Marathon Petroleum
Pre-65 Retiree Vision Plan

Effective January 1, 2017

Pre-65 Retiree Vision Plan

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Pre-65 Retiree Vision Plan

This document serves both as the plan document and the summary plan description ("SPD") for the Marathon Petroleum Pre-65 Retiree Vision 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 Vision Plan is to provide routine eye exams and vision wear, including eyeglass frames and eyeglass lenses or contact lenses at reduced and discounted costs 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.

Coverage for Eligible Dependents

Any of your eligible Dependents, as defined later in this Plan (see pages 28 – 29 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 the Marathon Petroleum 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 day of the month after turning age 26); or
- The date of your death.

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 Vision Plan (the active employee Vision Plan) Plan;
- the loss of coverage under the Marathon Petroleum Vision Plan (the active employee Vision 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 unless the Plan the reason for dropping coverage was to enroll in the Marathon Petroleum Vision Plan (the active employee Vision 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 Vision Plan (the active employee Vision 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 $ 7.00
- Retiree + Spouse $12.00
- Retiree + Child(ren) $13.00
- Retiree + Family $20.00

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.

Schedule of Benefits[1]

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

Covered Services	Copayments/Maximums	
	In-Network Provider	**Out-of-Network Provider**
Routine Eye Exam Once every calendar year	$0 copayment	Reimbursed up to $35
Eyeglass Lenses (Standard Plastic)		
• Single Vision Lenses	$10 copayment	Reimbursed up to $25
• Bifocal Lenses	$10 copayment	Reimbursed up to $40
• Trifocal Lenses	$10 copayment	Reimbursed up to $55
Limited to one set of lenses per Member every calendar year (in lieu of contact lenses for that calendar year)		
Eyeglass Lens Enhancements		
• Transitions® Lenses (for child under age 19)	$0 after eyeglass lens copay	
• Standard Polycarbonate (for child under age 19)	$0 after eyeglass lens copay	
• Factory Scratch Coating	$0 after eyeglass lens copay	
® Transitions are registered trademarks of Transitions Optical, Inc.		
Eyeglass Frames One set of frames per Member every other calendar year	$130 allowance; 20% discount off remaining balance	Reimbursed up to $45
Prescription Contact Lenses (traditional or disposable)		
• **Elective Contact Lenses** Available once every calendar year in lieu of eyeglass lenses for that calendar year. The Contact Lens benefit is paid toward materials first; any remaining amount will be applied to professional fitting fees). Professional fitting fees are not a Covered Service but may be covered or partially covered by applying any remaining contact lens allowance unused for the materials (lens) purchase. Any remaining amount will be applied to the professional fitting fee of the prescribing Provider.	$130 allowance; 15% off remaining balance for conventional lenses. No additional discount for disposable lenses.	Elective Contact Lenses are reimbursed up to $105
• **Non-Elective Contact Lenses** Available once every calendar year in lieu of eyeglass lenses for that calendar year.	Covered in full	Non-Elective contact lenses are reimbursed up to $210

[1] The Schedule is a summary of the amount of benefit available when you receive Covered Services from a Provider. Please refer to the "Covered Services" section for more complete explanation of the specific vision services covered by the Plan.

Pre-65 Retiree Vision Plan

Optional Savings Available from In-Network Providers Only	In-Network Member Cost (after any applicable copay)
Retinal Imaging — at member's option can be performed at time of eye exam	Not more than $39
Eyeglass Lens Upgrade When obtaining eyewear from Blue View Vision Provider, you may choose to upgrade your new eyeglass lenses at a discounted cost. Eyeglass lens copayment applies.	
• Transitions® Lenses (adults)	$75
• Standard Polycarbonate (adults)	$40
• Tint (solid and gradient)	$15
• UV Coating	$15
• Progressive Lenses	
– Standard	$65
– Premium Tier 1	$85
– Premium Tier 2	$95
– Premium Tier 3	$110
• Anti-reflective Coating	
– Standard	$45
– Premium Tier 1	$57
– Premium Tier 2	$68
• Other Add-ons and Services	20% off retail price
Additional Pairs of Eyeglasses Anytime from any Blue View Vision In-Network Provider.	
• Complete Pair	40% off retail price
• Eyeglass materials purchased separately	20% off retail price
Eyewear Accessories Items such as non-prescription sunglasses, lens cleaning supplies, contact lens solutions, eyeglass cases, etc.	20% off retail price
Contact lens fit and follow-up A contact lens fitting and follow-up to you once a comprehensive eye exam has been completed.	
• Standard contact lens fitting[1]	Up to $55
• Premium contact lens fitting[2]	10% off retail price
Conventional contact lenses Discount applies to materials only.	15% off retail price
Some of the Additional Savings Available Through Our Special Offers Program	
1-800-CONTACTS® After your benefits for the coverage period have been used, you can save on contact lenses with this offer. (Discount can't be used in conjunction with your covered benefits.)	Save $20 on orders of $100 or more and receive free shipping
Laser vision correction surgery LASIK refractive surgery	Discount per eye

