Marathon Petroleum
Pre-65 Retiree Dental Plan

Effective January 1, 2017

Pre-65 Retiree Dental Plan

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Pre-65 Retiree Dental Plan

This document serves both as the plan document and the summary plan description ("SPD") for the Marathon Petroleum Pre-65 Retiree Dental Plan ("the 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.

Purpose

The purpose of the Pre-65 Retiree Dental Plan is to provide financial assistance for a broad range of dental treatment for eligible retirees and their eligible spouses and dependents.

Eligibility

Retirees

This Plan is offered to you as a retired employee who is not eligible for Medicare due to age (hereinafter referred to as "under age 65"). To be covered, you will have to enroll and pay monthly premiums.

Eligible Retirees are those who are (1) under age 65; and (2) have retired under the terms of the Marathon Petroleum Retirement Plan; and (3) are eligible for coverage under the Marathon Petroleum Retiree Health Plan at the time of retirement.

Retirees who meet these requirements are eligible for coverage on the day they retire under the terms of the Marathon Petroleum Retirement Plan.

Eligible Dependents

Any of your eligible Dependents, as defined later in this Plan (see pages 29 – 30 under the heading "Definitions"), can be covered. If Dependents are covered, you will be charged the Retiree+Spouse, Retiree+Child(ren) or Retiree+Family rate, depending on the number and type of Dependents covered.

Coverage for your eligible Dependent(s) begins:

- On the first day of your coverage, providing they meet the definition of an eligible Dependent on that date; or
- The date an individual meets the definition of an eligible Dependent, providing that:
  - You were covered as a Member on the day the individual met the dependent definition; and
  - You notify Marathon Petroleum Company's Benefits Service Center at 1-888-421-2199 within 60 days of the event.

Coverage for any Dependent ceases at the earlier of:

- The date you become eligible for Medicare due to age;
- The date the Dependent becomes eligible for Medicare due to age (if older than you);
- The date the Dependent no longer meets the definition of an eligible Dependent (for dependent children, coverage ends as of the first of the month after turning age 26); or
- The date of your death.

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Enrollment

A Retiree's election to enroll or re-enroll in the Plan must be made within 60 days of any of the following:

- the date of your retirement;
- the termination of COBRA coverage under the Marathon Petroleum Dental Plan (the active employee Dental Plan);
- the loss of coverage under the Marathon Petroleum Dental Plan (the active employee Dental Plan);
- the date your spouse who is also a Marathon Petroleum Retiree turns age 65, provided you were covered as a Dependent in this Plan at the time your spouse turns 65; or
- the death of your spouse who was also a Marathon Petroleum Retiree, provided you were covered as a Dependent in this Plan at the time of your spouse's death.

A Retiree cannot join the Plan during the annual benefits open enrollment period or when there is a qualifying life event. Once coverage is dropped, or not elected within 60 days of any of the above referenced events, a Retiree cannot rejoin the Plan unless the reason for dropping coverage was to enroll in the Marathon Petroleum Dental Plan (the active employee Dental Plan) as either an employee member or dependent member.

A Retiree can only waive coverage during the benefits open enrollment period, with the waiver effective the following January 1. A Retiree cannot waive coverage at any other time, even for a qualifying life event, unless the reason for waiving coverage is to enroll in the Marathon Petroleum Dental Plan (the active employee Dental Plan) as either an employee member or dependent member — otherwise, coverage must remain in place for the remainder of the calendar year.

Premiums

The following are the monthly premium rates (as of January 1, 2017):

- Retiree Only $23.00
- Retiree + Spouse $46.00
- Retiree + Child(ren) $50.00
- Retiree + Family $79.00

Premiums are based on claim experience and administrative costs of the Plan. Changes in monthly premiums will be provided to Members prior to the start of each calendar year. Members will receive monthly billing statements from the billing administrator, PayFlex Systems USA, Inc. Premiums are due the first of the month with a 30-day grace period and can be submitted by using automatic bank draft, check or money order, or by setting up one time or recurring payment through the billing administrator's online account access. The billing administrator will provide Members with information regarding methods of payment.

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Schedule of Benefits[1]

The Plan covers services provided by In-Network and Out-of-Network Providers. **If you select an In-Network Provider from Cigna's Advantage network, your cost will be less than if you select an Out-of-Network Provider.**

Deductibles	Deductibles are expenses to be paid by you or your Dependent. Deductibles are in addition to any Coinsurance. Once the Deductible maximum in the Schedule has been reached you and your family need not satisfy any further dental deductible for the rest of that year.
In-Network Provider Payment (Cigna's Advantage Network)	In-Network (the Advantage network) Provider services are paid based on the Contracted Fee agreed upon by the provider and Cigna.
Out-of-Network Provider Payment	Out-of-Network Provider services are paid based on the Contracted Fee that Cigna would pay to an In-Network Provider.
Simultaneous Accumulation of Amounts	Benefits paid for In-Network and Out-of-Network Provider services will be applied toward both the In-Network and Out-of-Network Provider maximum shown in the Schedule. Expenses incurred for either In-Network or Out-of-Network Provider charges will be used to satisfy both the In-Network and Out-of-Network Provider Deductibles shown in the Schedule.

