgent care facility	20%	40%	$50 copay*	40%
g. Independent medical evaluation/second surgical opinion (if required and approved)	$0	$0	$0	$0
h. Radiologists, anesthesiologist, pathologists services and assistant surgeon	20%	40%	20%	40%
3. Mental/Behavioral Health and Substance Use Disorder				
a. Outpatient services	20%	40%	$20 copay*	40%
b. Virtual office visit (licensed psychologist or therapist via LiveHealth Online)	$49	Not covered	$10 copay*	Not covered
c. Inpatient Services	20%	40%	20%	40%

* Copay not subject to deductible.

(continued)

Expense Type	Saver HSA (After Deductible, Member Pays)		Classic (After Deductible, Member Pays)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
4. Emergency Room (ER) Charges, Including Physician Charges	20% (After deductible is met, 20% after member pays $200 ER copay; copay waived if admitted)	20% (After deductible is met, 20% after member pays $200 ER copay; copay waived if admitted)	20% (After member pays $200 ER copay*; copay waived if admitted)	20% (After member pays $200 ER copay; copay waived if admitted)
4a. Non-Emergency Use of Emergency Room (ER), including Physician charges	40% (After deductible is met, 40% after member pays $200 ER copay)	40% (After deductible is met, 40% after member pays $200 ER copay)	40% (After member pays $200 ER copay*)	40% (After member pays $200 ER copay)
5. Ambulance Services				
a. Emergency	20%	20%	20%	20%
b. Non-emergency (subject to medical necessity)	20%	20%	20%	20%
6. Diagnostic Tests (that are not preventive)	20%	40%	20%	40%
7. Therapeutic Treatments				
a. Physical, occupational and non-educational speech therapy (30 visit maximum per each therapy per diagnosis; medical review required for additional visits)	20%	40%	20%	40%
b. Manipulation (subject to 20 visits per year per covered member limit)	20%	40%	$50 copay*	40%
8. Immunizations (which are not preventive), Injections, and Allergy Shots	20%	40%	20%	40%
9. Treatment for TMJ	20%	40%	20%	40%
10. Other Covered Expenses	20%	40%	20%	40%
11. Hospital Alternatives: Home Health Care and Hospice Care	$0	$0	$0	$0
12. Skilled Nursing (limited to 180 days maximum per year/365 days lifetime, combined in- and out-of-network)	$0	40%	$0	40%
13. Case Management	$0	$0	$0	$0
14. Transplant Management Program (using Center of Excellence)	$0	40%	$0	40%
15. Transplant (not using Center of Excellence)	40%	40%	40%	40%

* Copay not subject to deductible.

XI. Physical Examination and Preventive Services (Preventive Services)

A. Eligibility

All members covered by this Plan, either as a Member or a dependent, are eligible for the benefits under Preventive Services.

B. Deductible

There is no separate deductible under the Preventive Services Program. Benefits are or are not subject to the medical/surgical deductible as follows:

1. In-Network Level of Benefits

Benefits for in-network covered services **are not** subject to the medical/surgical in-network deductible.

2. Out-of-Network Level of Benefits

Benefits for out-of-network covered services **are** subject to the medical/surgical out-of-network deductible.

C. Out-of-Pocket Maximum Limit

There is no separate out-of-pocket maximum under the Preventive Services Program.

The Preventive Services Program is subject to the medical/surgical out-of-pocket maximum limit. Since designated preventive services are covered at 100%, except for out-of-network preventive services, the Preventive Services Program is generally not affected by the medical/surgical out-of-pocket maximum limit.

D. Covered Expenses

Coverage for the preventive services designated below is at the coinsurance amounts indicated on the chart in Article XI, "Physical Examination and Preventive Services (Preventive Services)," Section E. For individuals enrolled in either the Classic or Saver HSA Options, the coinsurance amount depends on if the preventive service is obtained using a network provider (in-network) or a non-network provider (out-of-network). Pursuant to provisions of the Patient Protection and Affordable Care Act (PPACA), the Plan will cover, at no cost to Member, preventive services as recommended by the U.S. Preventive Services Task Force, provided that such services are provided by an in-network provider. To access the federal government's website listing of Recommended Preventive Services (which may be updated from time to time), go to http://www.healthfinder.gov/HealthCareReform/Default.aspx. For other preventive services that are not on the Recommended Preventive Services list, but are nonetheless deemed a preventive service, such expenses are generally covered at 100%, limited to the Maximum Allowed Amount, Negotiated Fee Schedules, and other Plan limitations. Questions concerning specific preventive services and coverage under the Plan should be directed to Anthem BC/BS at 1-855-698-5676.

The preventive services coverage is generally limited to preventive screening services and immunizations for wellness purposes. The purpose of preventive services is to provide early detection before you become aware that you have an illness or injury. Your visit to the physician is no longer considered preventive if you are having symptoms of an illness or injury — such a visit is considered diagnostic and is not covered under the Preventive Services Program. In addition, coverage is not to treat a condition you currently have. While those expenses are not covered under this Preventive Services Program, the expenses may be covered under the Medical/Surgical Program provisions of the Plan.

Routine visits to your physician are important to assist you in maintaining your health. However, not every individual needs the same preventive screening tests every year or at the same interval. Your need for certain tests depends upon several factors including your age, gender and heredity, as well as your lifestyle. You should discuss the purpose of your visit as a routine preventive examination when scheduling the appointment with your physician.

1. **Well-Baby and Well-Child Care**

   Covered are charges incurred by a covered individual through 18 years of age for routine physical examinations, designated screening tests, and designated preventive immunizations.

2. **Adults — Routine Physical Examination, Preventive Screening Tests and Preventive Immunizations**

   Covered are charges for a routine physical examination, designated screening tests and designated preventive immunizations for individuals age 19 and older. Coverage is limited to one such service per individual per year or as recommended by the U.S. Preventive Services Task Force pursuant to provisions of the Patient Protection and Affordable Care Act (PPACA). (For example, one routine physical exam, one screening mammogram, one prostate specific antigen (PSA) test, etc., per individual per year.)

   a. **Routine Physical Exam**

      To assure that procedures are age and gender appropriate, Anthem BC/BS, working together with your physician and pursuant to the provisions of the Patient Protection and Affordable Care Act, will determine which tests should be performed and their recommended frequency.

   b. **Preventive Immunizations**

      The Plan will also rely on Anthem BC/BS to follow the preventive care recommendations of the U.S. Preventive Services Task Force, to determine what preventive immunizations will be covered. In general most common preventive immunizations (including those required for international travel) will be covered at 100%. Please note that if your physician requires you to purchase a vaccine at the pharmacy prior to administration, the Managed Prescription Drug (Prescription) Program through Express Scripts will cover the vaccine at 100%. Charges to administer the vaccine would still be covered by the Medical/Surgical Program portion of the Health Plan.

3. Claims for Covered Preventive Services

In order for a claim for covered preventive services to be paid properly, the provider must use standard procedure and diagnostic codes for preventive/routine services when billing. If the claim is submitted for services that are not covered by the Preventive Services Program or with a diagnosis or procedure code that is not normally used for a wellness/routine service, the claim will be subject to the Medical/Surgical Program provisions of the Plan. A routine chest X-ray is not a covered preventive service.

E. Preventive Services Program Coinsurance and Coverage Chart

Expense Type	Classic and Saver HSA In-Network (No Deductible)	Classic Out-of-Network (After Med/Surgical Out-of-Network Deductible)	Saver HSA Out-of-Network (After Med/Surgical Out-of-Network Deductible)
1. Well Baby/Child Care (through age 18)	100%	60%	60%
2. Physician Charges for Routine Physical Exam (only designated services covered)	100%	60%	60%
3. Preventive Screening Tests (only designated services)	100%	60%	60%
Radiologist and Pathologist Services Rendered for Preventive Screening Tests	100%	60%	60%
4. Preventive Immunizations (only designated immunizations covered)	100%	60%	60%

Note: County health departments and similar government agencies are not PPO Network participating providers. However, for purposes of this Preventive Services Program only, county health departments and similar government agencies will be considered as if they were "network providers" for benefit payment purposes and coverage will be at the in-network level of benefits when immunizations are obtained at such facilities.

Immunizations, except for the influenza vaccine, obtained at a drug store, grocery store, or other similar locations will not be covered at the in-network benefit level. A claim for a flu shot obtained at an Express Scripts pharmacy location should be able to be automatically processed at the pharmacy at 100% of the cost. If a flu shot is obtained at a non-Express Scripts pharmacy or grocery store or other public flu shot provider, you will need to pay for the service and then file a claim with Anthem for 100% reimbursement.

XII. Classic and Saver HSA Options

A. How Do the PPO Options Work?

The Classic Option and the Saver HSA Option (the PPO Options) offer you the freedom to choose the benefit level you will receive each time you access medical care. The benefit level depends on whether or not medical care is provided by a provider participating in the Anthem BC/BS PPO Network. The two benefit levels available under the PPO Options are **in-network** benefits and **out-of-network** benefits.

If medical care is provided by a provider participating in the PPO Network, the Member receives in-network benefits which offer a higher benefit level. In addition to higher benefits, Members using a PPO Network provider will benefit from having lower out-of-pocket costs (in the way of coinsurances) because the PPO Network providers generally charge lower fees to PPO Option Members than to non-Members.

The PPO Network is a network of health care providers (including, but not limited to physicians, hospitals, and providers of ancillary services such as diagnostics and therapy) which is managed by Anthem BC/BS, with whom the Plan has contracted for PPO Option Members to use their network of providers.

If medical care is not provided by a PPO Network provider, the individual is subject to out-of-network benefits which result in higher out-of-pocket expenses.

It is important that you show your Anthem BC/BS I.D. card to your provider.

B. How to Locate a Provider Who Participates in the PPO Network

You can obtain information on participating Providers by contacting Anthem as follows:

Anthem Member Services Phone Number: 1-855-698-5676
(Specify you are looking for PPO providers)

Anthem's website: www.Anthem.com

C. General PPO Coverage

Fees for services provided by a provider participating in the PPO Network are subject to the Negotiated Fee Schedule of the PPO Network. The Network Negotiated Fee Schedule is the maximum allowable reimbursement for services rendered by a provider participating in the PPO Network. Providers accept the lesser of the charged fee or the Network fee as payment in full for covered services. Fees for services provided by a provider not participating in the PPO Network are subject to the Maximum Allowed Amount regardless of the level of coverage paid under the PPO Option.

D. Using the PPO Options

Here are the basic guidelines for receiving health care through the PPO Options.

1. To be eligible to receive in-network benefits for covered services, all medical care must be obtained from a PPO Network participating provider. PPO Network providers will generally try to refer patients to other PPO Network providers. **However, it is your responsibility to make sure the provider from whom you or your covered dependent is receiving health care services participates in the PPO Network before care is given.**
2. If medical care is not obtained from a PPO Network participating provider, you are subject to the provisions of the out-of-network benefit level.

> **PPO Network**
>
> The Anthem BC/BS PPO Network (the PPO Network) includes both primary and specialty care physicians. Primary care physicians include general and family practitioners, pediatricians, general internists, OB/GYNs, certified nurse midwives, nurse practitioners, physician assistants, geriatrics and clinical/multi specialty groups. Examples of specialists include surgeons, cardiologists, allergists, chiropractors and oncologists. Both primary and secondary hospitals are included in the PPO Network. Providers of ancillary services, such as diagnostic services (X-ray and laboratory) and therapy services (physical, speech, and occupational) are also included in the PPO Network.