[1] Includes spherical clear contact lenses for conventional wear and planned replacement. Examples include but not limited to disposable and frequent replacement.

[2] Includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but not limited to toric and multifocal.

Coordination With Active Vision Plan

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

Provider Directory/Networks

The Anthem Blue View Vision's national network consists of over 10,000 locations and 13,000 Providers, including independent optometrists and ophthalmologists, as well as 800 LensCrafters® retail stores nationwide. For Anthem Blue View Vision Provider locations, Members may access the Provider directory on the www.anthem.com home page, or call the Anthem Blue View Vision Interactive Voice Response (IVR) line at 1-866-723-0515.

How to Obtain Covered Services

In-Network Services and Benefits

If an In-Network Provider renders your care, benefits will be provided at the In-Network level. Refer to the "**Schedule of Benefits**." No benefits will be provided for care that is not a Covered Service even if performed by an In-Network Provider. The Claims Administrator may inform you that a service you received is not a Covered Service under the Plan. You may appeal this decision. See the "**Appeals Procedure**" section of this Plan.

In-Network Providers are professional Providers and other facility Providers who contract with the Claims Administrator to perform services for you. You will not be required to file any claims for services you obtain directly from In-Network Providers.

Out-of-Network Services and Benefits

Services that are not obtained from an In-Network Provider will be considered an Out-of-Network Service. In addition, certain services may not be covered unless obtained from an In-Network Provider, and/or may result in higher cost-share amounts. See your "**Schedule of Benefits**." You will be required to file claims for services that you obtain directly from an Out-of-Network Provider.

Relationship of Parties (Anthem — In-Network Providers)

The relationship between Anthem and In-Network Providers is an independent contractor relationship. In-Network Providers are not agents or employees of Anthem, nor is Anthem, or any employee of Anthem, an employee or agent of In-Network Providers.

The Plan shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Provider or in any Provider's facilities.

Your In-Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to provision of services or referrals to other Providers, including In-Network and Out-of-Network Providers. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or the Claims Administrator.

Not Liable for Provider Acts or Omissions

The Plan is not responsible for the actual care you receive from any person. The Plan does not give anyone any claim, right, or cause of action against the Plan based on what a Provider of vision care, services or supplies, does or does not do.

Covered Services

This section describes the Covered Services available under your vision care benefits when provided and billed by eligible Providers. All Covered Services are subject to the exclusions listed in the "**Exclusions**" section and all other conditions and limitations of the Plan. The amount payable for Covered Services varies depending on whether you receive your care from an In-Network Provider or an Out-of-Network Provider and whether or not you choose optional services and/or custom materials rather than standard services and supplies. Payment amounts are specified in the "**Schedule of Benefits**."

The following are Covered Services:

- Routine vision examinations;
- Standard eyeglass lenses;
- Frames; and
- Contacts lenses in lieu of eyeglass lenses.

Services and materials obtained through an Out-of-Network Provider are subject to the same exclusions and limitations as services through an In-Network Provider.

If you choose a frame that is valued at more than the Maximum Allowable Amount, you are responsible for the difference in cost.

If a Member elects to purchase contact lenses in a calendar year, no benefits will be available for eyeglass lenses until the next calendar year.

Vision Eye Examination

The Plan covers up to a comprehensive eye examination including dilation as needed minus any applicable Copayment. The eye examination may include the following:

- Case history;
- Recording corrected and uncorrected visual acuity;
- Internal exam;
- External exam;
- Pupillary reflexes;
- Binocular vision;
- Objective refraction;
- Subjective refraction;
- Glaucoma test;
- Slit lamp exam (Biomicroscopy);
- Dilation;

- Color vision;
- Depth perception; and
- Diagnosis and treatment plan.