Benefit Highlights	In-Network Provider (Advantage Network)	Out-of-Network Provider*
Classes I, II, III Combined Calendar Year Maximum	$1,000 per person	
Calendar Year Deductible • Individual • Family Maximum	 $50 per person Not Applicable	
Class I Preventive Care	Plan covers 100%, no deductible	Coverage limited to the amount paid for in-network care**
Class II Basic Restorative	Plan covers 80% after plan deductible	Coverage limited to the amount paid for in-network care**
Class III Major Restorative	Plan covers 50% after plan deductible	Coverage limited to the amount paid for in-network care**

* Members are responsible for payment of the difference between the **maximum allowed charge** and the **full fee charged by the provider**. The Plan pays both In-Network Providers (the Cigna Advantage network) and Out-of-Network Providers the same amount for a particular service; therefore, if you go to an Out-of-Network Provider (who does not have a contract with Cigna with negotiated lower charges), then your out-of-pocket costs will be higher than if you go to an In-Network Provider.

** Coverage differs from the active employee Dental Plan.

[1] The Schedule is a brief outline of your maximum benefits which may be payable under your coverage. For a full description of each benefit, refer to the "Covered Services" section below.

Coordination With Active Dental Plan

If you are a member of the Marathon Petroleum Dental Plan (the active employee Dental Plan) in the year you retire, any benefits received or expenses incurred under that plan do not count toward benefits received or toward deductible under the Pre-65 Retiree Dental Plan.

Alternate Benefit Provision

If more than one covered service will treat a dental condition, payment is limited to the least costly service provided it is a professionally accepted, necessary and appropriate treatment. This alternate benefit provision does not apply for fillings and crowns.

If the Member requests or accepts a more costly covered service, he or she is responsible for expenses that exceed the amount covered for the least costly service. Therefore, the Plan recommends predetermination of benefits before major treatment begins.

Predetermination of Benefits

Predetermination of benefits is a voluntary review of a Dentist's proposed treatment plan and expected charges. It is not preauthorization of service and is not required.

The treatment plan should include supporting pre-operative X-rays and other diagnostic materials as requested by Cigna's dental consultant. If there is a change in the treatment plan, a revised plan should be submitted.

Cigna will determine covered dental expenses for the proposed treatment plan. If there is no predetermination of benefits, Cigna will determine covered dental expenses when it receives a claim.

Review of proposed treatment is advised whenever extensive dental work is recommended (when charges exceed $200).

Predetermination of benefits is not a guarantee of a set payment. Payment is based on the services that are actually delivered and the coverage in force at the time services are completed.

Missing Teeth Limitation

There is no payment for replacement of teeth that are missing when a person first becomes covered.

This payment limitation no longer applies after 24 months of continuous coverage.

Note: This provision does not apply if you were covered by the Marathon Petroleum Dental Plan for active employees immediately prior to enrolling in this plan.

In-Network and Out-of-Network Providers

Payment for a service delivered by an In-Network Provider is the Contracted Fee multiplied by the benefit percentage that applies to the class of service, as specified in the Schedule. Members are responsible for the balance of the Contracted Fee.

Payment for a service delivered by an Out-of-Network Provider is the Contracted Fee multiplied by the benefit percentage that applies to the class of service, as specified in the Schedule. Members are responsible for the balance of the provider's actual charge.

Provider Directory/Networks

You may access a list of providers who participate in the Advantage network by visiting www.Cigna.com, or you may call Cigna customer service toll free at 800-244-6224. Representatives are available to answer your questions 24 hours a day, 7 days a week.

Covered Services

The following section lists covered dental services. The Plan may agree to cover expenses for a service not listed. To be considered, the service should be identified using the American Dental Association Uniform Code of Dental Procedures and Nomenclature, or by description and then submitted to Cigna.

Class I Services — Diagnostic and Preventive

- Clinical oral examination: Only 2 per person per calendar year.
- Palliative (emergency) treatment of dental pain, minor procedures, when no other definitive dental services are performed. (Any X-ray taken in connection with such treatment is a separate dental service.)
- X-rays — Complete series: Only one per person, including panoramic film, in any 3 calendar years.
- Bitewing X-rays: Only 2 charges per person per calendar year.
- Panoramic (Panorex) X-ray: Only one per person in any 3 calendar years.
- Prophylaxis (Cleaning): Only 2 per person per calendar year.
- Periodontal maintenance procedures (following active therapy), Periodontal Prophylaxis.
- Topical application of fluoride (excluding prophylaxis): Limited to persons less than 19 years old. Only one per person per calendar year.
- Topical application of sealant, per tooth, on a posterior tooth: Only one treatment per tooth in any 5 calendar years.
- Space Maintainers, fixed unilateral: Limited to non-orthodontic treatment.

