# Marathon Petroleum Health Reimbursement Account Plan (MPHRA)

**Effective January 1, 2018**

# Health Reimbursement Account Plan (MPHRA)

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# Health Reimbursement Account Plan (MPHRA)

This document serves both as the Plan instrument and the Summary Plan Description (SPD) for the Marathon Petroleum Health Reimbursement Account Plan that the Company is required to provide to Plan participants. 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. Introduction

Marathon Petroleum Company LP has established the Marathon Petroleum Health Reimbursement Account Plan (the "MPHRA Plan" or "Plan"). Effective January 1, 2016, no additional contributions will be made to employee health reimbursement accounts ("HRA"). Only Employees with existing balances in their HRA as of December 31, 2015 are eligible to participate in this Plan. Also effective January 1, 2016, this Plan is a limited purpose HRA plan and will reimburse only eligible dental and vision expenses. However, Retirees with HRA balances may also receive reimbursement for retiree health insurance premiums.

This Plan is intended to be a health reimbursement arrangement as defined under IRS Notice 2002-45. The expenses reimbursed under the Plan are intended to be eligible for exclusion from Participants' gross income under Section 105(b) of the Internal Revenue Code ("Code"). This Plan is intended to be an employer-provided medical reimbursement plan under Code §§ 105 and 106, and a limited-scope excepted benefit plan under 45 CFR §146.145(b). With respect to the reimbursement of retiree health insurance premiums from Retiree HRA's, that portion of the Plan is a retiree-only plan and not available to any current Employee.

Existing HRA balances consist of contributions made by the Company pursuant to and in accordance with the terms of the Marathon Petroleum Health Plan and Wellness Plan prior to December 31, 2015. Because HRA balances carry forward from year to year, many Participants continue to have HRA balances under this Plan.

## II. Eligibility

Employees and Retirees with a positive balance in an HRA as of December 31, 2015 are eligible to receive reimbursement under the Plan for eligible dental and vision expenses up to the remaining balance in their HRA.

LTD Terminated Employees are eligible to participate in the MPHRA Plan, provided they have a remaining balance in their HRA as of January 1, 2016, and remain eligible for Long Term Disability benefits under the Marathon Petroleum Long Term Disability Plan.

Retirees are eligible for the Retiree-Only Plan Benefit, which allows for reimbursement from their HRA of the cost of retiree health insurance premiums, in addition to dental and vision expenses.

## III. Description of Benefits

Beginning January 1, 2016, Participants with HRA balances can receive reimbursement from the Plan up to the remaining balance in their HRA for eligible dental and vision expenses incurred by the Participant and his or her spouse and Covered Dependents (which would include children and other qualified dependents recognized under Code Sections 152 and/or 213(d)(5)).

Eligible expenses include dental and vision expenses that are not paid by an insurer, claims administrator, or other third party payer on the participant's behalf. Such expenses may include:

- Copayments for dentist and optometrist visits
- Coinsurance for dental or orthodontia services
- New eyeglasses
- Lasik surgery
- Dentures
- Teeth cleaning, fluoride treatments, sealants, X-rays, fillings, extractions, braces

Services or procedures performed purely for cosmetic purposes may not be reimbursed from the HRA, including teeth whitening. Qualified dental and vision expenses are defined in Section 213(d) of the Code. You may consult IRS Publication 502 for clarification, or seek advice from a tax advisor, as to which services or expenses may be eligible.

## IV. Retiree Only Plan Benefit

Retirees with positive balances in their HRA as of the date of retirement are eligible to receive reimbursement from their HRA for the cost of retiree health insurance premiums. Retirees may also continue to receive reimbursement from their HRA for eligible dental and vision expenses, until the HRA reaches a zero balance. No active employee may receive reimbursement from their HRA for expenses other than eligible dental or vision expenses. If a Retiree is rehired by the Company, he or she will not be eligible for this Retiree Only Plan Benefit.

## V. Marathon Petroleum Health Reimbursement Account (MPHRA) Highlights

Participant HRA's are funded entirely with Company contributions. No HRAs include Participant contributions, through salary reduction or otherwise. All amounts payable under this Plan will be paid from the general assets of the Company. No trust, fund, or other form of segregation of assets will be maintained for the benefit of any Participant.

