Marathon Petroleum Dental Plan

Effective January 1, 2017

Dental Plan

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Dental Plan

This document serves both as the plan document and the Summary Plan Description ("SPD") for the Marathon Petroleum 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.

I. Purpose

Marathon Petroleum Company LP ("MPC" or "the Company") established the Plan to improve the dental health of employees and their dependents. The Plan is specifically designed to encourage preventive dental care. Dental problems are cumulative and early treatment helps avoid later, more serious care. The Plan also provides financial assistance for a broad range of dental treatment. While use of network providers is not required, this plan offers a Dental PPO (preferred provider organization or "DPPO") Network feature which provides for negotiated discounts for dental services when members use a Network provider. Cigna network providers will be either a 1) Cigna DPPO Advantage provider, or a 2) Cigna DPPO provider. Together, these two tiers are called Total Cigna DPPO. Members will get the best discounts by using a Cigna DPPO Advantage provider.

II. Classes of Membership and Eligibility

A. Members — The following individuals are eligible for membership in the Plan at the times indicated:

1. Employees who work on a Regular "full-time" or Regular "part-time" basis (Employee Members) — On the first day of employment with the Company, provided such employee is not a member of an employee group for whom the Company provides or contributes to other medical or dental care coverage. For purposes of benefit eligibility, Regular "full-time" basis means the employee has a normal work schedule of at least 40 hours per week or at least 80 hours on a bi-weekly basis.

   Regular Part-time means the employee is a non-supervisory employee, as defined by MPC, who is employed to work on a part-time basis (minimum of 20 hours but less than 35 hours per week), and not on a time, special job completion, or call-when-needed basis.

   Regular employees who work on a full-time or part-time basis must be specifically designated as such by the Company to be eligible to participate in the Plan.

   Casual employees and common law employees who have not been designated by the Company as Regular employees who work on a full-time or part-time basis are excluded from eligibility to participate. Specifically excluded from eligibility to participate in the Plan are any individuals who have signed an agreement, or have otherwise agreed, to provide services to the Company as an independent contractor, regardless of the tax or other legal consequences of such an arrangement. Also specifically excluded are leased employees compensated through a leasing entity, whether or not the leased employee falls within the definition of "leased employee" as defined in Section 414(n) of the Internal Revenue Code.

   Expatriate, Inpatriate or Third County National employees are not eligible for coverage under this Marathon Petroleum Dental Plan.

2. Surviving spouses of deceased Employees (Surviving Spouse Members) — The surviving spouse, who is not eligible for Medicare due to age (hereinafter referred to as "under age 65"), of a deceased Employee on the date of the death may be eligible to participate as a Surviving Spouse Member. The spouse must satisfy the definition of a spouse under the Plan on the day of the employee's death, and such employee must have been eligible for coverage in the Plan on the day of their death.

   An under age 65 surviving spouse who is covered under the Plan as a dependent spouse of the employee on the date of death will have their coverage begin as a Surviving Spouse Member on the day following the death of the employee.

   For an under age 65 surviving spouse who is not covered under the Plan as a dependent spouse on the date of the employee's death, the surviving spouse's first date of eligibility under the Plan as a surviving spouse is the day after the date of death.

3. Eligible Child or Dependent Disabled Child of a deceased Employee or Surviving Spouse Member — The child(ren) may participate in the Plan on the day following the death of the child's parent who was an employee, provided the employee was eligible to participate in the Plan on the day of their death, and the child's other parent is not eligible to join the Plan or is deceased.

   The child(ren) may participate in the Plan on the day following the death of the child's parent who was a Surviving Spouse Member of the Plan.

B. Dependent Coverage — Dependents of an Employee or Surviving Spouse Member are eligible for coverage on the same date as that of the member or on the date such dependents are acquired, whichever is later. In the case of Surviving Spouse Members electing Surviving Spouse and Children coverage, the dependents must have been eligible dependents of the deceased Employee. In addition, these dependents must continue to meet the definition of an eligible dependent of the Surviving Spouse Member under the provisions of the Plan. Eligible dependents include:

1. Spouse

   The term "spouse" will be interpreted to refer to any individuals who are lawfully married, including a same-sex spouse. "Spouse" shall also include a common law spouse established under the laws of a state in which common law marriage is legal and for which member can provide confirmation of such common law marriage as required in the Marathon Petroleum Affidavit of Common Law Marriage form.

2. Children

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

   a. Natural children of the first degree,

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

   c. Stepchildren,

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

3. Domestic Partner

   The qualified domestic partner, who is not eligible for Medicare due to age, of an Employee Member is an eligible dependent under the Plan. Employees must meet the requirements established in the *Marathon Petroleum Company Affidavit of Domestic Partner Relationship* form prior to benefit enrollment. A Domestic Partner is not eligible for coverage under the Plan upon the death of an Employee Member.

4. Children of Domestic Partner

   Children through end of the month during which they turn age 26 of a qualified under-age-65 domestic partner, who is enrolled in the Plan, are eligible dependents under the Plan. Employees must meet the requirement established in the *Marathon Petroleum Company Affidavit of Domestic Partner Relationship* form prior to benefit enrollment. Children of a Domestic Partner are not eligible for coverage under the Plan upon the death of an Employee Member.

5. Dependent Disabled Child

   A Dependent Disabled Child who has reached end of the month during which they turn age 26 but is not eligible for Medicare due to age and is incapable of self-support due to a mental or physical disability may continue as an eligible dependent through the end of the month prior to the month in which Dependent Disabled Child turns age 65 if the child:

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

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

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

6. Children Covered by Qualified Medical Child Support Order

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

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

C. Continued Members — A former member or an individual formerly covered as a qualified dependent who, pursuant to applicable federal law, has elected to continue coverage beyond the date coverage would otherwise terminate if not for such federal law (see "Continuation of Coverage Privilege" Article XII).

III. Who is Not Eligible

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

No individual is eligible for coverage under this Plan, who is also eligible for dental benefits:

A. Under another plan maintained in the United States toward which the Company makes contributions, except in the case where dependent coverage under the individual's spouse's plan to which the Company also contributes cannot be waived; or

B. Under another plan sponsored by a non-participating member of the controlled group which includes Marathon Petroleum Company LP.