Class II Services — Basic Restorations, Endodontics, Periodontics, Prosthodontic Maintenance and Oral Surgery

- Amalgam filling.
- Composite/resin filling.
- Root canal therapy: Any X-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate dental service.
- Osseous surgery: Flap entry and closure is part of the allowance for osseous surgery and not a separate dental service.
- Periodontal scaling and root planing: Entire mouth.
  - Adjustments: Complete denture.
- Any adjustment of or repair to a denture within 6 months of its installation is not a separate dental service.

- Re-cement bridge.
- Routine extractions.
- Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.
  - Removal of impacted tooth, soft tissue.
  - Removal of impacted tooth, partially bony.
  - Removal of impacted tooth, completely bony.
- Local anesthetic, analgesic and routine postoperative care for extractions and other oral surgery procedures are not separately reimbursed but are considered as part of the submitted fee for the global surgical procedure.
- General anesthesia: Paid as a separate benefit only when medically or dentally necessary, as determined by Cigna, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.
- I.V. sedation: Paid as a separate benefit only when medically or dentally necessary, as determined by Cigna, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.

Class III Services — Major Restorations, Dentures and Bridgework

- Crowns:

  Note: Crown restorations are dental services only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, composite/resin, silicate, acrylic or plastic restoration.
  - Porcelain Fused to High Noble Metal
  - Full Cast, High Noble Metal
  - Three-Fourths Cast, Metallic
- Removable appliances:
  - Complete (Full) Dentures, Upper or Lower
  - Partial Dentures
  - Lower, Cast Metal Base with Resin Saddles (including any conventional clasps, rests and teeth)
  - Upper, Cast Metal Base with Resin Saddles (including any conventional clasps, rests and teeth)
- Fixed Appliances:
  - Bridge Pontics — Cast High Noble Metal
  - Bridge Pontics — Porcelain Fused to High Noble Metal
  - Bridge Pontics — Resin with High Noble Metal
  - Retainer Crowns — Resin with High Noble Metal
  - Retainer Crowns — Porcelain Fused to High Noble Metal
  - Retainer Crowns — Full Cast High Noble Metal

- Prosthesis Over Implant: A prosthetic device, supported by an implant or implant abutment is a covered expense. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only payable if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.

Expenses Not Covered

Covered expenses will not include, and no payment will be made for:

- services performed solely for cosmetic reasons;
- replacement of a lost or stolen appliance;
- replacement of a bridge, crown or denture within 5 years after the date it was originally installed unless: (a) the replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or (b) the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is covered for these benefits;
- any replacement of a bridge, crown or denture which is or can be made usable according to common dental standards;
- procedures, appliances or restorations (except full dentures) whose main purpose is to: (a) change vertical dimension; (b) diagnose or treat conditions or dysfunction of the temporomandibular joint; (c) stabilize periodontally involved teeth; or (d) restore occlusion;
- porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars;
- bite registrations; precision or semiprecision attachments; or splinting;
- instruction for plaque control, oral hygiene and diet;
- dental services that do not meet common dental standards;
- services that are deemed to be medical services;
- services and supplies received from a hospital;
- orthodontic treatment;
- the surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index, or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant; and
- services for which benefits are not payable according to the “General Limitations” section.

General Limitations

No payment will be made for expenses incurred for you or any one of your Dependents:

- for or in connection with an injury arising out of, or in the course of, any employment for wage or profit;
- for or in connection with a sickness which is covered under any workers' compensation or similar law;
- for charges made by a hospital owned or operated by or which provides care or performs services for the United States Government, if such charges are directly related to a military-service-connected condition;
- services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- to the extent that payment is unlawful where the person resides when the expenses are incurred;
- for charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no coverage;
- to the extent that billed charges exceed the rate of reimbursement as described in the Schedule;
- for charges for unnecessary care, treatment or surgery;
- to the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid; or
- for or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.

Coordination of Benefits

Benefits paid from the Plan are determined using the "Benefit Less Benefit" method, by calculating the amount payable under Plan provisions, and then reducing that amount by the amount of payment due for the same charges from any other Group Plan or any Government Sponsored Plan. Coordination with other Group Plans follows the National Association of Insurance Commissioners (NAIC) Coordination of Benefits model utilizing the "Benefit Less Benefit" method. Among other guidelines, this model provides that 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. Coordination with Government Sponsored Plans follows the relevant federal statute or the regulations issued by the appropriate government agency.

Expenses for Which a Third Party May Be Responsible

This Plan does not cover:

1. Expenses incurred by a Member for which another party may be responsible as a result of having caused or contributed to an injury or sickness.
2. Expenses incurred by a Member 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.