The Plan Administrator has established a recordkeeping account for each Participant, which is the Participant's HRA. As of January 1, 2016, no additional contributions will be made by the Company to Participant HRAs. Each Participant's HRA will be debited as eligible expenses are reimbursed. Once a Participant's HRA balance equals zero, no additional claims will be reimbursed.

**Participants may review the status of their Account and/or any claims outstanding by logging on to www.payflex.com, the website of the Plan's record keeper, PayFlex Systems USA, Inc.**

Funds from the HRA will be used to reimburse eligible dental and vision expenses only. Each Participant's Account balance is carried over from year to year, unless the Participant terminates employment.

Therefore, qualified expenses will first be reimbursed from the Marathon Petroleum Health Care Spending Account Plan until that account balance is depleted. Qualified expenses will then be reimbursed from the MPHRA Plan. Since the balance carries over from year to year, the funds can be used for current expenses or saved for future expenses if the Participant remains employed by the Company or retires from the Company.

Participants may elect to opt out of the balance of their HRA, as a balance may prevent the Participants from obtaining a premium assistance tax credit if they decide to purchase health coverage through the Health Insurance Marketplace.

## VI. Participation While on a Leave of Absence

Participating Employees on a leave of absence during the Plan Year may continue participation in the MPHRA Plan, as follows:

A. Sick Leave

- Coverage continues for up to two (2) years.

B. Family Leave

- Coverage continues for the duration of the leave.

C. Personal leave

- Coverage continues

D. Military Leave

- Coverage continues while receiving Company pay offset.

E. Educational Leave

- Coverage continues for up to two (2) years.

F. Leave of absence for other reasons

- Coverage is terminated unless approval to continue coverage is granted by the Company. If no approval to continue is granted, the HRA remaining balance is forfeited.

## VII. Termination of Participation

Your participation in the Plan shall cease on the earlier of:

- The date your HRA balance is exhausted;
- The date your employment with the Company or any company within the Marathon Petroleum Company LP controlled group of companies terminates, unless you are a Retiree; or
- The date on which this Plan terminates.

## VIII. Continuation of Coverage after Termination of Employment

Federal law requires that Plan Participants and spouses and dependents be permitted to elect to continue coverage under the Plan when coverage terminates due to certain "qualifying events." Such "qualifying events" include a Participant's death, termination of employment, divorce or legal separation, or reduction in hours. In the case of a dependent, the dependent's ceasing to qualify as an eligible dependent is also a qualifying event. If coverage ceases due to such qualifying events, Participants will be offered COBRA continuation coverage. For information concerning your COBRA rights, contact PayFlex at 800-PAYFLEX (844-729-3539) or review your rights in Appendix B at the end of this document.

### A. Retirement

A Retiree will continue to have access to the balance of his or her HRA until the Account is exhausted.

### B. Death

If a Participant dies with a balance in his or her HRA the remaining balance may be used to reimburse eligible dental and vision expenses incurred by the Participant's surviving spouse or other surviving tax dependents. If there is no surviving spouse or eligible surviving tax dependents, the Account balance is forfeited.

### C. Termination

Participants whose participation terminates due to employment termination can continue to file claims for expenses that were incurred prior to their termination date until May 31st of the year following their termination date. At that time, any balance in their account will be forfeited. Expenses are incurred on the date the dental or vision service is furnished (not when the bill for the service is received).

Terminating employees will also be offered the opportunity to extend coverage under COBRA provisions for expenses incurred after their termination date.

## IX. General Tax Treatment

It is intended that Company contributions made to the Plan on behalf of a Participant shall not result in taxable income to the Participant and that all benefits provided under the Plan not be included in the Participant's taxable income as provided under Code Sections 105, 106 and other applicable regulations. In the event that a benefit provided under the Plan does not satisfy the requirements of Code Sections 105 and 106, and therefore becomes taxable to the Participant, the reimbursement will be paid no later than the last day of the taxable year following the taxable year in which the expense was incurred.

## X. Reimbursement Procedures

Once you have incurred an eligible expense, you may seek reimbursement from your HRA by submitting a claim for reimbursement.

**Mailed Claims:** PayFlex Systems USA, Inc.
P.O. Box 4000
Richmond, KY 40476-4000

**Faxed Claims:** 855-703-5305

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

Claim forms are available online at www.payflex.com after you register on the site, or by calling PayFlex. The forms are also available at www.mymcpbenefits.com.