E. Obtaining Medical Care in the Anthem PPO Network Area

1. Routine or Urgent Care in the Anthem PPO Network Area

When you utilize a provider in the PPO Network for routine or urgent care, you will receive the in-network level of benefits for covered charges that are medically necessary. If you do not use a provider in the PPO Network, you will be subject to the provisions of the out-of-network level of benefits.

2. Emergency Care in the Anthem PPO Network Area

a. When the covered individual is in an Anthem Network Area and emergency care is required, they should seek health care treatment immediately and go directly to the nearest emergency facility. If a provider is used who is participating in the PPO Network, they will receive the in-network level of benefits for covered charges.

b. If a provider is used in an emergency who is not participating in the PPO Network, the individual will receive the in-network level of benefits for covered charges provided Anthem determines the requirements have been satisfied to receive the in-network level of benefits.

c. If follow-up treatment after the emergency is required and provided by a physician or other provider who is not participating in the PPO Network, the individual will receive the in-network level of benefits for covered follow-up treatment for up to 90 days after the date of the emergency facility visit, provided Anthem determines the medical condition treated in the emergency facility was an emergency.

For more detailed explanation of what is an emergency or urgent situation, see Article II, "Helpful Terms," of this document.

F. Obtaining Medical Care When Temporarily Out of the Anthem Network Area

Covered charges for emergency and urgent medical care received when temporarily away from an Anthem Network Area due to business, vacation, or when a child is away at college will be covered at the in-network benefit level provided Anthem determines the requirements have been satisfied to receive the in-network benefit level. It is expected that non-emergency and non-urgent medical care will be obtained upon the Member's return to their Anthem Network Area.

For emergency care, seek health care treatment immediately and go directly to the nearest emergency facility.

Anthem has broad networks including both emergency and urgent care facilities. When you are temporarily away from your local network area and need emergency or urgent care, if you have the opportunity please call the number on your Health Care ID for a list of participating providers in the area. However if you are not able to check network status before seeking care at a facility, please do not hesitate to seek the care you need. It is probable the facility you choose will be an Anthem PPO Network participating facility anyway. However, if Anthem receives an emergency or urgent claim from an out-of-network facility and processes it as out-of-network, please call their number to have the claim reconsidered for payment at the in-network level of benefits.

1. Living Outside of the United States

Active employees assigned to a permanent work station outside the United States will be offered an opportunity to enroll in the Company Sponsored International Medical Plan. Unless Anthem has special international relationships, Plan members who choose to live outside the United States will be required to return to the United States to seek coverage in the Anthem Network or work with Anthem to file the claims as out of network. Anthem BC/BS Option has a Blue Cross Blue Shield Global Core benefits that may be explored by calling their service center at 1-800-810-2583, or call collect 1-804-673-1177 before you travel or move internationally. Blue Cross Blue Shield Global Core can provide you with access to medical assistance, doctors and hospitals in more than 200 countries around the world.

G. Exception Benefit Level

An Exception Benefit level exists in place of the out-of-network level of benefits for certain covered expenses when care is obtained from a provider not participating in the PPO Network. In rare instances the PPO Network may not have a physician specialty or ancillary service available within the PPO Network. An Exception Benefit level covers specialties or covered services not available through the PPO Network at 80%, subject to the in-network deductible, provided both of the following requirements are satisfied:

- Prior approval is obtained from Anthem. You will need to advise your referring physician that they must initiate this prior approval request. The phone number is: Anthem BC/BS PPO Option – Anthem BC/BS Precertification at 1-866-776-4793.

- There is no network provider who can perform the service within a 100 mile radius (as the crow flies) from the covered individual's permanent residence. (If there is a network provider who can perform the service within a 100 mile radius of the covered individual's permanent residence, the covered individual must use a network provider in order to receive the in-network level of benefits. If the covered individual in this situation does not use a network provider, they will receive the out-of-network benefit level.)

XIII. Managed Prescription Drug Program

The Managed Prescription Drug (Prescription) Program applies to all Members covered under the Plan. Prescription drug benefit levels differ based on the Option the employee enrolls in. The Prescription Program has a Retail Pharmacy component and a Mail Order component. Both are administered by Express Scripts. All coverage under the Prescription Program is subject to medical necessity determination and other Plan limitations.

Individual and family deductibles and out-of-pocket maximum amounts can be found in Appendix A at the back of this document.

Pursuant to provisions of the Patient Protection and Affordable Care Act (PPACA), the Plan will cover, at no cost to Member, vaccines, supplements and over-the-counter products (prescribed by a physician or other appropriate provider) which are recommended by the U.S. Preventive Services Task Force, provided that such vaccines, supplements and OTC products are provided by an in-network provider. To access the federal government's website listing of Recommended Preventive Services (which may be updated from time to time), go to http://www.healthfinder.gov/HealthCareReform/Default.aspx. Questions concerning specific preventive services and coverage under the Plan should be directed to Express Scripts at 1-877-207-1357.

A. Coverage

1. To Receive Coverage

To receive coverage under the Plan, outpatient prescription drugs (see below for explanation of what are outpatient prescription drugs) must be purchased through the Retail Pharmacy Component (through a participating Express Scripts retail pharmacy) or through the Mail Order component (from Express Scripts' Mail Order pharmacy) of the Prescription Program. Network pharmacies (both Retail and Mail Order pharmacies) offer discounted drug prices, drug utilization review to protect individuals from potentially dangerous drug interactions, and no claim forms to submit.

Except for certain exception situations explained in the Plan document, there is no coverage for outpatient prescription drugs that are not purchased through a Retail or Mail Order Network pharmacy.

Coverage levels vary depending on whether you use the Retail or Mail Order component.

Smoking cessation drug therapy is limited to 180 days of therapy (consisting of one or more prescriptions including prescribed over the counter medications) per year per individual.

2. Outpatient Prescription Drugs

a. Outpatient prescription drugs are prescription drugs which are:

i. Prescribed to be administered when the patient is not confined to a hospital as an inpatient (includes certain specialty medications — injectable medications administered either by the Member or a health care professional).

ii. Not billed by a home health agency, hospice agency, or sub-acute care facility (extended care facility).

iii. Federal legend drugs (prescription drugs), state restricted drugs, most hormone replacement therapies via compounded medications, and oral contraceptives.

iv. Insulin, with a prescription only, and covered diabetic supplies, with a prescription only.

- Test strips: Can be filled as a 30-day supply at any in-network pharmacy or 90-day supply at Smart90 Walgreens Program or Express Scripts Mail Order. Test strips are not subject to the retail maintenance third fill penalty.
- Glucometers, lancets and syringes: Members must use Smart90 Walgreens Program or Express Scripts Mail Order and will be subject to the retail maintenance third fill penalty if filled as a 30-day supply at in-network retail pharmacies.

(An insulin pump, as well as tubing and needles for the pump, are covered under the durable medical equipment provisions of the Medical/Surgical Program portion of the Plan and are not covered as a diabetic supply item under the Prescription Program.)

b. Not covered under the Prescription Program but subject to the provisions of the Medical/Surgical Program are:

i. Supply items (other than diabetic supplies), therapeutic devices, and durable medical equipment (durable medical equipment includes an insulin pump as well as tubing and needles for the pump); and

ii. Prescription drugs and covered diabetic supplies billed by a home health agency, hospice agency, or sub-acute care facility (extended care facility).

B. Saving Yourself and the Plan Money When You Buy Prescription Drugs

You can save yourself and the Plan money by following three guidelines when you purchase your prescriptions:

1. Purchase generics instead of brand name drugs;
2. If no generic is available, purchase brand name drugs on the Express Scripts Preferred Prescriptions Formulary list instead of brand name drugs not on the formulary, and
3. Purchase your maintenance prescriptions from Express Scripts Mail Order or from a Walgreens retail pharmacy instead of at other retail network pharmacies.

C. Prescription Drug Benefit Levels

1. Prescription drug benefit levels differ based on the Option in which Member is enrolled.

Under the Classic Option: When you use a participating retail pharmacy, you will first pay the Retail Pharmacy Component (Retail) deductible amount. After the Retail deductible amount is satisfied, you will pay your share through a copay. There is no deductible under the Mail Order Component (Mail Order) or Smart90 Walgreens program. Speedway employees who transfer to MPC and Speedway employees who are promoted into Salary Grade 12 and Above position will have any deductibles transferred to the Plan.

Classic Option	Member Pays	
Type of Medication	**Retail (30-Day Supply)**	**Mail Order or Smart90 Walgreens (90-Day Supply)**
Deductible	$100 individual/$200 family	None
Generics	$10 after deductible	$25, no deductible
Brand Name Drugs on the Formulary	$30 after deductible	$75, no deductible
Brand Name Drugs Not on the Formulary	$60 after deductible	$150, no deductible
Specialty Drugs*	Certain specialty drugs must be filled through Express Scripts Specialty Pharmacy after first fill (subject to retail deductible). Specialty drugs are subject to formulary and non-formulary brand copays.	

* To participate in manufacturer copay programs that will reduce costs to the Plan, copays for certain specialty medications may be set to the out-of-pocket maximum of the current plan design or any available manufacturer-funded copay assistance. This will not result in increased copay costs to the Member, and any manufacturer assistance provided will not be applied toward Member's deductible or out-of-pocket maximum.

Under the Saver HSA Option: When you use a participating retail pharmacy, you will first pay the deductible amount, which is combined with the Medical/Surgical Program. After the combined deductible amount is satisfied, you will pay your share through coinsurance. The deductible amounts can be found in Appendix A at the back of this document. Speedway employees who transfer to MPC and Speedway employees who are promoted into Salary Grade 12 and Above position will have deductibles transferred to the Plan.

Under the Saver HSA Option, the deductible does not apply for certain generic preventive medications (you just pay coinsurance).

HSA Saver Option	Member Pays	
Type of Medication	**Retail (30-Day Supply)**	**Mail Order or Smart90 Walgreens (90-Day Supply)**
Deductible	Combined with medical	Combined with medical
Generics	20% after deductible (for certain generic preventive drugs, the deductible does not apply*)	20% after deductible (for certain generic preventive drugs, the deductible does not apply*)
Brand Name Drugs on the Formulary	20% after deductible	20% after deductible
Brand Name Drugs Not on the Formulary	20% after deductible	20% after deductible
Specialty Drugs	Certain specialty drugs must be filled through Express Scripts Specialty Pharmacy after first fill. Member pays 20% after deductible.	

* There are certain prescription drugs that the IRS calls "preventive" because they prevent or treat catastrophic conditions, such as high blood pressure, high cholesterol and asthma. This list is different from the drugs covered at 100% under the provisions of the Patient Protection and Affordable Care Act (PPACA).

Under both Classic and Saver HSA Options: Deductibles and coinsurance will not be applied to vaccines, supplements and over-the-counter products (prescribed by a physician or other appropriate provider) recommended by the U.S. Preventive Services Task Force, provided that such vaccines, supplements and OTC products are provided by an in-network provider. Such items will be covered at 100%. To access the federal government's website listing of Recommended Preventive Services (which may be updated from time to time), go to http://www.healthfinder.gov/HealthCareReform/Default.aspx.