Eyeglass Lenses

Eyeglass lenses are available in standard or basic plastic (CR39) lenses including single vision, bifocal, and trifocal. If you choose progressive lenses that are no line bifocals, there will be an additional cost. All eyeglass lenses are subject to the applicable Copayment listed in the "**Schedule of Benefits**."

There will also be an additional cost for any add-ons to the lenses such as scratch-resistant coating or ultra-violet coating. These and any other lens add-ons may be discounted according to the Additional Savings Program.

Frames

The frame allowance is based upon the retail cost. The Member may apply the plan allowance toward the In-Network Provider's selection of frames. The "**Schedule of Benefits**" lists the frame allowance available under the Plan. If you choose a frame that is valued at more than the Maximum Allowable Amount you are responsible for the balance based upon the Additional Savings Program.

Elective Contact Lenses

The contact lens allowance must be completely used at the time of initial service. No amount of the allowance may be carried forward to use during another service date. The "**Schedule of Benefits**" lists the contact lens allowance available under the Plan.

Fitting Fees

The Member is responsible for 100% of the fitting fee at the time of service. The Contact Lens allowance is paid toward materials first; any remaining amount will be applied to the professional fitting fee.

Non-Elective Contact Lenses

This benefit is available for a limited number of diagnoses and is in lieu of the standard contact lenses or eyeglass lenses benefit.

Eligibility

Conditions that provide eligibility for consideration of this Non-Elective Contact Lens benefit include:

- Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle Lenses.
- High Ametropia exceeding –12 D or +9 D in spherical equivalent.
- Anisometropia of 3 D or more.
- Patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle Lenses.

Fitting Fees

The Member is responsible for 100% of the fitting fee at the time of service. However, the Plan's Maximum Allowable Amount reimbursement paid to the prescribing Provider for Non-Elective Contact Lenses may include a portion, or all, of the fitting fee. Any remaining amount will be applied to the Provider's fitting fee.

SPECIAL NOTE: The Plan will not reimburse for Non-Elective Contact Lenses for any Member who has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

Cosmetic Options

Benefits are available for the services below in accordance with the Additional Savings Program. The Member will be responsible for the following items at a discounted rate when provided by an In-Network Provider:

- Blended lenses;
- Contact lenses (except as noted herein);
- Oversize lenses;
- Progressive multifocal lenses;
- Photochromatic lenses, or tinted lenses;
- Coated lenses;
- Frames that exceed the Maximum Allowable Amount;
- Cosmetic spectacle lenses;
- Ultra-violet coating;
- Scratch resistant coating;
- Polycarbonate lenses;
- Anti-reflective coating; and
- Optional cosmetic items.

Expenses Not Covered

The following section indicates items that are excluded from benefit consideration, and are not considered Covered Services. Excluded items will not be covered even if the service or supply would otherwise be considered Medically Necessary. This information is provided as an aid to identify certain common items that may be misconstrued as Covered Services, but is in no way a limitation upon, or a complete listing of, such items considered not to be Covered Services.

The Plan does not provide vision benefits for services, supplies or charges:

1. Received from an individual or entity that is not a Provider, as defined in this Plan.
2. For any condition, disease, defect, aliment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

3. To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
4. For illness or injury that occurs as a result of any act of war, declared or undeclared.
5. For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.
6. For which you have no legal obligation to pay in the absence of this or like coverage.
7. Received from an optical or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
8. Prescribed, ordered, referred by, or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
9. For completion of claim forms or charges for medical records or reports unless otherwise required by law.
10. For missed or canceled appointments.
11. In excess of the Maximum Allowable Amount.
12. Incurred prior to your Effective Date.
13. Incurred after the termination date of this coverage except as specified elsewhere in this Plan.
14. For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
15. For sunglasses and accompanying frames.
16. For safety glasses and accompanying frames.
17. For inpatient or outpatient hospital vision care.
18. For orthoptics or vision training and any associated supplemental testing.
19. For non-prescription lenses.
20. For two pairs of glasses in lieu of bifocals.
21. For Plano lenses (lenses that have no refractive power).
22. For medical or surgical treatment of the eyes.
23. Lost or broken lenses or frames, unless the Member has reached his or her normal interval for service when seeking replacements.
24. For services or supplies not specifically listed in the Plan.
25. Certain brands on which the manufacturer imposes a no discount policy.
26. For services or supplies combined with any other offer, coupon, or in-store advertisement.