IV. Joining the Plan and Changing Coverage

Prospective members must complete online enrollment or sign and submit the proper enrollment form and will become covered under the Plan on the applicable participation dates as outlined below. Members must begin and change coverage under the Dental Plan subject to Dental Plan and 125 Plan rules (see Section D below).

Dental Plan

A. Enrollment for Employee Member, Surviving Spouse Member, Child Member Coverage

1. Enrollment When First Eligible for Coverage

   a. Employee Member Coverage

   Prospective Employee Members must enroll online or complete, sign, and submit the proper enrollment form as follows in order to be covered as an Employee Member under the Plan:

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

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

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

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

   Speedway employees who transfer to MPC and Speedway employees who are promoted into a Salary Grade 12 and Above position will maintain the same Dental Plan election as in effect under the corresponding Speedway Dental Plan for the remainder of the plan year with deductible amounts and benefits incurred transferred to this Plan.

   b. Surviving Spouse Member and Child Member Coverage

   (i) Prospective Surviving Spouse or Child Members who **are enrolled** in the Plan as a dependent of a Member on the day immediately prior to their first date of eligibility under the Plan as a Surviving Spouse Member or Child Member, will have their coverage automatically continued under the Plan. Such Surviving Spouse or Child Member will not be required to complete, sign and submit an enrollment form to the Company in order to commence Surviving Spouse or Child Member Coverage.

   (ii) Prospective Surviving Spouse or Child Members who **are not enrolled** in the Plan as a covered dependent of a Member on the day prior to their first date of eligibility as a Member must complete, sign, and submit the proper enrollment form to the Company in order to be covered as a Member under the Plan. If the enrollment form is received by the Company on or before the first date of eligibility, participation is effective on the eligibility date. If the enrollment form is received by the Company within 60 days after the first date of eligibility, participation is effective on the eligibility date.

2. Late Enrollment

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

3. Mid-Year Enrollment Changes

   The election you make upon hire and/or during Benefits Open Enrollment will remain in effect throughout the entire plan year. Except as set forth below, election changes cannot be made until the following Benefits Open Enrollment period and will be effective for the following plan year. Members can make changes during the plan year due to the following events, provided the change is consistent with the event:

   a. You have a change in legal marital status, including marriage, divorce, legal separation, annulment, death, or change in domestic partnership status.

   b. You have a change in the number of dependents, including birth, adoption, placement for adoption, death, or if a dependent ceases to be eligible for Plan benefits.

   c. You or your spouse or domestic partner or dependent experience a change in employment status which affects their eligibility for coverage under the Plan or another employer's plan. A change in employment status may include termination or commencement of employment, a reduction in hours or change in work hours, which affects plan eligibility, or return from an unpaid leave of absence.

   d. A court issues a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody, including the requirement to provide coverage under a Qualified Medical Child Support Order or National Medical Support Notice or Order, requirement a change in coverage for an employee's dependent.

   e. You, your spouse or dependent lose coverage under any group health plan sponsored by a governmental or educational institution, including a State's children's health insurance program (CHIP), a medical care program of an Indian Tribal government, a State health benefits risk pool, or a foreign government group health plan.

   f. You, your spouse or dependent becomes entitled to or lose coverage under Medicare or Medicaid.

   If the enrollment form is received on or before the date of any of the above events, participation is effective on the date of the event. If the enrollment form is not received on or before the date of the event and is received no later than 60 days following the event, then coverage will be effective the date the enrollment form is received by the Benefits Service Center or the date employee notifies the Benefits Service Center of such event.

B. Continued Member Coverage

See "Continuation of Coverage Privilege (COBRA)" Article XII.

C. Dependent Enrollment

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

   a. the first date of eligibility of the Member,

   b. the first date of eligibility of the dependent,

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

D. 125 Plan Restrictions

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

1. when the change is due to and consistent with the events defined in the 125 Plan, including a "change in family or employment status" (provided employee notifies the Benefits Service Center within 60 days of such change); or
2. during the Benefits Open Enrollment, at which time the election would be effective January 1 of the year following the election.

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

V. Waiver of Coverage

A member may not waive coverage under the Plan except:

A. When the waiver is due to a "change in family or employment status" as outlined in the 125 Plan; or

B. During Benefits Open Enrollment, at which time the election would be effective January 1 of the year following the election.

In all events, if member coverage is waived, all dependent coverage must also be waived.

A member and dependents may rejoin the Plan, subject to the procedures listed under "Joining the Plan and Changing Coverage" in Article IV above.

VI. Contributions

Cost of coverage is normally shared by the member and the Company. The Plan is designed so that the Company pays approximately 60% of the cost of the Plan and Members pay 40% of the Plan cost through contributions. Member contributions are subject to change. The total cost of the Plan is ultimately determined by claims experience and administrative costs. For Continued Member coverage, the Company will contribute only amounts required by law, if applicable.

A. Member Contributions

Member contributions are subject to change. Contributions for coverage will be made (pre-tax) through payroll check deductions. If the member is not receiving a payroll check from the Company, the member must pay their contributions (i) on a monthly basis on or before the applicable due date specified by the Company, if they are an Employee Member; (ii) at the times required by applicable law, if they are a Continued Member; or (iii) monthly in advance, if they are not an Employee Member or a Continued Member.

Effective January 1, 2017 (and subject to change), the monthly member contributions for the Plan are:

Member Only:	$13.00
Member & Spouse:	$26.00
Member & Children:	$28.00
Member & Family:	$41.00

B. Company Contributions

The Company pays all costs of the Plan in excess of the members' contributions.

VII. Benefit Coverage Under the Dental Plan

A. General

For the purpose of administering the Plan, the term "dentist" or "provider" will be considered to mean any dentist legally licensed to practice dentistry and any licensed limited practice professional in the dental care field practicing within the field for which legally licensed.