2. There are certain situations where you will pay more:

   a. Brand Name Drugs When a Generic Is Available (Generic Election Provision) — At both Retail and Mail Order, if you purchase a brand name drug when a generic equivalent is available, the plan benefit will be based on the cost of the generic equivalent drug. You will pay the coinsurance or copay (based on your Option) of the generic drug cost plus 100% of the difference in price between the generic drug and the brand name drug. The difference in price between the generic drug and the brand name drug will not be applied toward meeting any deductible or out-of-pocket maximum. The Generic Election Provision does not apply to insulin and covered diabetic supply items.

   b. Maintenance Drugs (Incentive Mail Order and Smart 90 Walgreens) — Under the incentive mail order and Smart90 Walgreens provisions, you will pay more for a "maintenance" drug purchased at a participating retail pharmacy instead of at Express Scripts Mail Order or a Smart90 Walgreens pharmacy the third time you purchase the drug at retail and each subsequent time that you purchase the "maintenance" drug at a retail pharmacy.

The first two times you fill a "maintenance" drug at a participating retail pharmacy your benefit coverage will be as indicated above under Article XIII, "Managed Prescription Drug Program," Section (C)(1) "Prescription Drug Benefit Levels." To encourage you to purchase "maintenance" drugs through Express Scripts Mail Order or Smart90 Walgreens, the third and later times you purchase a "maintenance" drug at a participating retail pharmacy (that is not through the Smart90 Walgreens program or Express Scripts Mail Order), you will pay 100% of the cost, which will not be applied toward any deductible or out-of-pocket maximum.

A "maintenance" drug is one taken for a long period of time and is designated by Express Scripts as a "maintenance" drug. Call Express Scripts' Customer Service at 1-800-841-3423 to find out if a prescription drug is designated as a "maintenance" drug by Express Scripts. Insulin is not categorized as a "maintenance" drug and is not subject to these "maintenance" drug provisions. The cost of prescription drugs is less when purchased through mail order than when purchased through a participating retail pharmacy. You are encouraged to purchase maintenance drugs through mail order.

Obtaining a new prescription for the exact same maintenance drug will not allow you to avoid the maintenance prescription coverage provision. If you obtain a new prescription at retail for the exact same maintenance drug, it will be treated as an extension of the previous retail maintenance prescription. For example, if you have obtained two fills of a maintenance drug at a participating retail pharmacy and obtain a new prescription for the exact same drug, your first fill of the new prescription will be considered the third time you filled the prescription and the Plan coverage will be 0%.

c. **Brand Name Drugs Not on the Formulary (Incentive Formulary Provision)** — You will pay more for brand name drugs that are not on the Express Scripts Preferred Prescription Formulary. The Generic Election Provision (Article XIII, Section C(2)(a)) also applies if you purchase a brand name drug not on the formulary and that brand name drug has a generic equivalent available. You will pay the coinsurance or copay (based on your Option) of the generic drug cost plus 100% of the difference in price between the generic drug and the non-formulary brand name drug. The difference in price between the generic drug and the non-formulary brand drug will not be applied toward meeting any deductible or out-of-pocket maximum.

   Call Express Scripts at 1-800-841-3423 to see if a drug is on the formulary or to request a copy of the formulary. You can also obtain information about the formulary online at www.express-scripts.com.

D. Using the Retail Pharmacy Component

Use the Retail Pharmacy Component when a prescription is to be taken on a short term basis or for your first prescription of a medication you will be taking for a long period of time (such as 60 days or more). Prescriptions (including covered diabetic supply items) under the Retail component are limited to a 30-day supply maximum. Present your Express Scripts ID card to the pharmacist at a participating pharmacy. At the pharmacy you will pay the deductible amount and after the deductible amount is satisfied, if enrolled in the Saver HSA option, you will pay the lesser of 1) the 20% coinsurance share, or 2) the retail price; or, if enrolled in the Classic option, you will pay the lesser of 1) the copay as listed in Article XIII, "Manage Prescription Drug Program," Section C(1), or 2) the retail price. No claim forms are required.

The names of participating pharmacies in your area or throughout the country (when you travel) are available by calling Express Scripts Customer Service at 1-800-841-3423 or from Express Scripts' website, www.express-scripts.com.

E. Exceptions

In certain situations, there are exceptions to these provisions. Each of the four following situations requires the submission of a claim form when outpatient prescription drugs (including covered diabetic supplies) are purchased as indicated. The four exception situations are as follows:

1. Outpatient prescription drugs purchased outside the United States by covered individuals who reside in the United States, but who are temporarily out of the country due to business or leisure and where a medical need arises, are covered by the Plan at 80% of the purchase price for generic or brand-name drugs after the deductible (if enrolled in the Saver HSA Option) or will be subject to the member copay amount after the deductible (if enrolled in the Classic Option). None of the following provisions apply in this situation: Generic Election Provision, Incentive Mail Order Provision and Incentive Formulary Provision.

2. If the covered individual receives outpatient prescription drugs in the situations listed below and is billed by an out-of-network pharmacy, coverage levels will be the same as coverage provided under the in-network Retail Pharmacy Component, however, the Incentive Mail Order Provision for maintenance drugs does not apply in this situation.

    a. Patient lives in and receives outpatient prescription drugs through a rest home, nursing home, sub-acute care facility (or other extended care facility or skilled nursing facility), convalescent hospital, or similar institution; or

    b. Patient receives outpatient prescription drugs from a hospice or home health agency.

3. If the covered individual purchases outpatient prescription drugs at a participating retail pharmacy but the claim is not filed electronically by the pharmacist for reasons listed below, coverage will be as indicated in Article XIII, "Managed Prescription Drug Program," Sections (C)(1) or (C)(2) "Prescription Drug Benefit Levels" after the deductible is paid. In both situations the Generic Election, Incentive Mail Order or Smart 90 Walgreens, and Incentive Formulary Provisions apply.

    a. For a new Member (within the first 30 days of coverage) not included in the Express Scripts system, coverage is based on the purchase price of the prescription drug.

    b. If the individual did not have their Express Scripts ID card, or for any other reason the claim was not filed electronically, coverage is based on the negotiated network price of the prescription drug.

4. If the covered Member resides in the United States and does not have access to (beyond 10 miles) a participating Network pharmacy, coverage will be as indicated in Article XIII, "Managed Prescription Drug Program," Sections (C)(1) or (C)(2) "Prescription Drug Benefit Levels" after the deductible is paid. In this situation the Generic Election, Incentive Mail Order or Smart90 Walgreens, and Incentive Formulary provisions apply.

F. Using the Express Scripts Mail Order Pharmacy or Smart90 Walgreens Program for Maintenance Drugs

If you have an ongoing condition that requires you to take an outpatient prescription drug over a long period of time (such as more than 60 days), you can order up to a 90-day supply of your prescription and have it mailed directly to your home through Express Scripts Mail Order. Or, through the Smart90 Walgreens program ("Smart90 Walgreens"), you can have your 90-day prescription filled at Walgreens retail pharmacies and affiliates (including Duane Reade pharmacies). There is no deductible under the Mail Order Pharmacy or Smart90 Walgreens component for the Classic Option. The combined Medical/Surgical Program and Managed Prescription Drug (Prescription) Program deductible applies for the Saver HSA Option.

It is more cost effective for you and the Plan to purchase your outpatient maintenance prescription drugs via Express Scripts Mail Order or Smart90 Walgreens. The cost of outpatient prescription drugs is less when purchased through Mail Order or Smart90 Walgreens than when purchased through other participating retail pharmacies because the outpatient prescription drug discounts at Express Scripts Mail Order and Smart90 Walgreens are greater than the discounts at other retail pharmacies. This means your share of the cost of the drug is less when using Express Scripts Mail Order or Smart90 Walgreens.

G. Prescription Drug Out-of-Pocket Maximum

To protect those who have illnesses requiring significant prescription drugs, there is an out-of-pocket maximum, which is combined with the Medical/Surgical Program out-of-pocket maximum under both Options. The combined medical and prescription drug out-of-pocket maximum limits are contained in Appendix A at the back of this document. Speedway employees who transfer to MPC and Speedway employees who are promoted into Salary Grade 12 and Above position will have out-of-pocket maximums transferred to the Plan.

When the coinsurances, copays and any cost differentials between generic and preferred/non-preferred brand an individual has paid, for medical and prescription drug combined, total the amount of the individual combined out-of-pocket maximum in a calendar year, covered charges for that individual under the Medical/Surgical Program and Prescription Program of the Plan are paid at 100% for the rest of the calendar year.

When the coinsurances, copays and any cost differentials between generic and preferred/non-preferred brand that a family has paid, for medical and prescription drug combined, total the amount of the family combined out-of-pocket maximum in a calendar year, covered charges for the family under the Medical/Surgical Program and Prescription Program of the Plan are paid at 100% for the rest of the calendar year.

You can refer to Article II, "Helpful Terms," of this document for more information about how the out-of-pocket maximum limit works.

H. Clinical Programs Administered by Express Scripts

The Health Plan has authorized Express Scripts to implement a number of clinical programs that assure the drugs are clinically appropriate and consistent with the Plan's intent. These programs are subject to change as Express Scripts continues to develop and enhance existing programs. As the pharmaceutical industry changes rapidly, the Plan will actively pursue administrative opportunities to assure patient safety and optimize health plan effectiveness for Plan Members. At any time a current list of clinical programs administered by Express Scripts can be requested and will be provided to the Member on a timely basis. The major clinical program areas are as follows:

- **Drug Utilization Review** — Concurrent and Retrospective to assure safety and appropriate use.
- **Specialty Pharmacy** — To provide enhanced pharmacy services for some conditions such as anemia, hepatitis C, multiple sclerosis, asthma, growth hormone deficiency, and rheumatoid arthritis that are treated with specialty medications. The Health Plan requires certain specialty drugs to be dispensed only through the Specialty Pharmacy after first retail fill. Specialty drugs are subject to the applicable formulary/non-formulary brand copays in the Classic option and subject to 20% member coinsurance in the Saver HSA option.
- **Coverage Management Programs** — These programs help ensure the appropriateness of coverage for specific drugs and specific amounts of drugs. The following programs are included under Coverage Management – Traditional Prior Authorization, SMART Prior Authorization, Dose Duration, Quantity Duration, Dispensing Quantity, and Dose Optimization.

These Clinical Programs will work with the prescribing physician, dispensing pharmacist and Member to assure that any conflicts that may arise are resolved in a prompt and safe manner.

I. Special Preventive Coverage

Your physician may prescribe a preventive vaccine that is available in oral form. Your physician may also write a prescription for you to purchase an injectable vaccine at the pharmacy, prior to administration in the physician's office. In such cases, the Managed Prescription Drug Program will cover the vaccine at 100% not subject to a deductible if purchased at Retail or Mail Order. Services to administer the vaccine would still be covered by the Medical/Surgical Program portion of the Health Plan.

XIV. Expenses Not Covered Under the Plan

The Plan does not cover certain types of services and supplies, as well as services for certain conditions. Your out-of-pocket expenses for such services do not count toward the annual deductible or out-of-pocket maximum limit.

