Marathon Petroleum
Pre-65 Retiree Dental Plan

Amended and Restated
January 1, 2021

Pre-65 Retiree Dental Plan

Table of Contents

Pre-65 Retiree Dental Plan

This document serves both as the plan document and the summary plan description ("SPD") for the Marathon Petroleum Pre-65 Retiree Dental Plan (the "Plan"). To the extent not preempted by the Employee Retirement Income Security Act of 1974 (ERISA), the provisions of this instrument shall be construed and governed by the laws of the State of Ohio.

I. Purpose

The purpose of the Pre-65 Retiree Dental Plan is to provide financial assistance for a broad range of dental treatment for eligible retirees and their eligible spouses and dependents. The Plan does not cover orthodontic treatment and services.

Delta Dental of Ohio, Inc. ("Delta Dental") is the Claims Administrator of the Plan. While use of Participating Providers is not required, the maximum benefit coverage for a specific service is equal to what the Plan would pay a Delta Dental **PPO** dentist. This means that if you visit a Delta Dental **Premier** dentist or a Nonparticipating Provider, the maximum benefit the Plan will pay for a covered service is what the Plan would pay a Delta Dental **PPO** dentist. This amount may be less than what the provider charges or what Delta Dental approves, and the Member is responsible for the difference. Members will receive the best discounts by using a Delta Dental **PPO** dentist.

A Nonparticipating Provider is any dentist who is not a Delta Dental PPO or Premier dentist.

II. Eligibility

Retirees

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

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

Dependents

Any of your eligible Dependents, as defined later in this section under *Definition of Dependent*, can be covered, provided such dependents were not acquired by you (for example, by marriage, birth or adoption) on or after your date of retirement. If Dependents are covered, you will be charged the Retiree+Spouse, Retiree+Child(ren) or Retiree+Family rate, depending on the number and type of Dependents covered.

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

[1] Additionally, eligibility was extended to Andeavor-Acquired Retirees who did not retire under the terms of the Marathon Petroleum Retirement Plan, but who were enrolled in the Marathon Petroleum Retiree Health Plan, who were offered a one-time opportunity to enroll in this Plan with coverage effective January 1, 2021. Retirees in this defined group are eligible to participate in the Plan.

Coverage for your eligible Dependent(s) begins:

- On the first day of your coverage, provided they meet the definition of an eligible Dependent on that date.

Coverage for any Dependent ceases at the earliest of:

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

Definition of Dependent

Dependents are:

- Your under age 65 spouse. The term spouse means a lawful spouse and will be interpreted to refer to any individuals who are lawfully married, including a same-sex spouse. Spouse also includes a common law spouse established under the laws of a state in which common law marriage is legal and for which the Member can provide confirmation of such common law marriage as required in the Marathon Petroleum Certification of Common Law Spouse Relationship form;
- Your under age 65 Domestic Partner if covered as your Domestic Partner under the active Dental Plan immediately prior to your retirement. The term Domestic Partner means a person for whom a Retiree has certified meets the requirements established in the *Marathon Petroleum Certification of Domestic Partnership Relationship* form; and
- Your children, up through the end of the month in which they turn age 26, are eligible dependents under the Plan. Children include your:
    a. Natural children of the first degree;
    b. Legally adopted children, and children placed with you for adoption;
    c. Stepchildren;
    d. Children, whose parents are both deceased and who permanently reside with you, and for whom you have legal custody as determined by a court of competent jurisdiction. A child covered on December 31, 2003, as a dependent of a Retiree Member under this legal custody provision and whose parents are not both deceased is allowed to remain covered under the Plan until their coverage is terminated or they otherwise cease to meet the dependent eligibility requirements of the Plan. Once coverage ends for such child, they will not be permitted to be reenrolled under the Plan by a Member using this legal custody eligibility provision unless both parents are deceased, and the child otherwise meets the dependent eligibility provisions of the Plan.