Treatment, services, and supplies must be prescribed by a dentist and must meet the standards of dental practice accepted by the American Dental Association.

The Claims Administrator reserves the right at any time to request additional information to substantiate the necessity of any dental service, supplies, or treatment for which benefits are claimed, including the right to have the member's dental treatment plan examined at the Company's expense by a dentist or dental consultant of its choice.

1. PPO Network Provider (Advantage Network)

For members who choose to take advantage of the PPO feature — Cigna has contracted with dental service providers to provide discounts for dental procedures. If you go to an Advantage Network provider, charges are covered as follows:

- Preventive & diagnostic services: 100% of the negotiated amount
- Basic dental services: 80% of the negotiated amount
- Major dental services: 50% of the negotiated amount
- Orthodontic services: 50% of the negotiated amount (subject to $2,000 lifetime maximum)

2. Out-of-Network Provider

For members who do not utilize the PPO feature and visit a provider that is not a participating provider in Cigna's Advantage Network, services are covered as follows:

- Preventive & diagnostic services: 100% of reasonable and customary
- Basic dental services: 80% of reasonable and customary
- Major dental services: 50% of reasonable and customary
- Orthodontic services: 50% of reasonable and customary (subject to $2,000 lifetime maximum)

The term "reasonable and customary" (or R&C) refers to the usual charge for a given procedure charged by most providers in a given geographic area. Cigna claim data is collected to determine what is customary in a geographic area for each covered procedure, and that average is used to determine what the Plan will pay when you visit an out-of-network provider.

For further information on how dental charges are covered under the above features, or to locate providers who participate in the Cigna DPPO Advantage Network or Cigna DPPO Network, members should call Cigna at 1-800-244-6224 or visit www.cigna.com.

B. Preventive and Diagnostic Expenses

To encourage proper dental maintenance which results in long-term dental health, the Plan will pay 100% of the reasonable and customary charges (or 100% of the negotiated amount if incurred at an Advantage Network provider) for the following covered expenses:

1. Oral examinations including scaling and cleaning of teeth, but not more than twice in any calendar year.
2. Topical application of sodium or stannous fluoride.
3. Dental X-rays, but not more than two sets of bitewing X-rays in any calendar year and not more than one set of full-mouth X-rays within any three consecutive calendar years.
4. Fixed and removable space maintainers.
5. Sealants (for children up to age 19).

C. Basic and Major Restorative Expenses

If the following services are incurred at an Advantage Network provider, they are reimbursed at 80% of the negotiated amount for basic services and 50% of the negotiated amount for major services, after the deductible has been satisfied. If services are incurred at an out-of-network provider, they are reimbursed at 80% of reasonable and customary for basic services and 50% of reasonable and customary for major services, after the deductible has been satisfied.

1. Extractions. (Basic Service)
2. Oral Surgery. (Basic Service)
3. Fillings. (Basic Service)
4. Anesthetics administered in connection with oral surgery or other covered dental services. (Basic Service)
5. Treatment of periodontal and other diseases of the gums and tissues of the mouth. (Basic Service)
6. Endodontic treatment, including root canal therapy. (Basic Service)
7. Injection of antibiotic drugs by the attending dentist. (Basic Service)
8. Initial installation (including adjustments during the six-month period following installation) of partial or full removable dentures to replace one or more natural teeth extracted while the individual is covered under the Plan. (Major Service)
9. Repeat or recementing of crowns, inlays, bridgework or dentures or relining of dentures. (Major Service)
10. Replacement of an existing partial or full removable denture or the addition of teeth to an existing removable denture to replace extracted natural teeth (Major Service), but only if the individual has been a member of the Plan for two years and evidence satisfactory to the Claims Administrator is presented that:
    a. The replacement or addition of teeth is required to replace one or more additional natural teeth extracted while the individual is covered under the Plan; or
    b. The existing denture was installed at least five years prior to its replacement and that it cannot be made serviceable.
11. Inlays, gold fillings, crowns (including precision attachments for dentures) and initial installation of fixed bridgework (including inlays and crowns to form abutments) to replace one or more natural teeth extracted while the individual is covered under the Plan. (Major Service)
12. Replacement of fixed bridgework or the addition of teeth to existing fixed bridgework to replace extracted natural teeth (Major Service), but only if evidence satisfactory to the Claims Administrator is presented that:
    a. the replacement or addition of teeth is required to replace one or more additional natural teeth extracted while the individual is covered under the Plan; or

b. the bridgework was installed at least five years prior to its replacement and that the existing bridgework cannot be made serviceable.

D. Oral Health Integration Program (Enhanced Services Related to Certain Medical Conditions)

The Plan provides enhanced services for members with certain medical conditions. If you have any of the medical conditions below, you qualify for 100 percent reimbursement (subject to the annual out-of-pocket maximum) of your coinsurance (but not deductible, if any) for certain related dental procedures.

Covered Dental Services	Cardio	Stroke	Diabetes	Maternity	Chronic Kidney Disease	Organ Transplants	Head & Neck Cancer Radiation
Periodontal Treatment & Maintenance (D4341, D4342, D4910[1])	✓	✓	✓	✓	✓	✓	✓
Periodontal Evaluation (D0180)				✓			
Oral Evaluation (D0120[2], D0140[2], D0150[2])				✓			
Cleaning (D1110[3])				✓			
Emergency Palliative Treatment (D9110[4])				✓			
Fluoride — topical application & varnish (D1203[5], D1204[5], D1206[5])					✓	✓	✓
Sealants (D1351[5])					✓	✓	✓

[1] Four times per year.

[2] One additional evaluation.

[3] One additional cleaning.

[4] No limitations.

[5] Age limits removed, all other limitations apply.

To use the Oral Health Integration Program, member will visit provider for the covered service. Once the claim is processed, member should pay the provider the coinsurance for the covered service, and then files a completed Cigna Dental Oral Health Integration Program Reimbursement Form, along with required documentation as indicated on the Form. For additional information and the Reimbursement Form, go to http://www.mympcbenefits.com/Documents/MPC-OHIP-Information.pdf.