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 eye 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; or
- 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.

Coordination of Benefits

This Plan is primary in all circumstances.

Payment of Benefits

To Whom Payable

As set forth in "How to File Your Claim" section, when services are received from an In-Network Provider, the Provider will submit the claim and receive its payment directly from Anthem Blue View Vision. The In-Network Provider, at the time of service, will only charge you only the applicable copayment(s) and other costs not covered under the Plan.

All Out-of-Network Benefits are payable to you, provided you submit properly completed and document claim form as indicated in the "How to File Your Claim Section."

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.

Time of Payment

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

Recovery of Overpayment

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.

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

When you use an In-Network Provider, the Provider will submit the claim and charge you only the applicable copayment(s) and other costs not covered under the Plan. To insure the proper benefits are received at time of service or payment, make sure you present the Anthem Blue View Vision ID Card to your In-Network Provider.

If you choose to receive care outside of the Blue View Vision network, you must pay the Out-of-Network Provider in full at the time of service and then file a claim for reimbursement. The prompt filing of any required claim form will result in faster payment of your claim. 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 Out-of-Network Claim form is available on the Marathon Petroleum Benefit website (www.myMPCBenefits.com) under "Forms," or you can call **Anthem Blue View Vision's Member services at 1-866-723-0515** and request a form be sent to you. Completed Out-of-Network Vision claims and accompanying receipts should be submitted to: Blue View Vision, Attn: Vision Claims, P.O. Box 8504, Mason, OH 45040-7111. Blue View Vision will only accept itemized paid receipts that indicate the services provided and the amount charged for each service. The services must be paid in full in order to receive benefits. Handwritten receipts must be on the Provider's letterhead.

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 (Anthem Blue View Vision) 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 Vision Plan, 539 S. Main Street, Findlay, OH 45840, 1-888-421-2199.

Claims for vision benefits are divided into four categories.

Post-service claims are claims for services already received.

Pre-service claims are claims for which you have not received services or for which prior authorization is required by the Plan.

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).

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 (Anthem Blue View Vision). 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 Anthem Blue View Vision at 1-866-723-0515 and explain your concern to one of its Member Services representatives. You may also express that concern in writing.

Anthem Blue View Vision will attempt to resolve the matter on your initial contact. If more time to review or investigate your concern it required, Anthem 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 Anthem Blue View Vision prior to filing the appeal in order to clarify any questions they may have on the reason for the denial by Anthem. 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 Vision 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 Vision Plan Appeals
Plan Administrator of the Marathon Petroleum Pre-65 Retiree Vision 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 Anthem Blue View Vision, the address for sending appeals to Anthem Blue View Vision is as follows:

Blue View Vision
Attn: Appeals
555 Middle Creek Parkway
Colorado Springs, CO 80921
Telephone Number: 866-723-0515

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 Anthem 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 Vision 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 Anthem, 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 Anthem Blue View Vision (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 Anthem Blue View Vision at the address above. (It is suggested that a copy of your written appeal to Anthem also be sent to the Plan Administrator at the address above.) That written appeal will be reviewed in accordance with the Anthem's internal appeal procedures. The written appeal must be received by Anthem within 180 days of the initial denial. Anthem must respond to your written appeal within 15 days for a Non-Urgent Pre-Service claim.

   If after receiving the response to a written appeal from Anthem 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 Anthem.

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 Anthem Blue View Vision 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 Anthem 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 Anthem's internal appeal procedures. The written appeal must be received by Anthem within 180 days of the initial denial. Anthem must respond to your written appeal within 30 days for a Post-Service Claim Appeal.

If after receiving the response to a written appeal from Anthem 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 Anthem.

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.

C. Appointment of Authorized Representative

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

An *Appointment of Authorized Representative* form may be obtained from, and completed forms must be submitted to, the Marathon Petroleum Benefits Service Center, 539 S. Main Street, Findlay, OH 45840, 1-888-421-2199, or the appropriate claims administrator. The form is also available on http://www.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.