Claims should contain such information as may be required by PayFlex to comply with the terms of the Plan. At a minimum, any claim submitted should include your name, address, Social Security Number, the name and relationship to you of the person on whose behalf eligible dental and vision expenses were incurred, the amount and date of the claim, the name of the person, organization or entity to which the expense was or is to be paid, the specific basis for the claim, and any additional information submitted to support the claim or which may be required. The claim will not be deemed to be effectively made until the claim, as filed, satisfies the requirements established by the Plan and PayFlex.

If a claim for a Plan benefit is wholly or partially denied by PayFlex, notice of the decision shall be furnished to the Participant within a reasonable period of time after receipt of the claim.

**PayFlex can be reached at 844-PAYFLEX (844-729-3539).**

The participant's account can be accessed at:
www.payflex.com

First time users must register as a new user.

## XI. Recovery of Overpayments

If it is later determined that a Participant received an overpayment or a payment in error (e.g., the Participant was reimbursed for an expense under the MPHRA Plan that is later paid for by the Dental Plan or Vision Plan or some other plan), the Participant will be required to refund the overpayment or erroneous reimbursement to the Company.

If the overpayment or erroneous payment is not refunded, the Plan reserves the right to debit the Participant's HRA by the amount of the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from the Participant's pay, to the extent allowed by applicable law. If these options are unsuccessful, the Plan Administrator may decide to treat the amount of the overpayment as taxable income. In addition, if the Plan Administrator determines that a fraudulent claim was submitted, the Plan Administrator may terminate the Participant's coverage under the MPHRA Plan and the Participant's remaining Account balance will be forfeited.

## XII. Benefit Claims

If a claim for a Plan benefit is wholly or partially denied by the Plan, notice of the decision shall be furnished to the Participant by the Plan or Plan Administrator within a reasonable period of time, but not later than 30 days after receiving the claim. If more time is needed to review the claim, the Plan may extend the time period up to an additional 15 days, explaining the reason for the extension and will notify the participant of the extension before the end of the first 30-day period. If an extension is necessary because of your failure to submit the information necessary to decide the claim, then the Plan Administrator will notify you regarding what additional information you are required to submit, and you will be given at least 45 days after such notice to submit the additional information. If you do not submit the additional information, the Plan Administrator will make the decision based on the information that it has. If your claim is denied, the notice that you receive shall include the following information:

- The specific reason or reasons for the denial;
- Specific reference to the Plan provisions on which the denial is based;
- A description of any additional material or information necessary to complete the claim and an explanation of why this material or information is necessary; and
- An explanation of the steps to be taken to submit the claim for review.
- A description of the Plan's internal review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA following a denial on review;
- If the Plan Administrator relied on an internal rule, guideline, protocol, or similar criteria in making its determination, either a copy of the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criteria was relied upon in making the determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request.

## XIII. Appeals of Denied Claims

A Participant or their duly authorized representative may appeal a denial of a claim by requesting a review by written application to the Plan Administrator or its designee no later than 180 days after receipt by the Participant of written notification of denial of a claim. Failure to make written request for appeal within the 180-day period after the receipt of the Plan Administrator's notice of denial of the claim shall render the Plan Administrator's decision regarding the claim final, binding and conclusive on all parties.

The Participant or their duly authorized representative:

- May review pertinent documents; and
- May submit issues and comments in writing as well as other relevant documents, records, or other information; and
- May request from the Plan copies of all documents, records, and other information related to the claim.

If the Plan Administrator receives new or additional evidence that he/she considered, relied upon, or generated in connection with the claim, other than evidence that you have provided, you will be provided with this information and given a reasonable opportunity to respond to the evidence before the due date for the notice of final adverse benefit determination.

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

Written notice will be provided to the Participant, advising if the appeal was granted or denied. If the appeal is denied, the notice will describe the specific reason for the denial; a reference to the specific Plan provision(s) on which the denial is based; a statement providing that you are required to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits; if an internal rule, guideline, protocol, or similar criterion was relied upon in make the determination, a copy of such rule, guideline or similar criterion; and a statement of your right to seek judicial review of the Plan's decision under ERISA.