E. Deductible Level

A deductible applies to all basic and major restorative dentistry and for orthodontic treatment. For all three types of treatment, the deductibles are cumulative, so that in any one calendar year, **the deductible cannot exceed $50 per individual**. The deductible is applied against the reasonable and customary amount or the provider fee, whichever is less. Once the individual deductible of $50 is met, the Plan will begin paying benefits.

If an employee is transferred to employment with the Company from a non-participating member of the controlled group of corporations to which the Company belongs, dental expenses incurred during the calendar year of the transfer and applicable to the deductible provisions of the previous employer's dental plan shall be recognized hereunder solely for purposes of satisfying the deductible provisions of the Plan.

F. Predetermination of Benefits

If a provider has advised a course of treatment which will exceed $100, the member is encouraged to have the provider submit a predetermination claim form prior to having the services performed. By so doing, the Claims Administrator, Cigna Health and Life Insurance Company can provide an advance estimate of how much may be payable under the Plan for the dental treatment. In addition, an equally effective, less costly alternate treatment plan could be suggested.

The claim form can be used for either predetermination or final claims. The form can be obtained from a local Human Resources office. After the provider completes the form, the provider should forward it directly to the Claims Administrator. The Claims Administrator will notify the member and provider of the approximate amount of benefits for covered services that the member will receive. If a predetermination is not submitted, no estimate of covered services will be available. Consequently, some services may not qualify for payment under the Plan.

G. Maximum Benefits Payable

Except for orthodontia, the Dental Plan has an unlimited lifetime maximum benefit. The maximum lifetime benefit for orthodontic treatment is $2,000 per individual.

There is a calendar year maximum of $2,000 in benefits for expenses (exclusive of orthodontia) incurred on a covered individual. Benefits payable for orthodontic treatment will not be applied toward this calendar year maximum.

H. 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.

I. Expenses For Which a Third Party May Be Responsible

This Plan does not cover:

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

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

1. Subrogation: The Plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a Participant may have against such party and shall automatically have a lien upon the proceeds of any recovery by a Participant from such party to the extent of any benefits paid under the Plan. A Participant or his/her representative shall execute such documents as may be required to secure the Plan's subrogation rights.
2. 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 Participant:

- Grants a lien and assigns to the Plan an amount equal to the benefits paid under the Plan against any recovery made by or on behalf of the Participant which is binding on any attorney or other party who represents the Participant whether or not an agent of the Participant or of any insurance company or other financially responsible party against whom a Participant may have a claim provided said attorney, insurance carrier or other party has been notified by the Plan or its agents;
- Agrees that this lien shall constitute a charge against the proceeds of any recovery and the Plan shall be entitled to assert a security interest thereon;
- 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; and
- 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.

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Additional Terms

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the Plan. The Plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the Plan without its written approval.
- The Plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine," "Rimes Doctrine," or any other such doctrine purporting to defeat the Plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No Participant hereunder shall incur any expenses on behalf of the Plan in pursuit of the Plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the Plan's recovery without the prior express written consent of the Plan. This right shall not be defeated by any so-called "Fund Doctrine," "Common Fund Doctrine," or "Attorney's Fund Doctrine."
- The Plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the Plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The Plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
- Any reference to state law in any other provision of this Plan shall not be applicable to this provision, if the Plan is governed by ERISA. By acceptance of benefits under the Plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the Plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.
- Failure to cooperate with the Plan's subrogation efforts and/or return funds within 60 days of receipt from a legal proceeding or settlement in which the Plan has a subrogation interest will result in the participant becoming permanently ineligible to participate in this Plan or any medical plan sponsored by the employers in the Company's controlled group.
- The Plan's right to subrogation and reimbursement apply to full and partial settlements, judgments, or other recoveries paid or payable to the participant, dependent, or representative.

- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

J. Coordination of Coverage

Transfer of Employment From a Non-Participating Company

If an employee is transferred to employment with the Company from a non-participating member of the controlled group of corporations to which the Company belongs, dental expenses incurred during the calendar year of the transfer and applicable to the deductible provisions of the previous employer's dental plan shall be recognized hereunder solely for purposes of satisfying the deductible provisions of the Plan. Copayments (unless recognized by the previous employer's dental plan towards satisfying their deductible) will not be recognized by the Plan for purposes of satisfying the deductible.

With the exception of transfers, the Plan will not recognize copayments or dental expenses from any other dental plan for deductible purposes.

There are no pre-existing conditions applied to transferees for dental coverage.

The Plan Administrator has the authority to establish any rules deemed necessary or appropriate for administering situations under the above "Coordination of Coverage" provisions.

K. Orthodontia

Benefits paid under the Plan for orthodontic treatments will vary according to the specifics of the treatment prescribed by a dentist and are subject to reasonable and customary determination. The following orthodontic treatments are covered, provided the treatment did not commence prior to the first day of Plan coverage under the Plan:

1. **Case Type Removable Treatment** (Phase I) includes diagnosis, removable appliances, post treatment stabilization and monthly treatments, including retention and observation, for treatment of permanent or transitional detention.
2. **Complete Full Banded Treatment** (Phase II) includes preliminary study, cephalometric radiograph, casts, and treatment plan and monthly treatments, including retention and observation, for treatment of permanent or transitional detention.

All orthodontic benefits are subject to a lifetime $2,000 orthodontia maximum per covered individual, and the yearly deductible amount.

Case Type Removable and Complete Full Banded Treatment Plan benefits will be calculated using the following method:

An initial payment amount will be equal to 25% of the total fee, not to exceed reasonable and customary, charged by the dentist. Subsequent monthly payment amounts are determined by dividing the remaining 75% of the total fee by the number of months needed to complete the treatment plan.

L. Limitations

Missing tooth limitation: Until insured for 24 months, the amount payable for expenses related to replacement of teeth missing prior to the effective date of coverage is 50% of the amount that would be otherwise payable; thereafter, is considered a Class III expense.