Limitations and Exclusions

No benefits are payable under the Plan for, and the term "Covered Charges" will not include, charges for:

1. Any charge not determined to be Medically Necessary by Anthem.
2. Expenses resulting from experimental or investigational procedures including experimental drugs, other than under the Clinical Program administered by Express Scripts or due to routine care costs incurred during participation in a qualifying clinical trial.
3. Treatment of illness or injury resulting from war in which the United States is an active participant.
4. Expenses in excess of the "Maximum Allowed Amount."
5. Treatment in a federal hospital, including a Veterans' Administration hospital, for an insured person with a military service-connected disability.
6. Expenses incurred because of an illness or an injury resulting from employment to the extent that these expenses could have been covered by Workers' Compensation.
7. Dental work or dental X-rays, except as required by accidental injury to sound natural teeth or to correct Temporomandibular Joint Dysfunction (TMJ).
8. Eye glasses, contact lenses or eye refractions, including examinations for these purposes.
9. LASIK surgery, radial keratotomies and other related eye surgeries whose sole purpose is to correct refractive problems.
10. Transportation other than emergency ambulance transportation unless authorized through Plan sponsored Case Management.
11. Services for manipulations, regardless of the provider type or specialty, are limited to a 20 visits per person per year benefit limit, except during confinement in a hospital.
12. Educational testing or training on account of mental, nervous, or emotional disorders except as approved as a mental health treatment.
13. Expenses related to educational speech therapy, except speech therapy with a diagnosis and for treatment of Autism Spectrum Disorder and Rett Syndrome as approved through Anthem's Autism Spectrum Disorders Program.
14. Professional services related to marriage counseling.
15. Expenses resulting from reversals of voluntary sterilizations and sex change operations or therapy.
16. Medical services generally considered to be cosmetic in nature (unless to correct for a congenital deformity or a deformity resulting from illness or injury), or complications resulting from such services.
17. Coverage for any surgical procedure for weight loss except as approved in advance with treatment rendered by a Plan recognized Center of Excellence.
18. Expenses for over-the-counter drugs, remedies, vitamins, dietary supplements and supplies, except as approved by the Managed Prescription Drug (Prescription) Program.
19. Expenses for weight reductions drugs except as approved by the Prescription Program.
20. Expenses for compounded medication (other than hormone replacement therapies).

21. Services and supplies for smoking cessation programs and treatment of nicotine addiction, including gum and patches, to eliminate or reduce the dependency on, or addiction to, tobacco and tobacco products unless otherwise required by law. This paragraph does not apply to smoking cessation drug therapy coverage that is limited to 180 days of therapy (consisting of one or more prescriptions-including prescribed over the counter medications) per year per individual under the Managed Prescription Drug Program provisions of the Plan.
22. Treatments or consultations provided by the patient's parents, siblings, children, current or former spouse, or domestic partner.

XV. Coordination of Coverage Due to Transfer of Employment or Change of Option

If an employee is transferred to the Company from a nonparticipating employer in the controlled group of corporations to which the Company belongs or is no longer eligible as a participant in a health plan sponsored by a union at a facility of the Company or another participating employer in the Company's controlled group, medical expenses incurred during the calendar year of the transfer and recognized by the former medical plan for purposes of satisfying its deductible and out-of-pocket maximum provisions, will be applied toward meeting the Marathon Petroleum Health Plan's Medical/Surgical deductible and Medical/Surgical out-of-pocket maximum.

If a "Designated International" employee (as defined by the International Medical Plan) enrolled in the International Medical Plan is transferred to a participating employer of the Health Plan and/or ceases to be a "Designated International" employee and elects coverage under the Health Plan, any out-of-pocket amounts incurred during the calendar year of the transfer will be recognized for purposes of satisfying the Medical/Surgical out-of-pocket maximum provisions of this Plan.

XVI. Coordination of Benefits

A. Coordination With Other Group Health Plans

The Marathon Petroleum Health Plan coordinates benefits with other health plans under which you or your dependents are covered (such as a spouse covered under their employer's plan). In these instances, the plans work together through what is called "coordination of benefits" or "non-duplication of benefits" provisions.

With the exception of benefits under the Managed Prescription Drug Program, when the Plan is secondary to another group plan, benefits paid are determined using the "Benefits Less Benefit" method of coordination of benefits. This method calculates the amount payable under standard Plan provisions, and then reduces that amount by the amount of payment due for the same charges from any other group plan that is primary to the Plan.

The Plan follows standard rules accepted by the insurance industry to determine which plan is primary when an individual is covered by more than one group plan. Some — but not all — of the rules are as follows:

- The plan that covers a Member as active is primary to a plan that covers the Member as inactive (for example, retired).

- The plan that covers an individual as a Member pays primary to a plan that covers the same individual as a dependent of a Member.
- The plan that has covered an individual the longest pays primary if the individual is covered in the same category by two plans (for example, an individual is actively employed by two different companies).
- If a child is covered as a dependent under two different group plans, coverage is primary under the plan of the parent whose birthday (month and day) occurs earlier in the calendar year. For example, if the father was born on August 16 and the mother on June 11, the mother's plan is primary and would pay benefits first.
- In the case of divorce or separation, the plan of the parent with custody of the dependent child usually pays benefits for the child first. If the person with custody remarries, the stepparent's plan pays second, and the plan of the parent without custody pays third. However, if a court decree places financial responsibility for the dependent child's medical care on one parent, that parent's plan always pays benefits first.

B. Coordination With Other Plans

Coordination with Medicare and other government-sponsored plans follows regulations as issued by the appropriate government agencies.

The following types of plans normally coordinate with the Marathon Petroleum Health Plan:

- Governmental benefit programs provided or required by law, other than Medicare and Medicaid.
- No-fault automobile insurance plans.
- Plans provided by an employer, union, trust, or other similar provider.
- Other group health care plans by which you or your dependents are covered, including student coverage provided through a school above the high school level.

XVII. Claims and Appeals

The Plan has formal procedures in place to for you to submit a claim for medical benefits or to appeal a decision denying your claim for medical benefits. Generally, if your claim is denied you may ask the claims administrator to review its decision. If the claims administrator determines that the claim continues to be denied, you may ask the Plan Administrator to review the claims administrator's decision. These two steps are referred to as "internal appeals." If you disagree with the claims administrator's or the Plan Administrator's decision, and the basis for the denial involves medical judgment or relates to a rescission of benefits, you may request that a third party independent organization review the decision. This is called an "external review." The decision by the third party independent review organization is final and binding on both you and the Plan, subject to any right to file a law suit in court.

The process outlined in this section relates to a claim for a particular benefit under the Plan. If you have an eligibility claim, that is, a claim to participate in the Plan or to change an election to participate in the Plan during the plan year, you should submit your claim to the Plan Administrator, Marathon Petroleum Health Plan, 539 S. Main Street, Findlay, OH 45840, 1-888-421-2199. Eligibility claims are not subject to the requirements for internal and external review.

Claims for medical benefits are divided into four categories.

1. **Post-service claims** are claims for medical services already received.
2. **Pre-service claims** are claims for which you have not received medical services or for which prior authorization is required by the Plan.
3. **Concurrent care claims** are claims for ongoing treatments over a period of time or number of treatments. For example, if you have been authorized to receive seven treatments from a doctor or therapist and during the course of your treatment your doctor or therapist suggests 10 treatments, this is a concurrent care claim. Some concurrent care claims are also urgent care claims (see below).
4. **Urgent care claims** are claims for medical care or treatment that requires immediate action if a delay in treatment could significantly increase the risk to health or the ability to regain maximum function, or cause severe pain or jeopardize the life or health of patient or a patient's unborn child.

A. Filing an Initial Claim for Benefits

To file an initial claim for benefits, you should contact the appropriate claims administrator for that benefit. For instance, if you have a claim for prescription drug coverage, you should contact Express Scripts; if you have a claim for a medical benefit under the Plan, contact the medical claims administrator, Anthem BC/BS. Contact information for each claims administrator is listed below. A claim for benefits may be filed by you or your authorized representative. All Health Plan claims not filed for you must be submitted to the appropriate address indicated below within six months after the end of the calendar year in which the claims were incurred. Claims filed after that time will be denied.

1. Medical/Surgical Claims and Preventive Services Claims

Medical/surgical claims must be submitted with the provider's original itemized bill.

Claims for benefits (for both in- and out-of-network claims), must be submitted to the appropriate address for your PPO Provider area as follows. Claims for services obtained from a PPO participating network provider will be submitted by the provider. Providers may require reimbursement for your portion of the bill (coinsurances and deductible) at the time of service.

- **Providers who *are participating* in the BC/BS Network** are to submit the claim to the local BC/BS claim office for the provider's location. If the provider does not have this address they can contact Anthem BC/BS Customer Service at 1-855-698-5676.

- **Providers who *are not participating* in the BC/BS Network** and Members submitting a claim directly are to send the claim to:

  Anthem BC/BS
  P.O. Box 105187
  Atlanta, GA 30348-5187

2. Managed Prescription Drug Program Claims

In general, when you purchase a prescription through the Retail Pharmacy component or the Mail Order component of the Managed Prescription Drug Program, no claim forms are needed. There is no coverage for outpatient prescription drugs not filled through a participating retail pharmacy or through the Express Scripts Health Mail Order Pharmacy.

a. However, four situations do require you to file a claim form:

- You or your covered dependent reside in the United States and, while temporarily outside the United States due to business or leisure, a medical need arises which requires an outpatient prescription drug to be purchased outside the United States;
- You or your covered dependent receive outpatient prescription drugs in the following situations and were billed by a pharmacy which is not a participating retail pharmacy for the prescription drugs.
  - Lives in and receives prescription drugs through a rest home, nursing home, sub-acute care facility (or other extended care facility or skilled nursing facility), convalescent hospital, or similar institution; or
  - Receives prescription drugs from a hospice or home health agency.
- You or your covered dependent purchased outpatient prescription drugs at a participating retail pharmacy, but the claim was not filed electronically by the pharmacist into Express Scripts' computer;
- You or your covered dependent do not have "access" to a participating retail pharmacy.

  Claim forms for use with the above four situations, and mail order forms can be obtained by calling Express Scripts at 1-877-207-1357. Submit claim forms to:

  Express Scripts
  P.O. Box 14711
  Lexington, KY 40512

The claims administrator will provide you with any instructions regarding what information you need to provide with your initial claim for benefits, but generally you should include a description of your claim and any relevant documentation. If you are filing an urgent care claim, you or your authorized representative should call the claims administrator and state that you are filing an urgent care claim.

For urgent care claims, you will be notified whether or not your claim is approved as soon as possible, taking into account medical exigencies (that is, the medical circumstances surrounding your claim), but no later than 72 hours after your claim has been received. If you do not follow the proper procedure or provide sufficient information to determine whether benefits are covered under the Plan, the claims administrator will notify you as soon as possible, but no later than 24 hours after your claim was received. You will have 48 hours to provide the information requested. In this case, you will be notified whether or not your claim is approved as soon as possible, but in no case later than 48 hours after the requested information is received or the end of the 48 hour period after you have received the request to provide additional information.

For post-service claims, you will be notified whether or not your claim is approved within 30 days from when your claim is received. This period may be extended for 15 days. If you do not provide sufficient information to determine whether benefits for a post-service claim are covered under the Plan, the claims administrator may notify you within 30 days that additional information is needed, and you will then have 45 days to provide the additional information. If you do not provide any additional information requested, the claim will be decided based on the information originally provided.

For pre-service claims, you will be notified whether or not your claim is approved within 15 days from when your claim is received. This period may be extended for an additional 15 days. If you do not provide sufficient information to determine whether benefits for a pre-service claim are covered under the Plan, the claims administrator may notify you within 15 days that additional information is needed, and you will then have 45 days to provide the additional information. If you do not provide any additional information requested, the claim will be decided based on the information originally provided.

For concurrent care claims, you will be notified whether or not your claim is approved within a time period sufficiently in advance of the reduction or termination of coverage to allow you to appeal and obtain a response to that appeal before your coverage is reduced or terminated. For concurrent care that is urgent, you will be notified within 24 hours (provided that you submit your claim at least 24 hours in advance of reduction or termination of coverage).