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.

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 vision 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 EPHI (EPHIA 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);
- 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 Vision 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.

Pre-65 Retiree Vision Plan

The Company has appointed Rodney P. Nichols as Plan Administrator of the Marathon Petroleum Pre-65 Retiree Vision 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 Anthem Blue View Vision 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 Anthem 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 Vision 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: 563

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 vision assistance coverage and is administered through an administrative services only contract with Anthem Blue View Vision.

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 and union halls, 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 collective bargaining agreements, 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 benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual 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 ("the Company") may exercise its reserved rights of amendment, modification or termination:

(i) By written resolution by the Board of Directors of the 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 the 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 the 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 the 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 LP, Speedway LLC and Speedway Prepaid Card LLC. Retiree 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

Additional Savings Program

A discount program included in the vision benefit program. It can be used with certain non-covered services and plan overages. The discount plan is subject to change at any time.

Administrative Services Agreement

The agreement between the Claims Administrator and Marathon Petroleum Company regarding the administration of certain elements of vision care benefits of Marathon’s group vision plan.

Calendar Year

The period of time that benefits are tracked. The member must wait until the calendar year interval of which they can receive Covered Services as listed in the Schedule of Benefits.

Claims Administrator

An organization or entity that Marathon contracts with to provide administrative and claims payment services under the Plan. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Coinsurance

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

Copayment

A specific dollar amount for Covered Services indicated in the Schedule of Benefits for which you are responsible.

Covered Services

Services and supplies or treatment as described in the Plan which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service the service, supply or treatment must be:

- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under the Plan is in force;
- Within the Maximum Allowable Amount;
- Not specifically excluded or limited by the Plan; and
- Specifically included as a benefit within 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 Marathon Petroleum Vision Plan (the active employee Vision 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 on-line 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.

Effective Date

The date when your coverage begins under the Plan.

Elective Contact Lenses

All prescription contact lenses that are cosmetic in nature.

Family Coverage

Coverage for the Member and eligible Dependents.

Identification Card

A card issued by the Plan that bears the Member's name, identifies the membership by number, and may contain information about your coverage. It is important to carry this card with you.

In-Network Provider

A Provider who has entered into a contractual agreement or is otherwise engaged by the Claims Administrator to provide Covered Services and certain administration functions for the Network associated with this Plan.

Lenses

Materials prescribed for the visual welfare of the patient. Materials would include single vision, bifocal, trifocal or other more complex lenses.

Maximum Allowable Amount

The maximum amount allowed for Covered Services you receive based on the fee schedule. The Maximum Allowable Amount is subject to any Copayments, limitations or Exclusions listed in this Plan.

For an In-Network Provider, the Maximum Allowable Amount is equal to the amount that constitutes payment in full under the In-Network Provider's participation agreement for this product. If an In-Network Provider accepts as full payment an amount less than the negotiated rate under the participation agreement, the lesser amount will be the Maximum Allowable Amount.

For an Out-of-Network Provider who is a physician or other non-facility Provider, even if the Provider has a participation agreement with the Claims Administrator for another product, the Maximum Allowable Amount is the lesser of the actual charge or the standard rate under the participation agreement used with In-Network Providers for this Product.

The Maximum Allowable Amount is reduced by any penalties for which a Provider is responsible as a result of its agreement with the Claims Administrator.

Member

The term Member means all covered individuals under this Plan. Members are sometimes called "you" and "your."

Non-elective Contact Lenses

Contact lenses which are provided for reasons that are not cosmetic in nature. Non-elective Contact Lenses are Covered Services when the following conditions have been identified or diagnosed:

- Extreme visual acuity or other functional problems that cannot be corrected by spectacle lenses; or
- Keratoconus — unusual cone-shaped thinning of the cornea of the eye which usually occurs before the age of 20 years; or
- High Ametropia — unusually high levels of near sightedness, far sightedness, or astigmatism are identified; or
- Anisometropia — when one eye requires a much different prescription that the other eye.

Out-of-Network Provider

A Provider who has not entered into a contractual agreement with the Claims Administrator for the Network associated with this Plan.

Plan

The group vision benefit plan provided by Marathon and described in 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