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

## XIV. 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.

## XV. Finality of Decision and Legal Action

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

## XVI. Administration of the Plan

| Important Plan Administration Information | |
|---|---|
| **Plan Name** | Marathon Petroleum Health Reimbursement Account Plan |
| **Plan Administrator (Agent for service of legal process)** | David R. Sauber<br>P.O. Box 1<br>539 South Main Street<br>Findlay, OH 45839-01<br>Phone: (419) 422-2121 |
| **Employer Identification Number** | 31-1537655 |
| **Type of Plan** | Welfare Plan |
| **Plan Sponsor** | Marathon Petroleum Company LP<br>539 South Main Street<br>Findlay, OH 45840 |
| **Plan Number** | 556 |
| **Inspection of Plan Documents** | Plan documents may be inspected by making a written request at any Company Human Resources office or by writing:<br><br>Marathon Petroleum Company LP<br>Benefits Administration<br>539 South Main Street<br>Findlay, OH 45840 |
| **Plan Year** | The Plan Year is January 1 through December 31. Records are kept on a calendar year basis. |
| **Recordkeeper** | PayFlex Systems USA, Inc (PayFlex)<br>P.O. Box 4000<br>Richmond, KY 40476-4000 |

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

In determining the eligibility of participants for benefits and in construing the Plan's terms, the Plan Administrator has the power to exercise discretion in the construction or interpretation of 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. In situations in which it is deemed 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 made with respect to the Plan, in the form of written administrative rulings, which, until revoked, or until superseded by Plan amendment or by a different administrative ruling, shall thereafter be followed in the administration of the Plan.

All decisions of the Plan Administrator made on all matters within the scope of his authority shall be final and binding upon all persons, including the Company, any trustee, all participants, and their heirs and personal representatives, and all labor unions or similar organizations representing participants. It is intended that the standard of judicial review to be applied to any determination made by the Plan Administrator shall be the "arbitrary and capricious" standard of review.

Any discretionary acts taken under this Plan by PayFlex, the Plan Administrator or the Company, shall be uniform in their nature and shall be applicable to all participants 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).

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

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

The Plan shall be construed, whenever possible, to be in conformity with the requirements of the Code and ERISA. To the extent not in conflict with the preceding sentence, the construction of the Plan shall be governed by the laws of the State of Ohio.

## XVII. Further Information

### A. Limitation Regarding Employment

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

### B. No Interest or Earnings

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

### C. Severability

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

### D. Internal Revenue Service (IRS) Regulations

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

### E. Missing Person

If, 5 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.

### F. Non-Assignability

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

## XVIII. Participation by Associated Companies and Organizations

Upon specific authorization and subject to any terms and conditions it may wish to establish, Marathon Petroleum Company LP may permit eligible employees of subsidiaries and affiliated organizations to participate in this Plan. Currently, these participating companies include, but are not limited to, Marathon Petroleum Company LP, Marathon Petroleum Corporation, Marathon Petroleum Service Company, Marathon Petroleum Logistics Services LLC, Marathon Refining Logistics Services LLC, Speedway LLC, Speedway Prepaid Card LLC, and MW Logistics Services LLC. Employee eligibility within these participating companies may be limited to certain employee subsets, as identified in Appendix C. In addition, eligible subsets of employees must satisfy all eligibility provisions otherwise provided by this Plan.

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

## XIX. Modification and Termination of the Plan

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

Marathon Petroleum Company LP may exercise its reserved rights of amendment, modification or termination:

(i) By written resolution by the Board of Directors of Marathon Petroleum Corporation;

(ii) By written resolution by the General Partner of Marathon Petroleum Company LP;

(iii) By written resolution by the Executive Committee;

(iv) By written actions exercised by any other committee, for example the Marathon Petroleum Corporation Salary and Benefits Committee (the Salary and Benefits Committee"), to which the Board of Directors of Marathon Petroleum Corporation or the Executive Committee has specifically delegated rights of amendment, modification or termination; or

(v) By written actions exercised by any other entity or person to which or to whom the Board of Directors of Marathon Petroleum Corporation, the Executive Committee or the Salary and Benefits Committee has specifically delegated rights of amendment, modification, or termination.