If your initial claim is denied, you will be provided with a notice explaining why the claim was denied. This notice will include the following information:

a. Description of the claim at issue, including date of service, healthcare provider, and the amount of the claim, as well as notification of your right to receive, upon request, the diagnosis and treatment codes related to your claim and the corresponding meanings of such codes;

b. Specific reason or reasons your claim was denied;

c. Plan provisions on which the decision was based;

d. Description of any information that may be needed to perfect the claim and an explanation of why such information is necessary;

e. Description of how you may have this decision reviewed, the time limits for requesting such review, and, for urgent care claims, a description of the expedited review process; and any internal procedures or clinical information on which the decision was based (or a statement that you may request this information free of charge).

B. Appealing a Denied Claim

If your claim for benefits is denied you may appeal the initial decision. The Plan provides for two levels of internal appeals for a claim for benefits — a first level mandatory appeal to the claims administrator who made the initial adverse benefit determination and a second "voluntary" appeal to the Plan Administrator. You may also seek external review by an Independent Review Organization ("external review") of an adverse benefit determination by either the claims administrator or the Plan Administrator. You must exhaust the first level mandatory appeal process to the claims administrator before seeking external review by an Independent Review Organization, if your claim is otherwise eligible for external appeal, unless the claim is urgent or the Plan does not follow the requirements for internal claims and appeals required by law. In this case, you may immediately seek an external review, unless the action by the Plan was de minimis, non-prejudicial, attributable to good cause beyond the control of the Plan, in the context of an ongoing exchange of information, and not reflective of a pattern or practice of non-compliance. You have the right to request an explanation of the plan's assertion that it met this standard before deciding whether to seek immediate external review or any remedies under state or federal law. In addition, you must exhaust the first level mandatory appeal process before bringing a lawsuit in court, unless the Plan does not follow the requirements for internal claims and appeals required by law.

1. First Level of Internal Appeal for Denied Claims (Mandatory)

For claims other than urgent care claims, you must file your appeal within 180 days from the date you receive notice of your denied claim, and your appeal should be directed to the claims administrator listed in the denial notice. For an appeal relating to a concurrent care decision, you must file your claim within a reasonable period of time, considering the time period scheduled for reduction or termination of benefits.

For urgent care claims, you must file your appeal within 180 days, however, you may file your appeal to both the claims administrator (first level of internal appeals) and seek expedited external review by the Independent Review Organization at the same time. (See Section XVII.B.3 below for instructions for seeking expedited external review.) You may file your appeal of a claim for urgent care orally, but must indicate that you are appealing an urgent care claim. You will be notified of the final decision relating to your appeal of a claim for urgent care within 72 hours.

When filing your appeal, you should include a copy of your claim denial notice, the reason or reasons for your appeal, and any relevant documentation. For post-service claims, you will be notified of the claims administrator's decision within 60 days. For pre-service claims, you will be notified of the claims administrator's decision within 30 days. For concurrent care claims, you will be notified of the claims administrator's decision before a reduction or termination of benefits would occur, but if the claim relates to an urgent care concurrent claim, you will be notified within 72 hours.

For claim appeal procedures that require the appeal be sent in writing to the claims administrator, the address for sending appeals to the various claim administrators under the Health Plan are as follows:

Anthem BC/BS (medical/surgical)
Attention: Appeals
P.O. Box 105568
Atlanta, GA 30348-5568
1-800-325-3377

Express Scripts (prescription drug program)
Attention: Appeals
P.O. Box 631850
Irving, TX 631850
1-877-207-1357

If your claim is denied, you will receive a letter of denial including the following information.

a) Description of the appeal at issue, including date of service, healthcare provider, and the amount of the claim, as well as notification of your right to receive, upon request, the diagnosis and treatment codes related to your claim and the corresponding meanings of such codes;

b) Description of the specific reason or reasons your appeal was denied;

c) Statement regarding the documents to which you are entitled, upon request and free of charge;

d) Any internal procedures, standard, or clinical information on which the decision was based, including any new or additional evidence considered by the claims administrator and a reasonable opportunity to respond to this new evidence;

e) The plan provisions on which the denial was based;

f) An explanation of how you may appeal the decision to the Plan Administrator or to an external review organization, if applicable, or your right to bring a lawsuit under federal law (i.e., Section 502(a) of ERISA);

g) The following statement, “You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency.”

If your appeal to the claims administrator is denied, you may appeal this decision to the Plan Administrator or seek external review. The decision by the claims administrator is a final mandatory internal appeal decision. No further appeals are required in order to exhaust internal administrative remedies.

2. Voluntary Second Level of Internal Appeal for Denied Claims

If you disagree with the claims administrator's decision on appeal, you may appeal the decision to the Plan Administrator. The second level appeal is voluntary; you are not required to complete a voluntary second level appeal prior to submitting a request for an independent external review or prior to bringing a lawsuit in court. The one year limitations period set forth in Section XVII.C. below will be tolled while a second voluntary appeal to the Plan Administrator is pending. The Plan waives any right to assert that a claimant has failed to exhaust administrative remedies because the claimant did not pursue a second level appeal to the Plan Administrator.

Contact information for the Plan Administrator is listed below. You may file your appeal of a claim for urgent care orally, but must indicate that you are appealing an urgent care claim. You will be notified of the final decision relating to your appeal of a claim for urgent care within 72 hours. A form for you to use to submit the appeal to the Plan Administrator can be found at www.myMPCbenefits.com in the Forms section. The form can also be obtained by requesting a copy from the Benefits Service Center at 1-888-421-2199.

You must file your appeal with the Plan Administrator within 30 days of receipt of the decision by the claims administrator. You should direct your appeal to the Plan Administrator at the contact information listed below.

Marathon Petroleum Health Plan Appeals
Plan Administrator of the Health Plan
539 S. Main Street, Room 3119
Findlay, OH 45840
Telephone: 1-888-421-2199
Fax: 1-419-427-4469

When filing your appeal, you should include a copy of your appeal denial notice, the reason or reasons for your appeal, and any relevant documentation. For post-service claims, you will be notified of the Plan Administrator's decision within 60 days. For pre-service claims, you will be notified of the Plan Administrator's decision within 30 days. For concurrent care claims, you will be notified of the claims administrator's decision before a reduction or termination of benefits would occur, but if the claim relates to an urgent care concurrent claim, you will be notified within 72 hours.

3. External Review by an Independent Review Organization

If your first or second level internal appeal of a claim for benefits is denied by the claims administrator or the Plan Administrator, and that denial is based on medical judgment or relates to a rescission of benefits, you may seek review of that denial by a third party Independent Review Organization. For example, if your claim was denied because it was determined that the claim did not meet a medically necessary standard set forth in the Plan, you may request an external review of the denial. You may also request an external review if your coverage is terminated retroactively ("rescinded") for reasons other than nonpayment of premium or fraud or misrepresentation. A request for an external review must be in writing unless the Plan Administrator or claims administrator determines it is not reasonable to require a written statement. Except in cases of urgent/concurrent care claims, you must exhaust the first level mandatory internal appeal process before requesting external review.

For pre-service claims involving urgent/concurrent care, you may proceed with an expedited external review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including the claims administrator's decision, can be sent between the claims administrator and you by telephone, facsimile or other similar method. To proceed with an expedited external review, you or your authorized representative must contact the claims administrator at the number shown on your Plan identification card and provide at least the following information:

- *The identity of the claimant;*
- *The date of the medical service;*
- *The specific medical condition or symptom;*
- *The provider's name;*
- *Any service or supply for which approval of benefits was sought; and*
- *Any reasons why the appeal should be processed on a more expedited basis.*

You must request external review within four (4) months after date of receipt of an adverse benefit determination or final adverse benefit determination. A request for an external review should be sent to the following address:

Marathon Petroleum Health Plan Appeals
The Plan Administrator of the Health Plan
539 S. Main Street, Room 3119
Findlay, OH 45840
Telephone: 1-888-421-2199

Within 5 days of receiving your request, the Plan Administrator (or designee) will review your request and determine whether the request is eligible for external review based on whether you were covered by the Plan at the time the medical care, item, or service was received, whether you exhausted the internal claims procedures, and whether the final internal review decision was based on medical judgment or rescinded coverage. If your claim is eligible for external review based on these criteria, the Plan will notify you within one day of completing the review. If eligible for external review, the claim will be referred to an Independent Review Organization. The Independent Review Organization will notify you of your eligibility for review and inform you of your right to submit any additional information within 10 days. The Independent Review Organization will review the claim "de novo," which means it will not take into account any prior decisions at the internal appeal level. You will be provided with the Independent Review Organization's decision within 45 days. If the internal decision denying benefits is reversed, the Plan will immediately provide or pay benefits to you. Urgent care claims that are externally appealed will be decided within 72 hours after the request.

In order to avoid the appearance of any conflicts of interest, the Plan Administrator contracts with three separate Independent Review Organizations and rotates claims for external review among those three organizations. None of these organizations receive any financial incentive from the Plan to support a denial of the claim.

The decision of the external Independent Review Organization is binding on both parties, subject to any rights to bring a lawsuit in court.

C. Finality of Decision and Legal Action

A claimant must follow and fully exhaust the applicable claims and appeals procedures described in the 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 the 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. A decision by the claims administrator following the first level mandatory internal appeal is the final decision under these procedures. However, the one year period is tolled during the pendency of a voluntary appeal to the Plan Administrator or external review by an Independent Review Organization.

D. 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.

E. Non-Assignability

The claims administrator, on behalf of the Plan, may make payments directly to Providers, pharmacies, and other vendors for covered expenses and prescription drugs. In some cases, the claims administrator may make payments directly to a Member (or an alternate recipient, custodial parent, or designated representative). Any payments made by the claims administrator will discharge the Plan's obligation to pay for covered expenses and/or prescription drugs. The right of any Member to receive any benefits or payments under this Plan shall not be alienable by the Member by assignment or any other method and shall not be subject to claims by the Member's creditors or health care providers by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to the extent required by law.

F. Outstanding Claim Checks

The Plan has the authority to cancel and stop payment on any claim checks issued by a claim payer under the Plan if the check has been outstanding and not cashed for one year or more. Such action shall not, however, prohibit the Plan from making the claim payment if approached by a Member or designated representative for payment after the claim check has been cancelled.

XVIII. Miscellaneous Situations Affecting Your Plan Benefits

A. Expenses for Which a Third Party May be Responsible

This Plan does not cover:

- Expenses incurred by you or your covered dependent (hereinafter individually and collectively referred to as a "Participant,") for which another party may be responsible as a result of having caused or contributed to an injury or sickness.
- Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage.

1. Third Parties

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages;
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages;
- worker's compensation cases/claims;

- any person or entity who is or may be obligated to provide you with benefits or payments under:
  - underinsured or uninsured motorist insurance;
  - medical provisions of no-fault or traditional insurance (auto, homeowners or otherwise);
  - worker's compensation coverage; or
  - any other insurance carrier or third party administrator

2. Subrogation/Right of Reimbursement

If a Participant incurs a covered expense for which, in the opinion of the Plan or its claim administrator, another party may be responsible or for which the Participant may receive payment as described above:

- **Subrogation:** The Plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a Participant may have against such party and shall automatically have a lien upon the proceeds of any recovery by a Participant from such party to the extent of any benefits paid under the Plan. A Participant or his/her representative shall execute such documents as may be required to secure the Plan's subrogation rights.
- **Right of Reimbursement:** The Plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in immediately preceding paragraph, but only to the extent of the benefits provided by the Plan.