- Children of Domestic Partner

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

- Dependent Disabled Child

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

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

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

  c. Met the disabled dependent child eligibility requirements of the Marathon Petroleum Dental Plan (the active employee Dental Plan) prior to enrollment in this Plan; and

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

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

- Children Covered by QMCSOs

  The Plan will determine if a "medical child support order," as that term is defined under ERISA Section 609, is a "qualified medical child support order" (QMCSO), as that term is also defined under ERISA Section 609, in accordance with the Plan's QMCSO procedures. Administration of the QMCSO by the Plan will be in accordance with the terms of the Plan and the Plan's QMCSO procedures adopted by the Plan Administrator. A copy of the Plan's QMCSO procedures is available by written request from the Assistant Plan Administrator and is available on-line at http://www.mympcbenefits.com/Documents/MPC-Qualified-Medical-Child-Support-Order-Procedures.pdf.

III. Enrolling in the Plan

Coverage can be waived upon initial eligibility to participate in the Plan. In the event of such waiver, such individual will be permitted a one-time opportunity to enroll in the Plan at a future date, either during the Annual Enrollment period or due to a qualifying event, provided eligibility requirements are satisfied, and further, that such individual provides evidence of continuous dental coverage during the period of waived coverage.

Once enrolled, a Retiree can only drop coverage during the annual enrollment period, with the termination of coverage effective the following January 1. A Retiree cannot drop coverage at any other time, even for a qualifying life event, unless the reason for dropping coverage is to enroll in the Marathon Petroleum Dental Plan (the active employee Dental Plan) as either an employee member or dependent member, otherwise, coverage must remain in place for the remainder of the calendar year. A member who terminates participation in the Plan will not be eligible to re-enroll at a future date (unless participation was terminated to enroll in the Marathon Petroleum Dental Plan for active employees and such enrollment is continuous until re-enrollment in this Plan).

A. Member Enrollment

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

1. Enrollment When First Eligible for Coverage

Prospective Retiree Members may, within 31 days of the effective date of their retirement (including the retirement date), elect to enroll through BenefitSolver at www.myMPCbenefits.com/mybenefits or by calling BenefitSolver at 1-844-408-2575 in order to be covered as a Member under the Plan. If the enrollment election is received by BenefitSolver within 31 days of the first date of eligibility (including the eligibility date), participation is effective on the first date of eligibility.

Enrollment elections submitted after the 31-day election period will not be accepted.

2. Late Enrollment

In addition to Annual Enrollment, if you previously waived Plan coverage upon your initial eligibility, you may late enroll in the Plan due to the following events, provided that you otherwise meet Plan eligibility requirements, and further, that if your retirement date is on or after January 1, 2021, you provide evidence of your continuous dental coverage during the entire period of waived coverage:

a. Your loss of eligibility for coverage under another employer's group health plan providing dental coverage or under other health insurance coverage providing dental coverage that was obtained through self-employment, or

b. The exhaustion of COBRA continuation of coverage by you under another employer's group health plan providing dental coverage.

All enrollments or election changes due to the above events must be made within 31 days of the event (including the event date) through BenefitSolver at www.myMPCbenefits.com/mybenefits or by calling BenefitSolver at 1-844-408-2575. Any required documentation also must be submitted within 31 days of the event. If the enrollment is received on, before or within 31 days of any of the above events (including the event date), participation is effective on the date of the event. Enrollment elections or changes submitted after the 31-day election period will not be accepted.

Late enrollment is only available to you as an otherwise eligible Retiree Member. You may include in your late enrollment your eligible dependents, provided the dependents were not acquired on or after your date of retirement.

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

3. Annual Enrollment

There is an Annual Enrollment each year during the fall. During Annual Enrollment, if an individual has not previously enrolled in the Plan as a Member when initially eligible, they can late enroll in the Plan during Annual Enrollment, provided that Plan eligibility requirements are satisfied, and further, that such individual whose retirement date is on or after January 1, 2021, provides evidence of continuous dental coverage during the period of waived coverage. Member coverage will be effective the following January 1.

A Retiree's election to enroll or re-enroll in the Plan may be made within 31 days of the effective date of retirement or other eligibility date (including the retirement or eligibility date) of any of the following events:

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

Enrollment elections submitted after the 31-day election period will not be accepted.