No benefits are payable under this Plan for:

1. Charges for any dental procedure for which an individual is covered under the Health Plan, including any coverage provided under a health maintenance organization.
2. Charges for services performed in a Veteran's Administration Hospital or in any charitable institution or government operation.
3. Charges for treatment other than by a dentist or for treatment that does not meet American Dental Association standards, except for scaling or cleaning of teeth performed by a licensed dental hygienist if the treatment is rendered under the supervision and direction of the dentist.
4. Charges for the initial installation of dentures and bridgework (including crowns and inlays forming the abutments), when such charges are incurred for replacement of teeth which were extracted while the individual was not covered under the Plans. The limitation does not apply to children if installation of the prosthetic device is for replacement of teeth which are congenitally missing.
5. Charges for services and supplies that are partially or wholly cosmetic in nature, including charges for personalization or characterization of dentures, athletic mouth guards, educational programs, oral hygiene or dietary instruction.
6. The effective date of treatment for prosthetic devices (including bridges, dentures and crowns) is the date on which the impression was taken. The Plan will not pay any charges for prosthetic devices if the impression was taken while the individual was not covered under the Plan. The Plan will not pay any charge for installation or follow-up fitting and adjustment of prosthetic devices if such charges are itemized and occur more than thirty (30) days after termination of coverage.
7. Charges for the replacement of a lost or stolen prosthetic device.
8. The Dental Plan does not cover certain types of charges such as expenses covered by Workers' Compensation or other laws including "No Fault" automobile insurance and treatment by other than a licensed physician or dentist.

VIII. Provisions for Termination or Continuation of Coverage

Listed below are examples of when coverage terminates or may be continued under the Plan. Continued coverage, to the extent required by federal law if applicable, may be available after termination of employment. See the "Continuation of Coverage Privilege" Article XII.

A. **If an Employee Member resigns, is discharged, or is terminated:**

Member and dependent coverage terminates on the date employment terminates.

B. **If a Member fails to pay the required member contributions on a timely basis:**

Member and dependent coverage terminates on the last date for which the required member contributions were paid.

C. **If an Employee Member is transferred to a non-participating member of the controlled group of corporations to which the Company belongs:**

Member and dependent coverage terminates on the date of transfer.

D. **If an Employee Member loses eligibility because of a change in their normally scheduled hours and reclassification to a Casual employee:**

Member and dependent coverage terminates on the date of the change.

E. **If an Employee Member retires:**

Member and dependent coverage terminates on the date the employee retires.

F. **If an Employee Member is temporarily laid off:**

Member and dependent coverage may be continued for three months.

G. **If an Employee Member is on loan to another employer:**

Member and dependent coverage may be continued.

H. **If an Employee Member is granted a Medical Leave:**

Member and dependent coverage may be continued for two years. Any further extension of coverage must be approved by the Plan Administrator. (Plan Administrator approval is not required when the member is on a leave which qualifies under the Family and Medical Leave Act as described under Family/Personal Leave below.) If the employee is not receiving sick benefits, vacation pay, or LTD benefits while on leave, participation may be continued provided:

1. The required monthly contributions are remitted in advance of the period of coverage, and
2. The employee does not become eligible to participate in similar group plans as an employee of another employer.

I. **If an Employee Member is on a Medical Leave while receiving LTD benefits or while on LTD appeal status:**

Member and dependent coverage may be continued provided the required monthly contributions are paid.

J. **If an Employee Member is on Family Leave or Personal Leave (included approved FMLA):**

Member and dependent coverage may be continued provided:

1. The required monthly contributions are remitted in advance of the period of coverage, and

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

The Company must maintain coverage continuously for the duration of a Family Leave of 12 workweeks or less at the level and under the conditions coverage would have been provided if the employee had remained on the job.

If the Company discontinues coverage as a result of non-payment of premiums while an employee is on a Family Leave of 12 workweeks or less (and which qualifies as a leave taken pursuant to the Family and Medical Leave Act of 1993), upon the employee's return to work, benefits must be restored to at least the same level and terms as were provided when Family Leave began, subject to any changes in benefit levels that may have taken place during the leave affecting the entire work force, unless otherwise elected by the employee. Therefore, the restored employee shall not be required to meet any qualification requirements such as a waiting period, a pre-existing condition exclusion, waiting for open enrollment or passing a medical exam.

K. **If an Employee Member is on a Military Leave (as defined in the Marathon Petroleum Military Leave Plan):**

Coverage for the employee and dependents will be continued subject to payment of the required monthly contribution by the employee.

L. **If an Employee Member is on a leave of absence for other reasons:**

Member and dependent coverage terminates, unless approval to continue coverage is granted by the Company.

M. **If an Employee Member dies:**

Surviving spouse and other dependents' coverage may be continued thereafter as long as they are eligible and they pay the required member contributions.

N. **If an Employee Member and spouse die simultaneously:**

Coverage for eligible children is continued, at Company expense, for 60 days following the date of death. The children or their legal guardian may continue the children's coverage as long as they remain eligible by paying the required contributions.

O. **If an Employee Member becomes divorced:**

Coverage for the spouse terminates at the effective date of the divorce. Coverage for eligible children may be continued.

P. **If a Surviving Spouse Member remarries:**

Coverage for the member and children terminates at the end of the month in which the marriage occurred. Coverage for the children may be reinstated provided that evidence is provided that no other coverage is available and the child(ren) pay the employee only rate (if one child) or the employee with children rate (if two or more children) to continue as Members.

Q. **If a Surviving Spouse Member dies:**

Coverage for the children may be continued provided the children or their legal guardian remain eligible by paying the required contributions.

R. **If a member or legal guardian of a member fails to remit contributions:**

Coverage will terminate at the end of the month for which contributions are paid.

S. **If a Surviving Spouse Member becomes eligible for Medicare due to age:**

Coverage for the member and children terminates on the effective date Surviving Spouse Member becomes eligible for Medicare due to age (generally, the first of the month in which the Member becomes eligible for Medicare due to age).

T. **When an eligible Child reaches first of the month following the month in which they turn age 26:**

Coverage for the Child terminates, unless the child qualifies for continued coverage as a Dependent Disabled Child.