3. Lien of the Plan

By accepting benefits under this Plan, a Participant:

- Grants a lien and assigns to the Plan an amount equal to the benefits paid under the Plan against any recovery made by or on behalf of the Participant which is binding on any attorney or other party who represents the Participant whether or not an agent of the Participant or of any insurance company or other financially responsible party against whom a Participant may have a claim provided said attorney, insurance carrier or other party has been notified by the Plan or its agents;
- Agrees that this lien shall constitute a charge against the proceeds of any recovery and the Plan shall be entitled to assert a security interest thereon; and
- Agrees to hold the proceeds of any recovery in trust for the benefit of the Plan to the extent of any payment made by the Plan.
- Agrees to cooperate with the Plan and its agents in a timely manner to protect its legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - Complying with the terms of this Plan document;
  - Providing any relevant information requested;

- Signing and/or delivering documents at its request;
- Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable;
- Responding to requests for information about any accident or injuries;
- Appearing at medical examinations and legal proceedings, such as depositions or hearings; and
- Obtaining the Plan's consent before releasing any party from liability or payment of medical expenses.

4. Additional Terms

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the Plan. The Plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the Plan without its written approval.
- The Plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine," "Rimes Doctrine," or any other such doctrine purporting to defeat the Plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No Participant hereunder shall incur any expenses on behalf of the Plan in pursuit of the Plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the Plan's recovery without the prior express written consent of the Plan. This right shall not be defeated by any so-called "Fund Doctrine," "Common Fund Doctrine," or "Attorney's Fund Doctrine."
- The Plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the Plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The Plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.

- Any reference to state law in any other provision of this Plan shall not be applicable to this provision, if the Plan is governed by ERISA. By acceptance of benefits under the Plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the Plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.
- Failure to cooperate with the Plan's subrogation efforts and/or return funds within 60 days of receipt from a legal proceeding or settlement in which the Plan has a subrogation interest will result in the participant becoming permanently ineligible to participate in this Plan or any medical plan sponsored by the employers in the Company's controlled group.
- The Plan's right to subrogation and reimbursement apply to full and partial settlements, judgments, or other recoveries paid or payable to the participant, dependent, or representative.
- The Plan Administrator has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

B. Limitations on Benefits You May Expect to Receive

The Plan contains numerous provisions regarding such items as eligibility, medical necessity, certification requirements, in-network benefit and out-of-network benefit entitlement, deductibles, excluded expenses, etc. Given these various limitations, it is important to carefully read and review all of the provisions of this document that may relate to whether or not you are entitled to coverage for a particular expense.

C. 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 an employee claiming a non-spouse as a spouse, or an ineligible individual as an eligible dependent, or not notifying the Company 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 coverage does not require the Plan to give you 30 days' advance written notice.

Furthermore, a rescission or cancellation of coverage will not, in most circumstances, qualify for a mid-year election change under the Marathon Petroleum 125 Plan. Therefore, participants may be required to continue making the same contributions for coverage even though coverage has been rescinded or cancelled.

D. Missing Person

If, within five years after any amount becomes payable by the Plan to a Participant, and the payment has not been claimed, provided due and proper care has been exercised by the Plan Administrator or those delegated authority in attempting to make such payment by providing notice at the Participant's last known address, the amount of the payment shall be forfeited and shall cease to be a liability of the Plan. In such case, the amount forfeited shall be retained by the Company in its general assets.

E. American Jobs Creation Act of 2004

Pursuant to the American Jobs Creation Act of 2004 and Section 409A of the Internal Revenue Code, in the event a benefit under this Plan does not satisfy requirements of IRS Code Sections 105 and 106 and therefore becomes taxable to the Plan Member, 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.

F. Genetic Information Nondiscrimination Act of 2008 (GINA)

Notwithstanding any provision of this Plan to the contrary, this Plan shall be operated and maintained consistent with GINA.

XIX. Your Legal Right to Continue Coverage Under COBRA

Required Notice: Participants of the Marathon Petroleum Health Plan, 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.

Participants may have other health coverage options available when they lose group health coverage under the Plan. For example, a participant may be eligible to buy an individual health insurance plan through the Health Insurance Marketplace. By enrolling in coverage through the Health Insurance Marketplace, a former participant in the Plan may qualify for lower costs on his or her monthly premiums and lower out-of-pocket costs. Additionally, a participant may qualify for a 30-day special enrollment period for another group health plan for which he or she is eligible (such as a spouse's plan) even if that plan generally does not accept late enrollees.

A. Group Covered

All Employee Group Members of the Plan (other than nonresident aliens with no U.S.-source earned income and the spouses and dependents of such individuals), including their covered eligible dependents, are subject to these COBRA provisions. Also covered by COBRA are dependents of certain former Members if those dependents are covered by the Plan.

B. Qualifying Events and Maximum Length of Continuation Periods

1. Employee Member Loses Coverage

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

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

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

2. Covered Spouse Loses Coverage

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

- because of the death of such Member;
- because of divorce or legal separation from such Member;
- because the 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
- because the Member of the Health Plan 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.

3. Eligible Child Loses Coverage

If an eligible **Child** of an Employee Member of the Health Plan loses coverage:

- because of the death of such Member;
- because the child no longer meets the Health Plan's definition of an eligible Child;

- because the Member of the Health Plan becomes entitled to benefits under Medicare;
- because the 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
- because the parents become divorced or legally separated.

then the eligible Child may be entitled to elect continuation of coverage.

C. 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.

D. 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 Section H, "Cost," below for the cost of continued coverage during the 19th through 29th month.)

Second Qualifying Event Extension: Eligible dependents of the Employee Member (or Medicare Primary Employee enrolled in OneExchange) 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:

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.

E. 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 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 day 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 employer in the controlled group which includes Marathon Petroleum Company LP provides any group health plan to any of its employees.

F. Notification Procedure

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

a. MPC will notify the Plan Administrator of such event within 30 days; and

b. The Plan Administrator will notify the employee/dependents of their rights under COBRA within 14 days after receiving notice from MPC.

2. In the event of the divorce or legal separation of a Member and spouse, or in the event that a Child no longer meets the Plan's definition of eligible dependent:

   a. The 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 Findlay, Ohio); and

   b. The Plan Administrator or representative will inform the Member's 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.

3. The Member/dependent must elect to continue coverage within a specified election period. This period ends on the **later** of 60 days from:

   a. the date of the notice from the Plan Administrator, if applicable; or

   b. the date of termination of coverage.

4. If no election is made within the election period, 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.

5. If you elect COBRA continuation coverage, you must make your initial payment for continuation coverage (including all premiums due but not paid) no later than 45 days after the date of your election. (This is the date the COBRA election notice is post-marked, if mailed.) If you do not make your initial payment for COBRA continuation coverage within 45 days after the date of your election, you will lose all COBRA continuation coverage rights under the plan. **Payment is considered made on the date it is sent to the plan.**

   After you make your initial payment for COBRA continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The premium due date and exact amount due each coverage period for each qualified beneficiary will be shown in the COBRA election notice you receive. Although periodic payments are due on the dates shown in the COBRA election notice, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment.

   If you elect COBRA continuation coverage but then fail to make an initial or periodic payment before the end of the 45- or 30-day grace period — respectively — for that coverage period, you will lose all rights to COBRA continuation coverage under the plan, and such coverage will be terminated retroactively to the last day for which timely payment was made (if any).

G. Special COBRA Election Period under the Trade Act of 2002

In addition to the regular 60-day election period indicated in Section E, "Notification Procedure," 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 Section E, "Notification Procedure," 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 this additional "special" election period, together with other information on trade adjustment assistance, including an expansion 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. To find the State Workforce Agency for your state go to www.workforceatm.org/links.cfm.

H. Type of Coverage

The coverage offered must be a continuation of the benefits currently being provided under the Plan to other similarly situated Members and dependents of the Health Plan, with respect to whom a qualifying event has not occurred. Subject only to the exception stated in Section (G)(2)(b) immediately 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.

1. Benefit Coverage

The benefit coverage a Continued Member receives is based on the group ("Employee Group") the Member and/or covered eligible dependent(s) were in on the day before the date of their initial qualifying event. Members who make up the "Employee Group" are Employee Members and Spouses of Medicare Primary Employees enrolled in OneExchange.

2. Change in Coverage Category

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

b. Addition of Eligible Dependents

i. 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.

ii. 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:

- a 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
- a 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.

The late enrollment provisions of the Plan are summarized in Article V, "Enrolling in the Plan," of this document. However, the right to add such dependent (i.e., dependents acquired either prior to or after the qualifying event) shall cease effective upon the date final Internal Revenue Service regulations are issued which do not require the Plan to permit the addition of such dependents.

3. The Continuation Period

During the continuation period, Continued Members are not permitted to move between Options of the Health Plan except as described in Article VI, "Changing Coverage Options While Enrolled," of this document.

4. Plan Amendments

Any amendments to the Plan applicable to non-continued Members in the "Employee Group" will also be applicable to similarly situated Continued Members who are in the "Employee Group."

5. Accumulated Amounts

Any amounts accumulated toward the deductibles or stop-loss limits by an individual before the qualifying event, will be carried over and used toward satisfying the applicable deductible or stop-loss provisions as a Continued Member for the remainder of the calendar year (including, but not limited to, deductibles and stop-loss provisions under the Managed Prescription Drug Program).

6. Coverage Under Another Plan

If continuation of coverage is elected and the Continued Member (or continued dependent) is or becomes covered under another group health plan, benefits paid from this Plan will be secondary to the benefits paid from the other group plan.

I. Cost

Continued Members who are in the "Employee Group" on the day before the date of their initial qualifying event, will be charged the entire premium applicable to any other Member who is a part of the "Employee Group" with the same coverage plus 2% of the total premium amount. The entire premium includes the portions formerly paid by both the Member and MPC.

Those individuals who are part of the "Employee Group" are Employee Members and their dependents covered under this Plan, Spouses of Medicare Primary Employees enrolled in OneExchange, and Child(ren) Members of Medicare Primary Employees enrolled in OneExchange.

(In the case of 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, the charge for the 19th through 29th month will be based on a 50% addition to the entire premium amount instead of a 2% addition.)

The rates will be established prior to their effective date, and be frozen at that level for a minimum of twelve months. Members or spouses with no dependents, and each former child who, because of losing child status, elects continuing coverage, will be charged the single (Member only) rate.

With the exception of the initial payment, all premium payments must be received in advance of the period of coverage.

J. Surviving Spouse and Surviving Dependents

Effective for the qualifying event of the death of an Employee Member on or after January 1, 2001, the covered spouse and covered children of the deceased Employee Member will be offered continuing coverage under COBRA subject to the provisions contained in Article XIX, "Your Legal Right To Continue Coverage Under COBRA," of this document. Such surviving spouse and dependents will be able to continue their "Employee Group" coverage at 102% of the "Employee Group" premium.

However, health care coverage for surviving spouses and dependents under the Marathon Petroleum Retiree Health Plan ("Retiree Health Plan) at Company-subsidized retiree rates is offered as an alternative to the COBRA continuing coverage consisting of "Employee Group" coverage at 102% of the "Employee Group" premium. If the surviving spouse and dependents elect COBRA coverage instead enrolling in the Retiree Health Plan, such surviving spouse and dependents will be eligible to cancel their COBRA continuation coverage and elect to enroll in the Retiree Health Plan's coverage during or at the end of their maximum 36 months of COBRA continuation coverage by completing the proper forms. Such election will be effective on the date the proper forms are signed by the surviving spouse.

In this case, the COBRA continuation coverage would last until the earlier of 36 months from the date of death, or the date of any of the events which would otherwise terminate COBRA continuation coverage.