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.

Subrogation/Right of Reimbursement

If a Member incurs a Covered Dental Expense for which, in the opinion of the Plan or its claim administrator, another party may be responsible or for which the Member 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 Member may have against such party and shall automatically have a lien upon the proceeds of any recovery by a Member from such party to the extent of any benefits paid under the Plan. A Member 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 paragraph 1, but only to the extent of the benefits provided by the Plan.

Lien of the Plan

By accepting benefits under this Plan, a Member:

- 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 Member which is binding on any attorney or other party who represents the Member whether or not an agent of the Member or of any insurance company or other financially responsible party against whom a Member 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.

Additional Terms

- No adult Member 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 Member 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 Member shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the Plan.
- The Plan's right of recovery shall be a prior lien against any proceeds recovered by the Member. 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 Member 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 Member, whether under comparative negligence or otherwise.
- In the event that a Member 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 benefits hereunder until the Member has fully complied with his reimbursement obligations hereunder, regardless of how those future 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 Member 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 dental 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 has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

Payment of Benefits

All dental benefits are payable to you. However, at the option of the Plan, all or any part of them may be paid directly to the person or institution on whose charge the claim is based.

If any person to whom benefits are payable is a minor or, in the opinion of the Plan, is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, the Plan may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

If you die while any of these benefits remain unpaid, the Plan may choose to make direct payment to any of your following living relatives: spouse, mother, father, child or children, brothers or sisters; or to the executors or administrators of your estate.

Payment as described above will release the Plan from all liability to the extent of any payment made.

Benefits will be paid by the Plan when it receives due proof of loss.

When an overpayment has been made by the Plan, the Plan will have the right at any time to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment.

Termination of Coverage

Coverage will cease as described below:

- When a Retiree turns 65, coverage will cease for the Retiree and his or her Dependents.
- If a Dependent Member turns 65, that Member loses coverage as of the first day of the month in which the Member turns 65.
- When a Retiree dies, coverage will cease for the deceased Retiree's Dependents as of the date of death.
- If a Dependent Child reaches age 26, that Member's coverage ceases as of the first of the month after turning age 26.

Dental Benefits Extension

An expense incurred in connection with a dental service that is completed after a person's benefits cease will be deemed to be incurred while he is covered if:

- for fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is covered and the device installed or delivered to him within 3 calendar months after his coverage ceases.
- for a crown, inlay or onlay, the tooth is prepared while he is covered and the crown, inlay or onlay installed within 3 calendar months after his coverage ceases.
- for root canal therapy, the pulp chamber of the tooth is opened while he is covered and the treatment is completed within 3 calendar months after his coverage ceases.

There is no extension for any dental service not shown above.

Group Plan Coverage Instead of Medicaid

If your income and liquid resources do not exceed certain limits established by law, the state may decide to pay premiums for this coverage instead of for Medicaid, if it is cost effective. This includes premiums for continuation coverage required by federal law.

How To File Your Claim

The prompt filing of any required claim form will result in faster payment of your claim. However, claims must be submitted within six months after the end of the calendar year in which the claims were incurred. Otherwise, the claim will be denied.

The first dental claim should be filed as soon as you have incurred covered expenses. Itemized copies of your bills should be sent with the claim form. If you have any additional bills after the first treatment, file them periodically.

CLAIM REMINDERS:

- NO MEMBER ID CARD IS NECESSARY FOR THIS PLAN. WHEN YOU CALL THE TOLL-FREE NUMBER 1-800-CIGNA24, PLEASE IDENTIFY YOURSELF WITH ACCOUNT ID 3334609 AND YOUR SOCIAL SECURITY NUMBER.
- HAVE YOUR PROVIDER SUBMIT A CLAIM USING THE MARATHON CLAIM FORM. THIS FORM IS PRE-PRINTED WITH THE PLAN GROUP NUMBER: 2499499. THE FORM IS ALSO AVAILABLE ON THE MARATHON PETROLEUM BENEFIT WEB SITE (www.myMPCBenefits.com) UNDER FORMS. MOST PROVIDERS HAVE THE ABILITY TO FILE ELECTRONIC CLAIMS WITH CIGNA, SO THERE MAY BE NO NEED TO USE A CLAIM FORM.
- PROMPT FILING OF ANY REQUIRED CLAIM FORMS RESULTS IN FASTER PAYMENT OF YOUR CLAIMS.

Claims and Appeals Procedures

The Plan has formal procedures in place to for you to submit a claim for benefits or to appeal a decision denying your claim for benefits. Generally, if your claim is denied you may ask the claims administrator (Cigna) 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.

The process outlined in this section relates to a claim for a particular benefit under the Plan. If you have an eligibility claim you should submit your claim to the Plan Administrator, Marathon Petroleum Pre-65 Retiree Dental Plan, 539 S. Main Street, Findlay, OH 45840, 1-888-421-2199.