U. **If a dependent of a member becomes a Regular employee (who works on a "full-time" basis) of the Company:**

Coverage normally terminates since the dependent can join the Plan as an employee. However, if the dependent is a spouse or eligible child, coverage as an employee or as a dependent is optional.

IX. Payment of Benefits

Expenses should be submitted as they occur. Payment from the Plan will begin as soon as the submitted expenses exceed the appropriate deductibles.

Claims must be submitted within six months after the end of the calendar year in which the claims were incurred.

Most providers will submit claims directly to Cigna, in which case benefit payment is generally issued directly to the provider by Cigna. If a provider does not submit claims, then a completed claim form must be submitted to:

Cigna HealthCare Service Center
P.O. Box 188037
Chattanooga, TN 37422-8037

for any expense for which a benefit may be received. When a claim form is submitted to Cigna by the member, all benefits will be paid directly to the member unless the member requests that certain benefits be paid directly to the dentist.

The dentist may require the patient to always bring a claim form to the dentist's office. Forms will be available at the local Human Resources office. The dentist should complete the form and mail it to the Cigna office address listed above. Both the member and the dentist will receive a brief description of amounts payable under the Plan for services rendered after the claim has been processed by Cigna.

It is very important that members keep a record of their dental expenses, since a number of maximum benefit limits are included in the Plan.

To the extent that subsequent information indicates that claim payments were inappropriately made, the Plan reserves the right to recover the inappropriate amount by offsetting the amount from future amounts payable by the Plan or by any other reasonable means, as determined by the Plan Administrator.

Questions concerning dental claims or benefits for procedures should be directed to Cigna at 1-800-244-6224.

X. Claim Appeal 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, Marathon Petroleum 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 Dental Plan is as follows:

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

An appeal form can be found on http://www.myMPCbenefits.com 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: Marathon Petroleum Dental Plan – Claim Appeals.

If the appeal is made in writing, the appeal is to be sent to the Plan Administrator at the address stated at the beginning of this Article X.

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 Article X) 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 found at the beginning of this Article X. (It is suggested that a copy of your written appeal to Cigna 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 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 stated at the beginning of this Article X. 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 Article X 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 found at the beginning of this Article X. (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 stated at the beginning of this Article X. (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.

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.

XI. 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.

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

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

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

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

XIII. Continuation of Coverage Privilege (COBRA)

Federal law requires that Plan members and dependents be permitted to elect to continue coverage under this Plan in accordance with such law. The continuation provisions are included in the Plan as Appendix A.

Employees who are terminated within 24 months of a Change of Control, as defined in the Change in Control Severance Benefits Plan (including terminated retirement eligible employees) will be eligible to receive extended coverage, at current employee rates, under Marathon's Dental Plans, or successor plans, for a period of 18 months as described in Appendix A.

XIV. Extended Benefits

Dental coverage for an employee and covered dependents ceases immediately upon the employee's termination of employment or retirement. However, if dentures or other supplies or materials have been ordered prior to, and are installed within 30 days following termination of employment or retirement, benefits will be extended to cover these items. For orthodontia, however, only expenses incurred for services rendered and supplies received prior to date of termination or retirement are covered.

XV. Conversions

If you retire, change employers, are covered by COBRA, or your COBRA coverage expires, you and/or your dependents may have the privilege of converting to an Individual Dental Plan at the prevailing conversion levels.

XVI. Special Provisions Relating to Medicaid

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

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

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

XVII. 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 employees of subsidiaries and affiliated organizations to participate in this Plan. Currently, these participating companies include, but are not limited to, Marathon Petroleum Company LP, Marathon Petroleum Corporation, Marathon Petroleum Service Company, Catlettsburg Refining LLC, Marathon Petroleum Logistics Services LLC, Blanchard Refining LLC, MW Logistics Services LLC, Speedway LLC and Speedway Prepaid Card LLC. Employee eligibility within these participating companies may be limited to certain employee subsets, as identified in Appendix B. In addition, eligible subsets of employees must satisfy all eligibility provisions otherwise provided by this Plan.

The terms "Company," "Employer," "Employee," "Member," and words of similar import as used in this Plan shall be deemed to include Marathon Petroleum Company LP and such subsidiaries and affiliated organizations and their employees.

XVIII. American Jobs Creation Act of 2004

Pursuant to the American Jobs Creation Act of 2004 and Section 409A of the IRC, in the event a benefit under this Plan does not satisfy requirements of IRS Code Sections 105 and 106 and therefore becomes taxable to the Plan member, any reimbursement or benefit will be paid no later than the last day of the taxable year following the taxable year in which the expense was incurred.

XIX. Modification and Termination of Plan

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

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

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

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

(iii) By written resolution by the Executive Committee;

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

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

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

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

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

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

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

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

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

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

(ii) $500,000.

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

XX. The Use and Disclosure of Protected Health Information

The Plan will use protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations. The Plan will disclose PHI only to the Plan Administrator and other members of the Company's workforce who are authorized to receive such PHI, and only to the extent and in the minimum amount necessary for that person to perform Plan administrative functions. "Members of the Company's workforce" generally include certain employees who work in the Company's employee benefits department, human resources department, payroll department, legal department, and information technology department. The Plan Administrator keeps an updated list of those members of the Company's workforce who are authorized to receive PHI.

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

- Investigation of the incident to determine whether the breach occurred inadvertently, through negligence or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

- Appropriate sanctions against the persons causing the breach which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment;
- Mitigation of any harm caused by the breach, to the extent practicable; and
- Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

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

- Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law, including HIPAA privacy standards;
- Implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of EPHI that the Company creates, receives, maintains or transmits on behalf of the Plan;
- Ensure that the adequate separation between the Plan and the Company described above is supported by reasonable and appropriate security measures;
- Ensure that any agents, including a subcontractor, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Company with respect to such PHI;
- Ensure that any agent to whom it provides EPHI shall agree, in writing, to implement reasonable and appropriate security measures to protect the EPHI;
- Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Company;
- Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Report to the Plan Administrator any security incident of which it becomes aware;
- Make PHI available to an individual in accordance with HIPAA's access requirements;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make available the information required to provide an accounting of disclosures;
- Make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA;
- If feasible, return or destroy all PHI received from the Plan that the Company still maintains in any form, and retain no copies of such PHI when no longer needed for the purposes for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible);

- To use reasonable and appropriate security measures to protect the security of all PHI, including EPHI, and to support the separation between the Plan and the Company, as needed to comply with the HIPAA Security Standards.