IV. Premiums

The following are the monthly premium rates as of January 1, 2021:

- Retiree Only $23.00
- Retiree + Spouse $46.00
- Retiree + Child(ren) $50.00
- Retiree + Family $77.00

V. Coordination with Active Dental Plan

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

VI. Participating and Nonparticipating Providers

While use of Participating Providers is not required, the maximum benefit coverage for a specific service is equal to what the Plan would pay a Delta Dental **PPO** dentist. This means that if you visit a Delta Dental **Premier** dentist or a Nonparticipating Provider, the maximum benefit the Plan will pay for a covered service is what the Plan would pay a Delta Dental **PPO** dentist. This amount may be less than what the provider charges or what Delta Dental approves, and the Member is responsible for the difference. To locate providers who participate in the Delta Dental PPO or Premier Networks, Members may call Delta Dental at 1-800-524-0149 or visit www.deltadentaloh.com/marathon. Members will receive the best discounts by using a Delta Dental **PPO** dentist.

How You Can Save		
Delta Dental PPO Dentists	**Delta Dental Premier Dentists**	**Nonparticipating Dentists**
• Submits claims for you • Only charges you for your coinsurance and deductible, if any; no balance billing • Out-of-pocket costs are likely to be lower • Payment will be sent directly to your dentist	• Submits claims for you • Only charges you for your coinsurance and deductible, if any, and the difference between the Delta Dental PPO fees and the Premier Provider maximum allowable fees • Out-of-pocket costs are likely to be lower • Payment will be sent directly to your dentist	• May require you to submit your own claims • May charge you the full cost of a procedure • May ask for payment in full up front • You will be responsible for making full payment to your dentist and Delta Dental will send you the check for the covered service

VII. Covered Services

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

Class I Services — Diagnostic and Preventive

The Plan will pay 100% of the maximum approved fee that would be paid to a Delta Dental **PPO** Provider for the following covered expenses. This amount may be less than what the provider charges or what Delta Dental approves, and the Member is responsible for the difference.

- Oral examinations including scaling and cleaning of teeth, but not more than twice in any calendar year. Prophylaxes (cleanings) are payable twice per calendar year. Periodontal maintenance procedures are also payable twice in the same calendar year. Full mouth debridement is payable once per lifetime.

- Topical application of sodium or stannous fluoride twice per calendar year with no limitation.
- 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.
- Fixed and removable space maintainers (space maintainers for Member through age 18) with no limitation.
- Sealants (for Member through age 18).

Class II and III Services — Basic and Major

The Plan will pay 80% of the maximum approved fee that would be paid to a Delta Dental **PPO** Provider for basic services and 50% of the maximum approved fee that would be paid to a Delta Dental **PPO** Provider for major services for the following covered expenses. This amount may be less than what the provider charges or what Delta Dental approves, and the Member is responsible for the difference.

- Extractions. (Basic Service)
- Oral Surgery. (Basic Service)
- Fillings. (Basic Service)
- Anesthetics administered in connection with oral surgery or other covered dental services. (Basic Service)
- Treatment of periodontal and other diseases of the gums and tissues of the mouth. (Basic Service)
- Endodontic treatment, including root canal therapy. (Basic Service)
- Injection of antibiotic drugs by the attending dentist. (Basic Service)
- Initial installation (including adjustments during the six-month period following installation) of partial or full removable dentures to replace one or more natural teeth. (Major Service)
- Repeat or recementing of crowns, inlays, bridgework or dentures or relining of dentures. (Major Service)
- 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 evidence satisfactory to the Claims Administrator is presented that the existing denture was installed at least five years prior to its replacement and that it cannot be made serviceable.
- Inlays, crowns (including precision attachments for dentures) and initial installation of fixed bridgework (including inlays and crowns to form abutments). (Major Service)
- 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 the bridgework was installed at least five years prior to its replacement and that the existing bridgework cannot be made serviceable.

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 may qualify for the additional services shown below (subject to the annual out-of-pocket maximum, but not deductible, if any) for certain related dental procedures. The provider should submit the claim to Delta Dental as usual, along with a narrative on the medical condition which warrants the service, and Delta Dental will review to determine the benefit, if any. Questions regarding these enhanced services should be directed to Delta Dental at 1-800-524-0149.

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.

Alternate Benefit

If the Member selects a more expensive service than is customarily provided, Delta Dental may allow an alternate benefit for certain services based on the fee for the customarily provided service. The Member is responsible for the difference in cost. In all cases, Delta Dental will make the final determination regarding any available alternate benefit provided for such service. Listed below are services for which the Plan will provide an alternate benefit for the optional treatment.