Claims for dental benefits are divided into four categories.

1. **Post-service claims** are claims for services already received.
2. **Pre-service claims** are claims for which you have not received 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. Some concurrent care claims are also urgent care claims (see below).
4. **Urgent care claims** are claims for 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.

Filing an Initial Claim for Benefits

To file an initial claim for benefits, you should contact the claims administrator (Cigna). A claim for benefits may be filed by you or your authorized representative. All Plan claims 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.

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, 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;

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;

f. Any internal procedures or clinical information on which the decision was based (or a statement that you may request this information free of charge); and

g. Instructions for filing an appeal of the decision.

If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you may call Cigna at 1-800-244-6224 and explain your concern to one of its Member Services representatives. You may also express that concern in writing.

Cigna will attempt to resolve the matter on your initial contact. If more time to review or investigate your concern it required, Cigna will get back to you as soon as possible, but in any case within 30 days.

Appeals Procedure

If a claim for benefits has been denied in full or in part, or if the covered individual does not agree with how the claim was paid, they or their duly authorized representative are entitled to appeal the decision and the appeal must be made by following the appeal procedures outlined below.

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

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

- A statement that a formal appeal under the Plan is being made and the type of appeal (Urgent Pre-Service Claim Appeal, Non-Urgent Pre-Service Claim Appeal or Post-Service Claim Appeal).
- The name of the individual for whom the claim was denied.
- The Social Security number of the covered Member and, if the individual for whom the claim was denied is not the covered Member, the name of the covered Member.
- Name of Plan the individual is covered under. (For example, MP Pre-65 Retiree Dental Plan.)
- Identify the claim denied for which the appeal is being made. Include the date of service, name of the provider and/or facility.
- Any and all information necessary for a complete and thorough review of the claim appeal. Provide the complete name and phone number of any medical professionals to contact for additional information supporting the approval of the appeal.
- Address and telephone number of the individual or duly authorized representative, making the appeal.
- Authorization for release of personal health information if appropriate and necessary.

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

For those claim appeal procedures that require that the appeal be sent in writing to the Plan Administrator, the address for the Plan Administrator of the Marathon Petroleum Pre-65 Retiree Dental Plan is as follows:

Marathon Petroleum Dental Plan Appeals
Plan Administrator of the Marathon Petroleum Pre-65 Retiree Dental Plan
539 South Main Street
Room 3119
Findlay, OH 45840

An appeal form can be found on www.myMPCBenefits.com/retirees under "Forms."

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

Cigna Dental Appeals Unit
P.O. Box 18804
Chattanooga, TN 37422-8044
Telephone: 1-800-244-6224

A. Pre-Service Claim Appeal

If a request for dental care was denied before the dental care is rendered (such as a result of a pretreatment estimate) by Cigna under the Plan, the claim is a pre-service claim and the covered individual may appeal by following the pre-service claim appeal procedures. In addition, the pre-service claim appeal procedures depend on if it is an urgent or a non-urgent claim. An urgent claim appeal is a claim for medical care or treatment where withholding immediate treatment could seriously jeopardize the life or health of the patient or would jeopardize the functionality that existed prior to the onset of the current condition.

1. Urgent Pre-Service Claim Appeal

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

If the appeal is made by telephone or facsimile, the covered individual is to make the appeal by contacting the Benefits Service Center at 1-888-421-2199. Listen for the prompt in the opening message for filing an urgent pre-service claim appeal. Information for filing an appeal by phone or facsimile will be provided. If the appeal is made by facsimile, the covered individual is to make the appeal by sending the appeal to the Plan Administrator at 1-419-421-3057, Attention: MP Dental Plan – Claim Appeals.

If the appeal is made in writing, the appeal is to be sent to the Plan Administrator at the address provided above.

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

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

2. Non-Urgent Pre-Service Claim Appeal

   A covered individual, or their designated representative, should first telephone Cigna (at the telephone number indicated at the beginning of this section) and ask that the claim be reviewed.

   If, after the claim has been reviewed in response to the telephone call, the covered individual continues to disagree with the handling and disposition of the claim, they are entitled to submit a written appeal to Cigna at the address above. (It is suggested that a copy of your written appeal to Cigna also be sent to the Plan Administrator at the address above.) That written appeal will be reviewed in accordance with the Cigna's internal appeal procedures. The written appeal must be received by Cigna within 180 days of the initial denial. Cigna must respond to your written appeal within 15 days for a Non-Urgent Pre-Service claim.

   If after receiving the response to a written appeal from Cigna you continue to disagree with the handling and disposition of the claim, you or your designated representative may appeal a denial decision of a non-urgent pre-service claim. (Such appeal must be in writing. Non-urgent pre-service claim appeals cannot be submitted by telephone, facsimile or e-mail.) The appeal to the Plan Administrator must be received within 30 days of the date of the denial of the first appeal by Cigna.