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

XXI. Further Information

This text is intended to describe the 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 Dental Plan, P.O. Box 1, 539 South Main Street, Findlay, Ohio 45840, Phone (419) 422-2121. 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 formal name of the Plan is the Marathon Petroleum Dental Plan. The employer of the employees covered by the Plan is the Plan Sponsor Marathon Petroleum Company LP, 539 South Main Street, Findlay, Ohio 45840. The Plan is a self-insured welfare benefit plan, and is administered through an administrative services only contract with Cigna Dental Health, Hartford, Connecticut 06152. Marathon's employer identification number is 31-1537655 and the Plan number is 553. Plan documents may be inspected by submitting a request to your local Human Resources Office or to Marathon Petroleum Company LP, Benefits Service Center, 539 S. Main Street, Findlay, Ohio 45840. The Plan year ends on December 31, and the Plan's records are kept on a calendar year basis. The agent for service of legal process is the Plan Administrator, P.O. Box 1, 539 South Main Street, Findlay, Ohio 45840.

XXII. Your Rights Under Federal Law

As a participant in the Marathon Petroleum Company Dental 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 Plans and Benefits

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

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, and copies of the latest annual reports (Form 5500 Series) and updated summary plan descriptions. The administrator may make a reasonable charge for the copies.

Receive, as required by law, a summary of the plan's annual financial reports.

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual reports from the plans and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

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

Appendix A

COBRA

Required Notice: Participants of the Marathon Petroleum Dental Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to continue health care coverage for themselves, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. Participants and their dependents may have to pay for such coverage.

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

I. Group Covered

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

II. Qualifying Events and Maximum Length of Continuation Periods

A. If an Employee Member of the Plan loses coverage:

1. Because of termination of employment (including retirement), either voluntary or involuntary, for reasons other than gross misconduct;
2. Because of a reduction of work hours (that is, a change from regular to casual status); or
3. Because of layoff;

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

B. If the covered spouse of an Employee Member of the Plan loses coverage:

1. because of the death of the Employee Member;
2. because of divorce or legal separation from an Employee Member; or
3. because the Employee Member's employment with the Company ends for any reason other than gross misconduct, or because of a reduction of work hours (e.g., change from Regular to Casual status or layoff); or
4. because the Employee Member becomes entitled to benefits under Medicare;

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

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

1. because of the death of the Employee Member;
2. because the dependent no longer meets the Plan's definition of an eligible Child; or
3. because the Employee Member's employment with the Company ends for any reason other than gross misconduct, or because of a reduction of work hours (e.g., change from regular to Casual status, or layoff); or
4. Because the Employee Member becomes entitled to benefits under Medicare;

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

III. Maximum Length of Continuation Periods

COBRA continuation coverage is a temporary continuation of health coverage. When the qualifying event is the employee's termination of employment (other than for gross misconduct) or reduction of work hours, COBRA continuation coverage for the employee and the employee's covered spouse and dependent children generally lasts for only up to a total of 18 months from the date of the qualifying event.

When the qualifying event is the death of the employee, your divorce [or legal separation], or the employee's Medicare entitlement, COBRA continuation coverage for the employee's spouse and/or dependent children (but not the employee) lasts for up to a total of 36 months from the date of the qualifying event. Also, the employee's dependent children are entitled to COBRA continuation coverage for up to 36 months after losing eligibility as a dependent child under the terms of the plan.

IV. Extension of Maximum Length of Continuation Periods

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

Second Qualifying Event Extension: Eligible dependents of the Employee Member who are entitled to a maximum 18-month COBRA continuation coverage period will have that period extended to a maximum of 36 months from the date of the first qualifying event if any of the following subsequent qualifying events occur during the maximum 18-month period (or during the maximum 29-month period, if applicable) and results in a loss of coverage:

1. The death of the Employee Member;
2. The divorce or legal separation of the Employee Member;
3. The Child no longer meets the Plan's definition of an eligible dependent;
4. The Employee becomes entitled to benefits under Medicare.

In the case of events (2) and (3) above, however, the period will be extended only if notice of the event is provided to the Plan Administrator by the Member or dependent in accordance with "Notification Procedure" below.

Employee Member's Medicare Entitlement Occurs Before a Qualifying Event That Is Member's Termination of Employment or Reduction of Work Hours: In addition, if an Employee Member becomes entitled to benefits under Medicare and the Member's covered eligible dependents properly elect continuation coverage due to a qualifying event which occurs on or after the date of such entitlement to Medicare, the Eligible Dependents will be eligible for a minimum of 36 months of continuation of coverage measured from date of entitlement to benefits under Medicare.

V. Termination of Continued Coverage

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

A. The date the Continued Member (or continued dependent) first becomes covered after the date of their COBRA election, by another group health plan which does not contain any exclusion or limitation with respect to any preexisting condition of that individual, either as an employee, retiree, dependent or otherwise;

B. The date the Continued Member (or continued dependent) first becomes entitled, after the date of their COBRA election, to benefits under Medicare;

C. The last day of coverage for which timely premiums have been paid;

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

E. For an individual (employee or eligible dependent) who has had their maximum period of continued coverage extended from 18 months to 29 months due to a determination of disability for Social Security purposes, and who later receives a final determination that they are no longer disabled for Social Security purposes, the later of a) the first day of the month that begins more than 30 days after the date of the final determination, and b) the end of the 18-month period;

F. The first date on which no member of the controlled group which includes the Company provides any group health plan to any of its employees.