- Resin, porcelain fused to metal, and porcelain crowns, bridge retainers, or pontics on posterior teeth — The Plan will pay only the amount that it would pay for a full metal crown.

- Overdentures — The Plan will pay only the amount that it would pay for a conventional denture.
- Resin, or porcelain/ceramic onlays on posterior teeth — The Plan will pay only the amount that it would pay for a metallic onlay.
- Inlays, regardless of the material used — The Plan will pay only the amount that it would pay for an amalgam or composite resin restoration.
- All-porcelain/ceramic bridges — The Plan will pay only the amount that it would pay for a conventional fixed bridge.
- Implant/abutment supported complete or partial dentures — The Plan will pay only the amount that it would pay for a conventional denture.
- Gold foil restorations — The Plan will pay only the amount that it would pay for an amalgam or composite restoration.
- Posterior stainless steel crowns with esthetic facings, veneers or coatings — The Plan will pay only the amount that it would pay for a conventional stainless steel crown.

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.

Pre-Treatment Estimate

If a provider has advised a course of treatment which will exceed $100, the Member is encouraged to have the provider submit a proposed dental treatment in advance of providing the treatment. By so doing, Delta Dental can provide an estimate of how much may be payable under the Plan for the dental treatment.

- The benefits estimate provided on a Pre-Treatment Estimate notice is based on benefits available on the date the notice is issued.
- A Pre-Treatment Estimate is not a prerequisite or condition for approval of future benefits payment.
- Receipt of a Pre-Treatment Estimate does not guarantee payment or coverage and is not a formal adjudication of a claim.
- Pre-Treatment Estimates do not assess whether a Member is specifically eligible for a covered service or whether the Member has reached any applicable annual or lifetime maximum benefit under the Plan.

Maximum Benefits Payable

The Plan has an unlimited lifetime maximum benefit. There is a calendar year maximum of $1,000 in benefits for expenses paid per covered Member. Orthodontia is not a covered benefit under the Plan.

VIII. Expenses Not Covered

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

- Orthodontic treatment.
- Charges for any dental procedure for which an individual is covered under the Health Plan, including any coverage provided under a health maintenance organization.
- Charges for services performed in a Veteran's Administration Hospital or in any charitable institution or government operation.
- 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.
- 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.
- 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.
- Charges for the replacement of a lost or stolen prosthetic device.
- The 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.

IX. 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.

X. Expenses for Which a Third Party May Be Responsible

This Plan does not cover:

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

Third Parties

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a sickness, injury or damages, or who is legally responsible for the sickness, injury or damages;
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the sickness, injury or damages;
- Worker's compensation cases/claims;
- Any person or entity who is or may be obligated to provide you with benefits or payments under:
  - Underinsured or uninsured motorist insurance;
  - Medical provisions of no-fault or traditional insurance (auto, homeowners or otherwise);
  - Worker's compensation coverage; or
  - Any other insurance carrier or third party administrator.

XI. Subrogation/Right of Reimbursement

If a Member incurs a Covered Dental Expense for which, in the opinion of the Plan or its claim administrator, another party may be responsible or for which the Member may receive payment as described above:

- **Subrogation:** The Plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a Member may have against such party and shall automatically have a lien upon the proceeds of any recovery by a Member from such party to the extent of any benefits paid under the Plan. A Member or his/her representative shall execute such documents as may be required to secure the Plan's subrogation rights.
- **Right of Reimbursement:** The Plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the Plan.

XII. Lien of the Plan

By accepting benefits under this Plan, a Member:

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

Additional Terms

- No adult Member hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Member without the prior express written consent of the Plan. The Plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No Member shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the Plan.
- The Plan's right of recovery shall be a prior lien against any proceeds recovered by the Member. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine," "Rimes Doctrine," or any other such doctrine purporting to defeat the Plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.