K. Change of Control

1. 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:

    a. 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 Health Plan have the opportunity to continue coverage under the terms and conditions of the Health Plan 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 with respect to coverage during the 18 months following the termination date and, thereafter (if applicable), the full COBRA rate with respect to such coverage.

        i. 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.

        ii. Effective with the completion of the 18 months of extended coverage, Marathon Petroleum Retiree Health Plan coverage is available to otherwise eligible participants at rates resulting from recognition of the maximum available Company contributions for retiree health coverage, and as otherwise provided under the terms of the Plan.

    b. 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 and full COBRA rate shall not exceed a period of 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 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.

    c. Eligible terminated employees who elect coverage under the Change in Control provisions described in this section, will be permitted to change Options to any available Option having a lower COBRA premium rate to be effective the first day after the Company-subsidized COBRA continuation of coverage ends, provided the election is made before the end of the first 18 month period. Any medical expenses incurred during the calendar year of the option change and applicable to the deductibles and stop-loss provisions of the previous option shall be recognized hereunder solely for purposes of satisfying the applicable deductibles and stop-loss provisions of the new option (including, but not limited to, deductibles and stop-loss provisions under the Managed Prescription Drug Program) In addition, expenses incurred under any previous option of the Plan and applicable to the Plan's overall maximum provision of the respective option shall be recognized for purposes of meeting the Plan's overall maximum provisions of the new Option.

L. Alternatives to COBRA Continuation Coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options available to the Member and his or her family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's employer's group health plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. More information about these options is available at www.healthcare.gov.

XX. Administrative Information

The Marathon Petroleum Health Plan is governed by ERISA (the Employee Retirement Income Security Act of 1974, as amended). This section provides important legal and administrative information you may need such as:

- how to contact the Plan Administrator;
- information about the claims administrator or insurance companies that provide or administer the health plan and how to contact them.

If you have any questions about any of the following, call the Benefits Service Center at 1-888-421-2199.

A. Type of Plan

The Plan is a group health plan providing coverage for various types of health services and supplies.

B. Plan Sponsor and Administrator

The Plan is sponsored by Marathon Petroleum Company LP, 539 South Main Street, Findlay, OH 45840, an employer whose regular full-time and regular part-time employees, and casual employees who meet work hour requirements, are eligible for coverage under the Plan. The Plan Administrator of the Plan is listed below. The Company may appoint assistant administrators as may be deemed necessary.

The Plan Administrator
Stephen A. Nelson
539 South Main Street
Findlay, OH 45840
419-422-2121

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 ruling which, until revoked or until superseded by Plan amendment or by a different administrative ruling, shall thereafter be followed in the administration of Plan.

The Plan Administrator may employ agents, attorneys, accountants or other persons (who also may be employed by the Company), and allocate or delegate to them such powers, rights, and duties as the Plan Administrator may consider necessary or advisable to properly carry out the administration of the Plan.

C. Plan Funding

The Plan is funded by the contributions of plan Members and the general assets of Marathon Petroleum Company LP. The total cost of the plan is ultimately determined by claims experience and administrative costs. In general, costs are shared on an 80%Company/20% Member basis, but in certain circumstances, Members may pay a higher percentage, and in certain circumstances the Company may pay a higher percentage.

D. Plan Identification Number and Plan Name

When dealing with or referring to the Plan in terms of claim appeals or other correspondence, you will receive a more rapid response if you identify the Plan fully and accurately. To identify a plan, you need to use Marathon Petroleum's employer identification number (EIN): 31-1537655. You also need to know the Plan's official name and number. The Health Plan's official name is the Marathon Petroleum Health Plan. It is sometimes referred to, informally, as the Marathon Petroleum Health Plan, or just the Health Plan. The plan number is 555.

E. Plan Year

The Plan Year is January 1 through December 31. December 31 is the end of the year for purposes of maintaining the Plan's fiscal records.

F. Type of Administration

The Plan is self-insured and is administered in part by the Plan Sponsor and in part by various third-party claims administrators through administrative-services-only contracts. These various third-party claims administrators assist in the processing of claims and in performing various other Plan functions, but they do not insure any of the benefits provided by the Plan.

Claim Administrators

- **Medical/Surgical Program — Anthem BC/BS PPO Options**

  Anthem Insurance Companies, Inc.
  220 Virginia Avenue
  Indianapolis, IN 46204
  www.Anthem.com

- **Managed Prescription Drug Program — Express Scripts**

  Express Scripts
  100 Parsons Pond
  Franklin Lakes, NJ 07417
  www.express-scripts.com

G. 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.

H. Use and Disclosure of Protected Health Information

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;

- 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.mympcbenefits.com/documents/mpc-hipaa-notice-of-privacy-practices.pdf.

XXI. Special Provisions Relating to Medicaid

In enrolling an individual as a Plan Member or beneficiary, or in determining or making any payments for benefits of an individual as a Plan Member or beneficiary, the fact that the individual is eligible for or is provided medical assistance under title XIX of the Social Security Act will not be taken into account.

Payment for benefits with respect to a Member under the Plan will be made in accordance with any assignment of rights made by or on behalf of such Member or beneficiary as required by a State plan for medical assistance approved under title XIX of the Social Security Act pursuant to section 1912 (a)(1)(A) of such Act (as in effect on August 10, 1993, the date of enactment of the Omnibus Budget Reconciliation Act of 1993.)

To the extent that payment has been made under a state plan for medical assistance approved under title XIX of the Social Security Act, in any case in which the Plan has a legal liability to make payment for items or services constituting such assistance, payment for benefits under the Plan will be made in accordance with any State law which provides that the State has acquired the rights with respect to a Member for such items or services.

XXII. Participation by Associated Companies or Organizations

Upon specific authorization and subject to such terms and conditions as it may establish, Marathon Petroleum Company LP may permit 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, MW Logistics Services LLC, Speedway LLC, and Speedway Prepaid Card 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 terms “Company” and other similar words shall include Marathon Petroleum Company LP and such other affiliated organizations. The term “employee” and other similar words shall include any eligible employee of these companies.

XXIII. Modification and Discontinuance of Plan

While the Company hopes that this Plan may be continued indefinitely, it is realized that conditions may change. The Company, therefore, 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 1% 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.

XXIV. Further Information

This text is intended to describe the Health Plan in an understandable manner. Additional terms of the Plan are outlined in the provisions of the administrative services agreements between the Plan and service providers. The Plan Administrator or their designee will make all final determinations concerning eligibility for benefits under this Plan.

The Company has appointed Stephen A. Nelson as Plan Administrator. The Company shall appoint assistant administrators as may be deemed necessary. The Plan Administrator shall be the named fiduciary under the Plan.

The Plan is funded by employee and Company contributions.

In determining the eligibility of Members and other individuals for benefits and in construing the Plan's terms, the Plan Administrator (or a Third Party Administrator in cases where a Third Party Administrator has the authority to make determinations concerning eligibility for benefits) has the power to exercise discretion in the construction or interpretation of doubtful, disputed or ambiguous terms or provisions of the Plan, as well as 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 itself. All decisions of the Plan Administrator (or a Third Party Administrator in cases where a Third Party Administrator has the authority to make determinations concerning eligibility for benefits) made on all matters within the scope of his (or its) authority shall be final and binding upon all persons, including the Company, all participants and beneficiaries, and their heirs and personal representatives, and all labor unions or other similar organizations representing participants. It is intended that the standard of judicial review to be applied to any determination made by the Plan Administrator (or by a Third Party Administrator in cases where a Third Party Administrator has the authority to make determinations concerning eligibility for benefits) shall be the "arbitrary and capricious" standard of review. Any discretionary acts taken under this Plan by the Plan Administrator or the Company, shall be uniform in their 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 Employee Retirement Income Security Act of 1974, as amended, (ERISA) and the Internal Revenue Code (the Code).

In situations in which the Plan Administrator deems it to be appropriate, the Plan Administrator may, but is not required to, evidence (i) the exercise of such discretion, or (ii) any other type of decision, directive or determination he may make with respect to the Plan, in the form of 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 Plan Administrator may employ agents, attorneys, accountants or other persons (who also may be employed by the Company), and allocate or delegate to them such powers, rights and duties as the Plan Administrator may consider necessary or advisable to properly carry out the administration of the Plan.

XXV. Your Rights Under Federal Law

As a participant in the Marathon Petroleum Company LP Benefit Plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act ("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 plans, 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 a summary of the plan's annual financial reports. The plan administrator is required by law to furnish each participant with a copy of the summary annual reports.

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 plans, called "fiduciaries" of the plans, 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 plans, you should contact the respective 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

Employee Member Contributions and Plan Option Comparison

Health Plan Employee Group Contributions — As of January 1, 2018

	Classic	Saver HSA
Employee Only	$106	$ 72
Employee + Spouse	$242	$166
Employee + Children	$210	$144
Employee + Family	$327	$224

Health Plan Summary of Provisions and Option Comparison — As of January 1, 2018

	Classic		Saver HSA	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Health Plan *(includes Medical, Surgical, Managed Mental Health and Chemical Dependency)*				
Individual Deductible	$600	$1,200	$1,400	$2,800
Family Deductible	$1,200	$2,400	$2,800	$5,600
Coinsurance	You pay 20% after deductible is met	You pay 40% after deductible is met	You pay 20% after deductible is met	You pay 40% after deductible is met
Individual Out-of-Pocket Maximum Cost	$3,500	$7,000	$5,000	$10,000
Family Out-of-Pocket Maximum Cost	$7,000	$14,000	$10,000*	$20,000
Preventive Services	Plan covers at 100% (no deductible)	You pay 40% after deductible is met, plus any amount over Maximum Allowed Amount	Plan covers at 100% (no deductible)	You pay 40% after deductible is met, plus any amount over Maximum Allowed Amount
Emergency Room (ER) Copay *(if not admitted to hospital)*	You are responsible for the first $200 of ER charge for each ER visit, then deductible, then 20% coinsurance (the $200 copay does not count toward other deductibles)	You are responsible for the first $200 of ER charge for each ER visit, then deductible, then 20% coinsurance (the $200 copay does not count toward other deductibles)	You are responsible for the deductible; after deductible is met, you are responsible for 20% coinsurance *after* a $200 copay for each ER visit (the $200 copay does not count toward the deductible)	You are responsible for the deductible; after deductible is met, you are responsible for 20% coinsurance *after* a $200 copay for each ER visit (the $200 copay does not count toward the deductible)

* Once one covered family member has reached the individual out-of-pocket maximum, the plan will pay 100% of covered services for that individual. This is known as an embedded out-of-pocket maximum. See Article II, "Helpful Terms," of this document for more information on the out-of-pocket maximum and how it works under both Options.

Company Contribution to Health Savings Account		
	Classic	**Saver HSA**
HSA Contribution	None	$350 employee/$700 family

Prescription Drugs (Rx)				
	Classic		Saver HSA	
	Retail (30-day supply)	**Mail Order or Smart90 Walgreens (90-day supply)***	**Retail (30-day supply)**	**Mail Order or Smart90 Walgreens (90-day supply)***
Annual Out-of-Pocket Rx Maximum	Combined with medical			
Annual Rx Deductible	$100 individual/ $200 family	None	Combined with medical	
Benefit Level				
– Generic	You pay $10 after deductible	You pay $25, no deductible	You pay 20% after deductible (for certain generic preventive drugs, the deductible does not apply**)	You pay 20% after deductible (for certain generic preventive drugs, the deductible does not apply**)
– Formulary Brand	You pay $30 after deductible	You pay $75, no deductible	You pay 20% after deductible	You pay 20% after deductible
– Non-Formulary Brand	You pay $60 after deductible	You pay $150, no deductible	You pay 20% after deductible	You pay 20% after deductible

* You pay 100% of cost at third and later fills of maintenance drugs.