VI. Notification Procedure

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

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

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

1. The employee or dependent must notify the Plan Administrator in writing of the effective date of that event within 60 days after that date. (This information can be submitted to the Plan Administrator through the Company's local Human Resources office or Benefits Administration in Findlay, Ohio), and
2. The Plan Administrator or representative will inform the employee/dependent of their rights under COBRA at the time of such notification, or mail the information within 14 days. Notification to the spouse will serve as notification for all dependents residing with the spouse.

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

1. The date of the notice from the Plan Administrator, if applicable; or
2. The date of termination of coverage.

D. No evidence of good dental health is needed.

E. If no election is made within the election period, coverage ceases at the time of the qualifying event. If you initially waiver COBRA continuation coverage, but revoke that waiver within the 60-day election period, coverage will only be effective from the date of the waiver.

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

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

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

VII. Type of Coverage

The coverage offered must be a continuation of the benefits currently being provided under the Plan to other members and dependents, with respect to whom a qualifying event has not occurred. Subject only to the exception stated in (B)(2)(b) immediately below, the right to elect continuation of coverage is offered only to those members and covered eligible dependents who on the day before the loss of coverage due to the qualifying event were covered under the Plan.

Change In Coverage Category

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

B. Addition of Eligible Dependents

1. Eligible Dependents at Time of Qualifying Event

   A Continued Member may elect, subject to the late enrollment provisions of the Plan, to cover any eligible dependents whom the Member did not cover at the time the Member lost their coverage due to the qualifying event.

2. Eligible Dependents Acquired After Qualifying Event

   a) A Continued Member or a covered eligible dependent who elected continuation coverage may add any eligible dependents whom they acquire after their qualifying event, subject to the late enrollment provisions of the Plan.

   b) Effective January 1, 1997, eligible dependent children who are added for continuation of coverage pursuant to the late enrollment provisions of the Plan by a Continued Member who was formerly an Employee Member of the Plan, and who are either:

      i. child that is a blood descendent of the first degree of the covered employee who is born during a period of COBRA continuation of coverage, or

      ii. child that has been “placed for adoption” with the covered employee during a period of COBRA continuation of coverage,

   shall be treated for COBRA continuation of coverage purposes as if they were covered eligible dependent children of the Continued Member at the time of the qualifying event except they will not be eligible to begin COBRA continuation of coverage until the date of their birth or the date of their placement for adoption with the covered employee, whichever is applicable.

C. Any amendments to the Plan applicable to similarly situated non-continued members will also be applicable to similarity situated Continued Members.

D. For individuals enrolled in the Plan on the date of their qualifying event, any amounts accumulated towards the deductible by an individual or family before the qualifying event, will be carried over and used towards satisfying the deductible as a Continued Member for the remainder of the calendar year. However, in all instances where the original family unit is split (i.e., divorce or loss of dependent status), the amounts accumulated by the original family unit will also be credited to the new unit, and the original family unit’s amounts will not be reduced because of the loss of the Continued Member from the family unit.

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

VIII. Cost

The Continued Member will be charged the entire premium applicable to any other member or family with the same coverage, including the portion formerly paid by the Company, plus 2% of this total premium amount. [In the case of an individual (employee or eligible dependent) who has had their maximum period of continued coverage extended from 18 months to 29 months due to a determination of disability for Social Security purposes, the charge for the 19th through 29th months will be based on a 50% addition to the entire premium amount instead of a 2% addition, provided the disabled beneficiary is part of the coverage group.] The rates will be established prior to their effective date, and be frozen at that level for a minimum of 12 months.

Members or spouses with no dependents, and each former eligible Child who, because of losing eligible child status, elects continuing coverage, will be charged the single rate. Current rates are available from the Company's local Human Resources office or Benefits Administration in Findlay.

IX. Surviving Spouse and Surviving Dependents

The "Classes of Membership and Eligibility" section of the Plan provide that a Surviving Spouse and dependents can continue coverage at Company-subsidized rates until a remarriage occurs. This section of the Plan also provides that an eligible dependent of certain types of former Employee Members can be covered in their own right at Company-subsidized rates until the individual no longer meets the criteria for dependency.

Continuing coverage under COBRA will be offered to these individuals if:

A. The remarriage or failure to satisfy the eligible dependent requirements of the Plan occurs within 36 months of the date of death, and

B. None of the events which would have terminated the 36-month period of COBRA continuation coverage (which otherwise would have been provided if not for the Company-subsidized coverage under the Plan) have occurred.

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

X. Administration

The continuation of coverage under the Plan is administered by PayFlex Systems USA, Inc. ("PayFlex"). After an election is made to continue coverage, PayFlex will bill the Continued Member for the first premium payment.

The premium for the succeeding months' coverage will be billed by PayFlex on a monthly basis. The succeeding premium payments are due on the first of the month for the month of coverage, i.e., in advance of the period of coverage.

XI. Special Continuing Circumstances

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

B. Change In Control

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

Eligible terminated employees (including those eligible to retire at the time of termination) and their eligible dependents who, immediately prior to termination were Members of the Dental Assistance Plan, have the opportunity to continue coverage under the terms and conditions of the Dental Assistance Plan as applied to active employees for a period of 18 months, provided the terminated employee is eligible for and timely elects continuation of such coverage in accordance with COBRA. The terminated employee shall pay the active employee rate with respect to coverage during the eighteen (18) months following the termination date and, thereafter (if applicable), the full COBRA rate with respect to such coverage.

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

The period of coverage provided under this section shall constitute continuation coverage required by COBRA. The eligibility of the terminated employee to continue such coverage at both the active employee rate and full COBRA rate shall not exceed a period of eighteen (18) months, unless a longer period is required by COBRA. Such benefits shall be governed by and subject to (i) the terms and conditions of the plan documents providing such benefits, including the reservation of the right to amend or terminate such benefits under those plan documents at any time provided that, for a period of two (2) years following a Change in Control, the Plan may not be amended in an adverse manner solely for employees eligible for benefits under this section; and (ii) the provisions of COBRA.

Appendix B

Eligible Employee Subsets of Participating Companies and Organizations

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