- No Member hereunder shall incur any expenses on behalf of the Plan in pursuit of the Plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the Plan's recovery without the prior express written consent of the Plan. This right shall not be defeated by any so-called "Fund Doctrine," "Common Fund Doctrine," or "Attorney's Fund Doctrine."
- The Plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Member, whether under comparative negligence or otherwise.
- In the event that a Member shall fail or refuse to honor its obligations hereunder, then the Plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The Plan shall also be entitled to offset the reimbursement obligation against any entitlement to future benefits hereunder until the Member has fully complied with his reimbursement obligations hereunder, regardless of how those future benefits are incurred.
- Any reference to state law in any other provision of this plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the Plan, the Member agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the Plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.
- Failure to cooperate with the Plan's subrogation efforts and/or return funds within 60 days of receipt from a legal proceeding or settlement in which the Plan has a subrogation interest will result in the participant becoming permanently ineligible to participate in this Plan or any dental plan sponsored by the employers in the Company's controlled group.
- The Plan's right to subrogation and reimbursement apply to full and partial settlements, judgments, or other recoveries paid or payable to the participant, dependent, or representative.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

XIII. Payment of Benefits

Claims should be submitted as they occur, but must be submitted within one year of the date the service was completed.

Most providers will submit claims directly to Delta Dental of Ohio. If a provider does not submit claims, then a claim must be submitted to the address below.

Delta Dental
P.O. Box 9085
Farmington Hills, MI 48333-9085

Claims will be processed within 30 days of receipt. If there is not enough information to adjudicate the claim, Delta Dental will notify you or your Provider within 30 days. The notice will (a) describe the information needed, (b) explain why it is needed, (c) request an extension of time in which to decide the claim, and (d) inform you or your Provider that the information must be received within 45 days or the claim will be denied if the services were performed by a Nonparticipating Provider, or disallowed if the services were performed by a Participating Provider. You will receive a copy of any notice sent to your Provider. Once Delta Dental receives the requested information, it has 15 days to adjudicate the claim. If you or your Provider does not supply the requested information, Delta Dental will deny the claim if the services were performed by a Nonparticipating Provider, or disallow the claim if the services were performed by a Participating Provider. Once Delta Dental adjudicates the claim, it will notify you within five days.

If your dentist is a Participating Provider, payment for covered services will be sent directly to the Participating Provider. If your dentist is a Nonparticipating Provider, payment for covered services will be made to the Member, and the Member is responsible for making full payment to the Nonparticipating Provider. The Member will be responsible for any difference between the Plan's payment and the provider's submitted amount.

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 Delta Dental at 1-800-524-0149.

XIV. Claim Appeal Procedures

If you receive notice of an Adverse Benefit Determination and you think Delta Dental incorrectly denied all or part of your claim, you or your dentist may contact Delta Dental's Customer Service department and ask them to reconsider the claim to make sure it was processed correctly. You may do this by calling the toll-free number, 1-800-524-0149, to speaking with a telephone advisor. You may also mail your inquiry to the Customer Service Department at Delta Dental Customer Service, P.O. Box 9089, Farmington Hills, Michigan, 48333-9089.

When writing, please enclose a copy of your explanation of benefits and describe the problem. Be sure to include your name, telephone number, the date, and any information you would like considered about your claim.

A request for reconsideration is not required and should not be considered a formal request for review of a denied claim. Delta Dental provides this opportunity for you to describe problems or submit an explanation or additional information that might indicate your claim was improperly denied and allow Delta Dental to correct any errors quickly and immediately.

Whether or not you have asked Delta Dental informally to reconsider its initial determination, you can request a formal review using the Formal Claims Appeal Procedure described below.

A. Formal Claims Appeal Procedure

If you receive notice of an Adverse Benefit Determination, you, or your Authorized Representative, should seek a review as soon as possible, but you must file your request for review within 180 days of the date you received that Adverse Benefit Determination.

To request a formal review of your claim, send your request in writing to:

Dental Director
Delta Dental
P.O. Box 9089
Lansing, MI 48909-7916

Please include your name and address, the Member ID, the reason why you believe your claim was wrongly denied, and any other information you believe supports your claim. You also have the right to review the contract between Delta Dental and the Contractor and any documents related to it. If you would like a record of your request and proof that Delta Dental received it, mail your request certified mail, return receipt requested.

The Dental Director or any person reviewing your claim will not be the same as, nor subordinate to, the person(s) who initially decided your claim. The reviewer will grant no deference to the prior decision about your claim. The reviewer will assess the information, including any additional information you have provided, as if he or she were deciding the claim for the first time. The reviewer's decision will take into account all comments, documents, records and other information relating to your claim, even if the information was not available when your claim was initially decided.