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

(i) With the opinion of counsel, technical amendments required by applicable laws and regulations;

(ii) With the opinion of counsel, amendments that are clarifications of Plan provisions;

(iii) Amendments in connection with a signed definitive agreement governing a merger, acquisition or divestiture such that, for MPC Employee Benefit Plans, needed changes are specifically described in the definitive agreement, or if not specifically described in the definitive agreement, the needed changes are in keeping with the intent of the definitive agreement;

(iv) Amendments in connection with changes that have a minimal cost impact (as defined below) to the Company; and

(v) With the opinion of counsel, amendments in connection with changes resulting from state or federal legislative actions that have a minimal cost impact (as defined below) to the Company.

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

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

(ii) $500,000.

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

## XX. Participant Rights Under the Employee Retirement Income Security Act of 1974 (ERISA)

As a participant in the Marathon Petroleum Health Reimbursement Account Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

### Receive Information About the Plan and Benefits

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

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report, as required by law.

### Continue Group Health Plan Coverage

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

### Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the employee benefit plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan participants and their beneficiaries. No one, including the Company or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit under the Plan or from exercising your rights under ERISA.

### Enforcement of 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 that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in Federal court. In such a case, the court may require the Plan Administrator to provide the materials and to 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 Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in 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 the 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 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 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 Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in telephone directories 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 participant rights and responsibilities under ERISA by calling the publications hotline for the Employee Benefits Security Administration.

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

The Plan will use protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

The Plan will disclose PHI only to the Plan Administrator and other members of the Company's workforce, who are authorized to receive such PHI, and only to the extent and in the minimum amount necessary for that person to perform Plan administrative functions. "Members of the Company's workforce" generally include certain employees who work in the Company's employee benefits department, human resources department, payroll department, legal department, and information technology department. The Plan Administrator keeps an updated list of those members of the Company's workforce who are authorized to receive PHI.

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

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

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

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

# Appendix A

## Definitions

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

**"Covered Dependent"** means a legal spouse or eligible child under age 26 who is considered a "dependent" under the Internal Revenue Code.

**"Company"** means Marathon Petroleum Company LP and all affiliated organizations participating in the Plan, as set forth in Section XVI.

**"Employee"** shall mean any individual employed by the Company.

**"ERISA"** shall mean the Employee Retirement Income Security Act of 1974, as amended.

**"LTD Terminated Employee"** means an individual receiving benefits under the Marathon Petroleum Long Term Disability Plan whose employment with the Company has been terminated.

**"HRA"** or **"Account"** means the recordkeeping account established by the Plan Administrator and credited, prior to January 1, 2016, with MPHRA Dollars which Participants may use to receive reimbursement of eligible dental and vision expenses. No money shall actually be allocated to any individual Participant HRA; all such Accounts shall be of a memorandum nature, maintained by the Plan Administrator for accounting purposes, and shall not be representative of any identifiable trust assets. No interest will be credited to or paid on amounts credited to the Account.

**"MPHRA Dollars"** means any amount that the Company, in its sole discretion, may have contributed on behalf of each Participant to provide benefits for such Participant and their Covered Dependents, if applicable, under the Plan. Effective January 1, 2016, no additional employer contributions will be made under this Plan into any HRA. In no event will any employer contributions be disbursed to a Participant in the form of additional, taxable compensation.

**"Participant"** means any person who has a balance in an HRA under this Plan as of January 1, 2016.

**"Plan"** means the Marathon Petroleum Health Reimbursement Account Plan.

**"Plan Year"** shall be the period of coverage from January 1, through December 31 of the same year.

**"Retiree"** means a former Company employee eligible for benefits under the Marathon Petroleum Retirement Plan. Retiree shall not mean in any instance any current active employee, including rehires, of the Company.

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

# Appendix B

## COBRA Continuation of Coverage

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

### I. Group Covered

All Participants of the Plan (other than nonresident aliens with no U.S.-source earned income), including their covered eligible dependents, are subject to these COBRA provisions.

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

A. If an **Employee Participant** loses coverage:

1. Due to termination of employment (including retirement), either voluntary or involuntary, for reasons other than gross misconduct,
2. or due to layoff;

then the Participant and his or her eligible dependents will be entitled to elect continuation of coverage for a maximum of 18 months from the date of the qualifying event.

B. If the covered **Spouse** of a Participant loses coverage:

1. Due to the death of a Participant, or
2. Due to the divorce or legal separation from a Participant

then the Spouse, and any other currently covered eligible dependents that lose coverage, will be entitled to elect continuation of coverage for a maximum of 36 months from the date of the qualifying event.