** There are certain prescription drugs that the IRS calls “preventive” because they prevent or treat catastrophic conditions, such as high blood pressure, high cholesterol and asthma. This list is different from the drugs covered at 100% under the provisions of the Patient Protection and Affordable Care Act (PPACA).

Note: If actual cost at retail or actual gross cost at mail order is less than minimum copay, you pay the lesser cost.

Appendix B

Pre-Certification List

(2018 Standard Pre-certification List)

The pre-certification list is subject to change and may be modified from time to time. To ensure coverage, the following services and procedures must be pre-certified by Anthem's review unit for medical necessity. To ensure compliance with the most up-to-date listing, it is best to contact the Anthem pre-certification review unit at 1-866-776-4793 prior to inpatient admissions, outpatient surgeries and other similar services as those listed below.

Inpatient Admission:

- Inclusive of all Acute Inpatient, Skilled Nursing Facility, Long Term Acute Rehab, and obstetric delivery stays beyond the federally mandated minimum length of stay (including newborn stays beyond the mother's stay)
- Emergency Admissions (Requires Plan notification no later than two business days after admission

Outpatient Services:

- Ablative Techniques as a Treatment for Barrett's Esophagus
- Air Ambulance (excludes 911 initiated emergency transport)
- Artificial Intervertebral Discs
- Balloon Sinuplasty
- Bariatric Surgery
- Bone-Anchored Hearing Aids
- Breast Procedures; including Reconstructive Surgery, Implants, Reduction, Mastectomy for Gynecomastia and other Breast Procedures
- Canaloplasty
- Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure
- Carotid, Vertebral and Intracranial Artery Angioplasty with or without Stent Placement
- Cochlear Implants and Auditory Brainstem Implants
- Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedures
- Cryoablation for Plantar Fasciitis and Plantar Fibroma
- Cryopreservation of Oocytes or Ovarian Tissue
- Cryosurgical Ablation of Solid Tumors Outside the Liver
- Deep Brain Stimulation

- Diagnostic Testing
  - Diagnosis of Sleep Disorders
  - Gene Expression Profiling for Managing Breast Cancer Treatment
  - Genetic Testing for Cancer Susceptibility
- Durable Medical Equipment/Prosthetics
  - Bone Growth Stimulator: Electrical or Ultrasound
  - Communication Assisting / Speech Generating Devices
  - External (Portable) Continuous Insulin Infusion Pump
  - Functional Electrical Stimulation (FES); Threshold Electrical Stimulation (TES)
  - Microprocessor Controlled Lower Limb Prosthesis
  - Oscillatory Devices for Airway Clearance including High Frequency Chest Compression and Intrapulmonary Percussive Ventilation (IPV)
  - Pneumatic Pressure Device with Calibrated Pressure
  - Power Wheeled Mobility Devices
  - Prosthetics: Electronic or externally powered and select other prosthetics
  - Standing Frame
- Electrothermal Shrinkage of Joint Capsules, Ligaments, and Tendons
- Extracorporeal Shock Wave Therapy for Orthopedic Conditions
- Functional Endoscopic Sinus Surgery
- Gastric Electrical Stimulation
- Implantable or Wearable Cardioverter-Defibrillator
- Implantable Infusion Pumps
- Implantable Middle Ear Hearing Aids
- Implanted Devices for Spinal Stenosis
- Implanted Spinal Cord Stimulators
- Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)
- Locally Ablative Techniques for Treating Primary and Metastatic Liver Malignancies
- Lumbar spinal surgeries
- Lung Volume Reduction Surgery
- Lysis of Epidural Adhesions
- Manipulation Under Anesthesia of the Spine and Joints other than the Knee
- Maze Procedure
- MRI Guided High Intensity Focused Ultrasound Ablation of Uterine Fibroids
- Oral, Pharyngeal & Maxillofacial Surgical Treatment for Obstructive Sleep Apnea

- Surgical Treatment of Migraine Headaches
- Occipital nerve stimulation
- Orthognathic Surgery
- Ovarian and Internal Iliac Vein Embolization as a Treatment of Pelvic Congestion Syndrome
- Partial Left Ventriculectomy
- Penile Prosthesis Implantation
- Percutaneous Neurolysis for Chronic Back Pain
- Photocoagulation of Macular Drusen
- Physician Attendance and Supervision of Hyperbaric Oxygen Therapy
- Plastic/Reconstructive surgeries:
  - Abdominoplasty, Panniculectomy, Diastasis Recti Repair
  - Blepharoplasty
  - Brachioplasty
  - Buttock/Thigh Lift
  - Chin Implant, Mentoplasty, Osteoplasty Mandible
  - Insertion/Injection of Prosthetic Material Collagen Implants
  - Liposuction/Lipectomy
  - Procedures Performed on Male or Female Genitalia
  - Procedures Performed on the Face, Jaw or Neck (including facial dermabrasion, scar revision)
  - Procedures Performed on the Trunk and Groin
  - Repair of Pectus Excavatum/Carinatum
  - Rhinoplasty
  - Skin-Related Procedures
- Percutaneous Spinal Procedures
- Private Duty Nursing
- Presbyopia and Astigmatism-Correcting Intraocular Lenses
- Radiation therapy
  - Intensity Modulated Radiation Therapy (IMRT)
  - Proton Beam Therapy
- Radiofrequency Ablation to Treat Tumors Outside the Liver
- Real-Time Remote Heart Monitors
- Sacral Nerve Stimulation as a Treatment of Neurogenic Bladder Secondary to Spinal Cord Injury
- Sacroiliac Joint Fusion
- Septoplasty

- Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiotherapy (SBRT)
- Subtalar Arthroereisis
- Suprachoroidal Injection of a Pharmacologic Agent
- Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other GU Conditions
- Thoracoscopy for Treatment of Hyperhidrosis
- Tonsillectomy in Children
- Total Ankle Replacement
- Transcatheter Closure of Cardiac Defects
- Transcatheter Uterine Artery Embolization
- Transmyocardial Preventicular Device
- Transtympanic Micropressure for the Treatment of Ménière's Disease
- Treatment of Obstructive Sleep Apnea, UPPP
- Treatment of Osteochondral Defects of the Knee and Ankle
- Treatment of Temporomandibular Disorders
- Vagus Nerve Stimulation
- Varicose Vein Treatment

Human Organ and Bone Marrow/Stem Cell Transplants:

- Inpatient admits for **ALL** solid organ and bone marrow/stem cell transplants (Including Kidney only transplants)
- Outpatient: All procedures considered to be transplant or transplant related including but not limited to:
  - Stem Cell/Bone Marrow transplant (with or without myeloablative therapy)
  - Donor Leukocyte Infusion

Out-of-Network Referrals:

Out of Network Services for consideration of payment at in-network benefit level (may be authorized, based on network availability and/or medical necessity.)

Mental Health/Substance Abuse (MHSA):

- Acute Inpatient Admissions
- Electric Convulsive Therapy (ECT)
- Transcranial Magnetic Stimulation (TMS)
- Intensive Outpatient Therapy (IOP)
- Partial Hospitalization (PHP)
- Residential Care
- Applied Behavioral Analysis (ABA)

Appendix C

Eligible Employee Subsets of Participating Companies and Organizations

- Marathon Petroleum Corporation
  - Regular employees
  - Casual employees who meet work hour requirements*
- Marathon Petroleum Company LP
  - Regular employees
  - Casual employees who meet work hour requirements*
- Marathon Petroleum Service Company
  - Regular employees
  - Casual employees who meet work hour requirements*
- Marathon Petroleum Logistics Services LLC
  - Regular employees
  - Casual employees who meet work hour requirements*
- Marathon Refining Logistics Services LLC
  - Regular employees
  - Casual employees who meet work hour requirements*
- MW Logistics Services LLC
  - Regular employees
  - Casual employees who meet work hour requirements*
- Speedway LLC
  - Regular employees in Salary Grades 12 and Above
- Speedway Prepaid Card LLC
  - Regular employees in Salary Grades 12 and Above

* Eligible casual employees are: 1) casual employees hired to work at least 30 hours per week for at least three consecutive months, including a co-op or intern; or 2) casual employees who meet the work hour requirements set forth in Appendix D.

Appendix D

Health Care Reform Measurement Periods

Initial Measurement Period: This starts when an employee is hired, the number of hours the employee will work cannot reasonably be determined and the employee is designated as a casual employee.

During this period, the employee has to work an AVERAGE of 30 hours per week (or more) to qualify for Health Plan Coverage for the Initial Stability Period.

Initial Stability Period: This is the period for which a casual employee who worked an average of 30 hour per week (or more) in the Initial Measurement Period will have coverage (or the period for which employer is not required to offer coverage to employees who did not work an average 30 hours per week or more).

Standard Measurement Period: A measurement period that starts and ends at the same time for all casual employees.

If a casual employee works an average of 30 hours per week (or more) during this period, they qualify for Health Plan coverage for the next Ongoing Stability Period. If a casual employee does not work an average of 30 hours per week (or more) during this period, the employer is not required to offer coverage during the next Ongoing Stability Period.

Ongoing Stability Period: This is the period that a casual employee who worked an average of 30 hours per week (or more) in the previous Standard Measurement Period qualifies for coverage. If a casual employee does not work an average of 30 hours per week (or more) during this period, the employer is not required to offer coverage during this period.

Administrative Period: This is the time period between the end of the Initial or Standard Measurement Period and the actual commencement of coverage.

Measurement + Administrative Periods cannot exceed 13 months (and a fraction) for newly hired, variable hour employees.

Cannot be longer than 90 days.

Definitions of the Above Periods

1. Initial Measurement Period — begins at date of hire and ends at the employee's one-year anniversary.
2. Initial Stability Period — begins the first of the month following the employee's one-year anniversary date and ends one year later.
3. Standard Measurement Period — begins on October 3 and ends on October 2 of the following year.
4. Ongoing Stability Period — Begins January 1 and ends December 31 of each year.
5. Administrative Period — The period of time between the end of an Initial Measurement Period or a Standard Measurement Period and the beginning of coverage. This will be less than 90 days.

Example:

Casual Employee on standard bi-weekly pay periods

03/16/2015	Hire Date
03/16/2015	Initial Measurement Period starts
10/03/2015	Standard Measurement Period #1 starts
03/16/2016	One year anniversary Initial Measurement Period ends Employee meets 30 hour average/week requirement
04/01/2016	Initial Stability Period starts Coverage Starts (eligible coverage start date)
10/02/2016	Standard Measurement Period #1 ends If Employee meets work hour requirements, then coverage is extended through 12/31/2017 If Employee does not meet work hour requirements, then coverage will end on 3/31/17 (end of Initial Stability Period)
10/03/2016	Standard Measurement Period #2 begins
10/03/2016 – 12/31/2016	Administrative Period
11/01/2016	Enrollment Materials sent to all casual employees who met eligibility requirements in Standard Measurement Period #1
01/01/2017	Casual employees who met eligibility requirements in Standard Measurement Period #1 have Coverage Start (eligible coverage start date) Ongoing Stability Period #1 begins
03/31/2017	Initial Stability Period ends If they qualified during Standard Measurement Period, then coverage continues until 12/31/2017 If they did not qualify, coverage ends and next evaluation is in October 2017
10/02/2017	Standard Measurement Period #2 ends

Note: After the Initial Measurement Period, all employees will only be measured on the Standard Measurement Period whether or not they 1) qualified during their Initial Measurement Period, or 2) waived coverage even if they were eligible.