If the decision is based, in whole or in part, on a dental or medical judgment (including determinations with respect to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate), the reviewer will consult a dental health care professional with appropriate training and experience, if necessary. The dental health care professional will not be the same individual or that person's subordinate consulted during the initial determination.

The reviewer will make a determination within 30 days of receipt of your request. If your claim is denied on review (in whole or in part), you will be notified in writing. The notice of an Adverse Benefit Determination during the Formal Claims Appeal Procedure will meet the requirements described below.

Manner and Content of Notice

Your notice of an Adverse Benefit Determination will inform you of the specific reasons(s) for the denial, the pertinent plan provisions(s) on which the denial is based, the applicable review procedures for dental claims, including time limits, and that, upon request, you are entitled to access all documents, records and other information relevant to your claim free of charge. This notice will also contain a description of any additional materials necessary to complete your claim, an explanation of why such materials are necessary, and a statement that you have a right to bring a civil action in court if you receive an Adverse Benefit Determination after your claim has been completely reviewed according to this Formal Claims Appeal Procedure. The notice will also reference any internal rule, guideline, protocol, or similar document or criteria relied on in making the Adverse Benefit Determination and will include a statement that a copy of such rule, guideline or protocol may be obtained upon request at no charge. If the Adverse Benefit Determination is based on a matter of medical judgment or medical necessity, the notice will also contain an explanation of the scientific or clinical judgment on which the determination was based, or a statement that a copy of the basis for the scientific or clinical judgment can be obtained upon request at no charge.

The Adverse Benefit Determination notice will inform you of your right to a managerial-level conference to complete the formal grievance procedure.

XV. Finality of Decision and Legal Action

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

XVI. 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.

XVII. 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.

XVIII. Termination of Coverage

Coverage will cease as described below:

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

Loss of Eligibility During Treatment

If a Member loses eligibility while receiving dental treatment, only covered services received while a Member of the Plan will be payable. However, an expense incurred in connection with a dental service that is completed after a Member's benefits cease will be deemed to be incurred while covered if:

- For fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while covered and the device installed or delivered within 60 days of the coverage termination date.
- For a crown, inlay or onlay, the tooth is prepared while covered and the crown, inlay or onlay installed within sixty days of the coverage termination date.
- For root canal therapy, the pulp chamber of the tooth is opened while covered and the treatment is completed within sixty days of the coverage termination date.

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

XIX. Group Plan Coverage Instead of Medicaid

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

XX. Rescission and Cancellation of Coverage

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

- The Plan retroactively terminates coverage because of a failure to timely pay required premiums or contributions for coverage.
- The Plan retroactively terminates a former spouse's coverage back to the date of divorce when full COBRA premiums are not paid.

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

XXI. COBRA Continuation Rights Under Federal Law

What is COBRA Continuation Coverage?

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

When is COBRA Continuation Available?

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

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

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

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

Who is Entitled to COBRA Continuation?

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

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

Termination of COBRA Continuation

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

- The end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
- Failure to pay the required premium within 30 calendar days after the due date;
- Termination of the Plan by the Company;
- After electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both);
- After electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage under a pre-existing condition provision. In such case coverage will continue until the earliest of: (a) the end of the applicable maximum period; (b) the date the pre-existing condition provision is no longer applicable; or (c) the occurrence of an event described in one of the first three bullets above; or
- Any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

How to Elect COBRA Continuation Coverage

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

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

How Much Does COBRA Continuation Coverage Cost?

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

When and How to Pay COBRA Premiums

First Payment for COBRA Continuation

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

Subsequent Payments

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

Grace Periods for Subsequent Payments

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

You Must Give Notice of Certain Qualifying Events

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

- Your divorce or legal separation or termination of domestic partner relationship;
- Your child ceases to qualify as a Dependent under the Plan; or

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

COBRA Continuation for Retirees Following Employer's Bankruptcy

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

XXII. Use and Disclosure of Protected Health Information

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

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

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

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

- Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law, including HIPAA privacy standards;
- Implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of EPHI that the Company creates, maintains or transmits on behalf of the Plan;
- Ensure that any agents, including a subcontractor, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Company with respect to such PHI;
- Ensure that any agent to whom it provides EPHI shall agree, in writing, to implement reasonable and appropriate security measures to protect the EPHI;
- Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Company;

- Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Report to the Plan Administrator any security incident of which it becomes aware;
- Make PHI available to an individual in accordance with HIPAA's access requirements;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make available the information required to provide an accounting of disclosures;
- Make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA;
- If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purposes for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible); and
- To use reasonable and appropriate security measures to protect the security of all PHI, including EPHI, and to support the separation between the Plan and the Company, as needed to comply with the HIPAA Security Standards.