   The covered individual, or their designated representative, is to send the appeal to the Plan Administrator at the address above. A determination by the Plan Administrator, or others delegated authority to hear final appeals by the Plan Administrator, will be made within 15 days of the Plan Administrator receiving the appeal request. The appeal determination will be sent to the individual making the appeal at the address provided in the appeal.

B. Post-Service Claim Appeal

A covered individual, or their designated representative, should first telephone Cigna at the phone number at the beginning of this section and ask that the claim be reviewed.

If after the claim has been reviewed in response to the telephone call, the covered individual continues to disagree with the handling and disposition of the claim, they are entitled to submit a written appeal to Cigna at the address above. (It is suggested that a copy of your written appeal also be sent to the Plan Administrator at the address stated at the beginning of this section.) That written appeal will be reviewed in accordance with Cigna's internal appeal procedures. The written appeal must be received by Cigna within 180 days of the initial denial. Cigna must respond to your written appeal within 30 days for a Post-Service Claim Appeal.

If after receiving the response to a written appeal from Cigna you continue to disagree with the handling and disposition of the claim, you or your designated representative may appeal a denial decision of a post-service claim in writing by sending the appeal to the Plan Administrator at the address above. (This is the 2nd level appeal phase. Such appeal must be in writing and cannot be submitted by telephone, facsimile or e-mail.) The appeal must be received by the Plan Administrator within 30 days of the date of the denial of the first appeal by Cigna.

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

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.

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.

Non-Assignability

The claims administrator, on behalf of the Plan, may make payments directly to providers and other vendors for covered benefits. 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 benefits. 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.

Rescission and Cancellation of Coverage

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

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

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

COBRA Continuation Rights Under Federal Law

What is COBRA Continuation Coverage?

Under federal law, you and/or your Dependents must be given the opportunity to continue health coverage when there is a "qualifying event" that would result in loss of coverage under the Plan. You and/or your Dependents will be permitted to continue the same coverage under which you or your Dependents were covered on the day before the qualifying event occurred.

When is COBRA Continuation Available?

Generally, in a retiree dental plan, only your spouse and dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event.

For your spouse and Dependents, COBRA continuation coverage is available for up to 36 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your death;
- your divorce or legal separation; or
- for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Under COBRA, if you are a retiree, you can only become a qualified beneficiary in the very unlikely event that the Company files for a proceeding in bankruptcy under Title 11 of the U.S. Code. If such a proceeding were filed, and if you and/or any family members lose coverage within one year before or after, and as a result of, the filing, you, your spouse and your dependents would become qualified beneficiaries.

Who is Entitled to COBRA Continuation?

Only a "qualified beneficiary" (as defined by federal law) may elect to continue health coverage. A qualified beneficiary may include the following individuals who were covered by the Plan on the day the qualifying event occurred: you, your spouse, and your Dependent children. Each qualified beneficiary has their own right to elect or decline COBRA continuation coverage even if you decline or are not eligible for COBRA continuation.

The following individuals are not qualified beneficiaries for purposes of COBRA continuation: domestic partners, grandchildren (unless adopted by you), stepchildren (unless adopted by you). Although these individuals do not have an independent right to elect COBRA continuation coverage, if you elect COBRA continuation coverage for yourself, you may also cover your Dependents even if they are not considered qualified beneficiaries under COBRA. However, such individuals' coverage will terminate when your COBRA continuation coverage terminates.

Termination of COBRA Continuation

COBRA continuation coverage will be terminated upon the occurrence of any of the following:

- the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
- failure to pay the required premium within 30 calendar days after the due date;
- termination of the Plan by the Company;
- after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both);
- after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage under a pre-existing condition provision. In such case coverage will continue until the earliest of: (a) the end of the applicable maximum period; (b) the date the pre-existing condition provision is no longer applicable; or (c) the occurrence of an event described in one of the first three bullets above; or

- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

How to Elect COBRA Continuation Coverage

The COBRA coverage election notice will list the individuals who are eligible for COBRA continuation coverage and inform you of the applicable premium. The notice will also include instructions for electing COBRA continuation coverage. You must notify the Plan Administrator of your election no later than the due date stated on the COBRA election notice. If a written election notice is required, it must be post-marked no later than the due date stated on the COBRA election notice. If you do not make proper notification by the due date shown on the notice, you and your Dependents will lose the right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed election form before the due date.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Continuation coverage may be elected for only one, several, or for all Dependents who are qualified beneficiaries. Parents may elect to continue coverage on behalf of their Dependent children. You or your spouse may elect continuation coverage on behalf of all the qualified beneficiaries. You are not required to elect COBRA continuation coverage in order for your Dependents to elect COBRA continuation.

How Much Does COBRA Continuation Coverage Cost?

Each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount may not exceed 102% of the cost to the group health plan for coverage of a similarly situated Retiree or family member.