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

1. Due to the death of a Participant,
2. Due to the dependent no longer meeting the Plan's definition of a Covered Dependent

then the eligible Child will be entitled to elect continuation of coverage for a maximum of 36 months from the date of the qualifying event.

## III. Extension of Maximum Length of Continuation Periods

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

Eligible dependents of an Employee Member who are entitled to a maximum 18-month 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):

1. The death of the Participant,
2. The divorce or legal separation of the Participant, or
3. The dependent child no longer meets the Plan's definition of a Covered Dependent.

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 Participant or dependent in accordance with the "Notification Procedure" in this Appendix.

## IV. Termination of Continued Coverage

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

A. The date on which the applicable 18-, 29-, or 36-month period ends; or

B. The date on which the HRA is exhausted.

## V. Notification Procedure

A. If coverage terminates due to the Participant's layoff, reduction in work hours, or termination of employment (for reasons other than gross misconduct:

   1. The Company will notify the Plan Administrator of such event within 30 days; and
   2. The Plan Administrator will notify the employee/dependent of their rights under COBRA within 14 days after receiving notice from Marathon Petroleum Company.

B. In the event of the divorce or legal separation of the Participant and spouse, or in the event that a dependent child no longer meets the Plan's definition of Covered Dependent:

   1. The Participant 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

   2. The Plan Administrator or representative will inform the Participant/dependent of their rights under COBRA at the time of such notification, or mail the information within 14 days. Notification to the spouse will serve as notification for all dependents residing with the spouse.

C. The Participant/dependent must elect to continue coverage within a specified election period. This period begins on the **earlier** of:

   1. The date notification is given to the Employee Member/dependent, or

   2. The date of termination of coverage;

   and ends on the **later** of 60 days from:

   1. The date of the notice from the Plan Administrator, if applicable, or

   2. The date of termination of coverage.

D. If an election is not made within the election period described above, coverage ceases at the time of the qualifying event.

E. The first premium payment must be made within 45 days of the election and, if the premium payment is made after the qualifying event, the payment must be sufficient to cover not only the advance premium amount but also the premium amount for the period beginning on the date coverage would have otherwise ceased and ending on the first date covered by the advance premium amount.

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

In addition to the regular 60-day election period indicated in the "Notification Procedure" section immediately above, the Trade Act of 2002 provides for an additional "special" election period for individuals deemed eligible for trade adjustment assistance (TAA) benefits and a health COBRA tax credit. This "special" election period is 60 days in length and applies to those who had not previously elected COBRA coverage during the election period indicated in the "Notification Procedure" section immediately above, and are deemed eligible for the tax credit provisions, but only if the tax credit eligibility determination occurs within six months of the loss of group health coverage (qualifying event date.) If COBRA coverage is elected under this special COBRA election period, it begins on the first day of that special period and continues for the applicable 18, 29 or 36 months (depending on the circumstances) from the date of the initial loss of group health coverage. There is no coverage for the period between the initial loss of group health coverage and the beginning of the additional special election period. The Department of Labor anticipates that information on the right to an additional "special" election period, together with other information on trade adjustment assistance and the health coverage tax credit, will also be made 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 us.jobs/state-workforce-agencies.asp.

## VII. Type of Coverage

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

## VIII. Cost

Those electing continued coverage under these COBRA provisions will not be charged a premium in order to continue to utilize the remaining balance in their Account.

## IX. Administration

The continuation coverage under the Marathon Petroleum Health Reimbursement Account Plan is administered in part by Marathon Petroleum Company LP and in part by PayFlex Systems USA, Inc, P.O. Box 3039, Omaha, NE 68103-3039. The toll-free number for PayFlex is 844-PAYFLEX (844-729-3539).

## X. Special Continuing Circumstances

A. General

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

B. Change in Control

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

Eligible terminated employees (including those eligible to retire at the time of termination) and their eligible dependents who immediately prior to termination were participants in the Health Reimbursement Account Plan have the opportunity to continue coverage under the terms and conditions of the 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.

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

The period of coverage provided under this section shall constitute continuation coverage required by COBRA.

# Appendix C

## Eligible Employee Subsets of Participating Companies and Organizations

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