When and How to Pay COBRA Premiums

First payment for COBRA continuation

If you elect COBRA continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment no later than 45 calendar days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first payment within that 45 days, you will lose all COBRA continuation rights under the Plan.

Subsequent payments

After you make your first payment for COBRA continuation coverage, you will be required to make subsequent payments of the required premium for each additional month of coverage. Payment is due on the first day of each month. If you make a payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.

Grace periods for subsequent payments

Although subsequent payments are due by the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly 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. However, if your payment is received after the due date, your coverage under the Plan may be suspended during this time. Any providers who contact the Plan to confirm coverage during this time may be informed that coverage has been suspended. If payment is received before the end of the grace period, your coverage will be reinstated back to the beginning of the coverage period. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

You Must Give Notice of Certain Qualifying Events

If you or your Dependent(s) experience one of the following qualifying events, you must notify the Plan Administrator within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would cease as a result of the qualifying event:

- Your divorce or legal separation;
- Your child ceases to qualify as a Dependent under the Plan; or

Notice must be made in writing and must include: the name of the Plan, name and address of the Retiree covered under the Plan, name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g., divorce decree, birth certificate, disability determination, etc.).

Newly Acquired Dependents

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your COBRA continuation coverage. However, only your newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event. COBRA coverage for your Dependent spouse and any Dependent children who are not your children (e.g., stepchildren or grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.

COBRA Continuation for Retirees Following Employer's Bankruptcy

If you are covered as a retiree, and a proceeding in bankruptcy is filed with respect to the Employer under Title 11 of the United States Code, you may be entitled to COBRA continuation coverage. If the bankruptcy results in a loss of coverage for you, your Dependents or your surviving spouse within one year before or after such proceeding, you and your covered Dependents will become COBRA qualified beneficiaries with respect to the bankruptcy. You will be entitled to COBRA continuation coverage until your death. Your surviving spouse and covered Dependent children will be entitled to COBRA continuation coverage for up to 36 months following your death. However, COBRA continuation coverage will cease upon the occurrence of any of the events listed under "Termination of COBRA Continuation" above.

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 EPHA (EPHA 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, maintains or transmits on behalf of the Plan;
- 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 Plan Sponsor 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); and
- To use reasonable and appropriate security measures to protect the security of all PHI, including EPHI, and to support the separation between the Plan and the Company, as needed to comply with the HIPAA Security Standards.

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

Further Information

This text is intended to describe the Pre-65 Retiree Dental 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 the Plan Administrator's designee will make all final determinations concerning eligibility for benefits under this Plan.

The Company has appointed Rodney P. Nichols as Plan Administrator of the Pre-65 Retiree Dental Plan. The Company shall appoint assistant administrators as may be deemed necessary. The Plan Administrator shall be the named fiduciary under the Plan.

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 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 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 made with respect to the Plan, in the form of a written administrative ruling which, until revoked, or until superseded by Plan amendment or by a different administrative ruling, shall thereafter be followed in the administration of the Plan.

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 this authority shall be final and binding upon all persons, including the Company, all participants and beneficiaries, and their heirs and personal representatives. It is intended that the standard of judicial review to be applied to any determination made by the Plan Administrator (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).

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.

The Plan Administrator has delegated to Cigna the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of claims under this Plan. Such discretionary authority is intended to include, but not limited to, the determination of the eligibility of persons to claim benefits under the Plan, the determination of whether a person is entitled to benefits under the Plan, and the computation of any and all benefit payments. The Plan Administrator also delegates to Cigna the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.

The name of the Plan is: Marathon Petroleum Pre-65 Retiree Dental Plan

The name, address, ZIP code and business telephone number of the sponsor of the Plan is:

Marathon Petroleum Company LP
539 South Main Street
Findlay, OH 45840
419-422-2121

Employer Identification Number (EIN): 31-1537655

Plan Number: 562

The name, address, ZIP code and business telephone number of the Plan Administrator (and agent for service of legal process) is:

Rodney P. Nichols
Marathon Petroleum Company LP
539 South Main Street
Findlay, OH 45840
419-422-2121

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

The Plan is a self-insured welfare benefit plan providing dental assistance coverage, and is administered through an administrative services only contract with Cigna Dental Health, Hartford, Connecticut 06152.

Statement of Rights

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

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts and collective bargaining agreements 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 Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive, as required by law, a summary of the Plan's annual financial report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, your 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 federal COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, 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 benefits 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 report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

Assistance With Your Questions

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

Plan Modification, Amendment and Termination

The Company reserves the right to modify or terminate this Plan, in whole or in part, in such manner as it shall determine. Such modification or termination can be applied, at the sole discretion of the Company, to any or all types of members and their dependents. Even if the Plan should be terminated, this will not affect any claim for covered expenses incurred prior to the termination of the Plan.

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.

Participation by Associated Companies and Organizations

Upon specific authorization and subject to such terms and conditions as it may establish, Marathon Petroleum Company LP may permit eligible retirees 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, Catlettsburg Refining LLC, Marathon Petroleum Logistics Services LLC, Blanchard Refining LLC, MW Logistics Services LLC, Speedway LLC and Speedway Prepaid Card LLC. Member eligibility within these participating companies may be limited to certain retiree subsets, as identified in Appendix A. In addition, eligible subsets of retirees must satisfy all eligibility provisions otherwise provided by this Plan.

The terms "Company" and Employer," as used in this Plan shall be deemed to include Marathon Petroleum Company LP and such subsidiaries and affiliated organizations and their retirees and employees.

Definitions

Coinsurance

The term Coinsurance means the percentage of charges for covered expenses that a covered person is required to pay under the Plan.

Contracted Fee — Cigna Dental Preferred Provider

The term Contracted Fee refers to the total compensation level that a provider has agreed to accept as payment for dental procedures and services performed on a Retiree or Dependent, according to the Retiree's dental benefit plan.

Covered Dental Expense

Covered Dental Expense means that portion of a Dentist's charge that is payable for a service delivered to a Member provided:

- the service is ordered or prescribed by a Dentist;
- is essential for the necessary care of teeth;
- the service is within the scope of coverage limitations;

- the deductible amount in the Schedule has been met;
- the maximum benefit in the Schedule has not been exceeded;
- the charge does not exceed the amount allowed under the Alternate Benefit Provision; and
- for Class I, II or III the service is started and completed while coverage is in effect, except for services described in the "Benefits Extension" section.

Dentist

The term Dentist means a person practicing dentistry or oral surgery within the scope of his license. It will also include a physician operating within the scope of his license when he performs any of the dental services described in the Plan.

Dependent

Dependents are:

- Your spouse. The term "spouse" shall mean a lawful spouse and 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 the Member can provide confirmation of such common law marriage as required in the Marathon Petroleum Affidavit of Common Law Marriage form;
- Your under age 65 Domestic Partner if covered as your Domestic Partner under the active Dental Plan immediately prior to your retirement; and
- Your children, up through the end of the month in 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 a Retiree 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.
- Children of Domestic Partner

  Children, up through the end of the month in which they turn age 26, of a qualified under age 65 Domestic Partner who is covered under this Plan, are eligible dependents under the Plan. Retirees must meet the requirement established in the *Marathon Petroleum Company Affidavit of Domestic Partner Relationship* form prior to benefit enrollment.
- Dependent Disabled Child

A Dependent Disabled Child who has reached the end of the month in which they turn age 26 but is less than age 65 and is incapable of self-support due to a mental or physical disability is an eligible dependent under the Plan 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 qualified as a dependent under the Internal Revenue Code as evidenced by you claiming the child as a dependent on your federal income tax return.

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

- Children Covered by QMCSOs

  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. A copy of the Plan's QMCSO procedures is available by written request from the Assistant Plan Administrator and is available online at http://www.mympcbenefits.com/Documents/MPC-Qualified-Medical-Child-Support-Order-Procedures.pdf.

Benefits for a Dependent child will continue through the last day of the month in which your Dependent turns age 26.

No one may be considered as a Dependent of more than one Retiree.

Domestic Partner

The term Domestic Partner means a person for whom a Retiree has certified meets the requirements established in the *Marathon Petroleum Company Affidavit of Domestic Partnership Relationship* form.

In-Network Provider — Cigna Dental Preferred Provider

The term In-Network Provider means: a Dentist, or a professional corporation, professional association, partnership, or other entity which is entered into a contract with Cigna to provide dental services at predetermined fees.

The providers qualifying as In-Network Providers may change from time to time. A list of the current In-Network Providers can be obtained from https://my.Cigna.com or by calling Cigna Customer Services at 1-800-244-6224.

Medicaid

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

Medicare

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

Member

The term Member means all covered individuals under this Plan.

Appendix A

Eligible Retiree Subsets of Participating Companies and Organizations

- Marathon Petroleum Corporation
  - Retirees who at the time of retirement were Regular employees
- Marathon Petroleum Company LP
  - Retirees who at the time of retirement were Regular employees
- Marathon Petroleum Logistics Services LLC
  - Retirees who at the time of retirement were Regular employees
- Marathon Petroleum Service Company
  - Retirees who at the time of retirement were Regular employees
- Blanchard Refining Company LLC
  - Retirees who at the time of retirement were Regular employees
- Catlettsburg Refining LLC
  - Retirees who at the time of retirement were Regular employees
- MW Logistics Services LLC
  - Retirees who at the time of retirement were Regular employees
- Speedway LLC
  - Retirees who at the time of retirement were Regular employees in Salary Grades 12 and Above
- Speedway Prepaid Card LLC
  - Retirees who at the time of retirement were Regular employees in Salary Grades 12 and Above