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

XXIII. Further Information

This text is intended to describe the Pre-65 Retiree Dental Plan in an understandable manner. Additional terms of the Plan are outlined in the provisions of the administrative services agreements between the Plan and service providers. The Plan Administrator or the Plan Administrator's designee will make all final determinations concerning eligibility for benefits under this Plan.

The Company has appointed Jonathan M. Osborne as Plan Administrator of the Pre-65 Retiree Dental Plan. The Company shall appoint assistant administrators as may be deemed necessary. he Plan Administrator shall be the named fiduciary under the Plan.

In determining the eligibility of Members and other individuals for benefits and in construing the Plan's terms, the Plan Administrator (or a Third Party Administrator in cases where a Third Party Administrator has the authority to make determinations concerning eligibility for benefits) has the power to exercise discretion in the construction or interpretation of terms or provisions of the Plan, as well as in cases where the Plan instrument is silent, or in the application of Plan terms or provisions to situations not clearly or specifically addressed in the Plan itself. In situations in which the Plan Administrator deems it to be appropriate, the Plan Administrator may, but is not required to, evidence (i) the exercise of such discretion, or (ii) any other type of decision, directive or determination made with respect to the Plan, in the form of a written administrative ruling which, until revoked, or until superseded by Plan amendment or by a different administrative ruling, shall thereafter be followed in the administration of the Plan.

All decisions of the Plan Administrator (or a Third Party Administrator in cases where a Third Party Administrator has the authority to make determinations concerning eligibility for benefits) made on all matters within the scope of this authority shall be final and binding upon all persons, including the Company, all participants and beneficiaries, and their heirs and personal representatives. It is intended that the standard of judicial review to be applied to any determination made by the Plan Administrator (or by a Third Party Administrator in cases where a Third Party Administrator has the authority to make determinations concerning eligibility for benefits) shall be the "arbitrary and capricious" standard of review. Any discretionary acts taken under this Plan by the Plan Administrator or the Company, shall be uniform in their nature and shall be applicable to all Members similarly situated, and shall be administered in a nondiscriminatory manner in accordance with the provisions of the Employee Retirement Income Security Act of 1974, as amended, (ERISA) and the Internal Revenue Code (the Code).

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

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

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

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

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

Employer Identification Number (EIN): 31-1537655

Plan Number: 562

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

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

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

The Plan is a self-funded welfare benefit plan providing dental assistance coverage, and is administered through an administrative services only contract with Delta Dental Plan of Ohio, Inc.

XXIV. Statement of Rights

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

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive, as required by law, a summary of the Plan's annual financial report.

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

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

Assistance With Your Questions

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

XXV. Plan Modification, Amendment and Termination

The Company reserves the right to modify, amend or terminate this Plan, in whole or in part, in such manner, as it shall determine, either alone or in conjunction with other plans for the Company. Modification or termination may be made by the Company for any reason.

XXVI. Participation by Associated Companies and Organizations

Upon specific authorization and subject to such terms and conditions as it may establish, Marathon Petroleum Company LP may permit eligible retirees of subsidiaries and affiliated organizations to participate in this Plan. Currently, these participating companies include, but are not limited to, Marathon Petroleum Company LP, Marathon Petroleum Corporation, Marathon Petroleum Service Company, Marathon Petroleum Logistics Services LLC, Marathon Refining Logistics Services LLC, Treasure Card Company LLC, Speedway LLC (prior to May 14, 2021) and Speedway Prepaid Card LLC (prior to May 14, 2021). Member eligibility within these participating companies may be limited to certain retiree subsets, as identified in Appendix B. In addition, eligible subsets of retirees must satisfy all eligibility provisions otherwise provided by this Plan.

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

Appendix A

Summary of Benefits[1]

	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Nonparticipating Dentist
	Plan Pays	*Plan Pays*[2]	*Plan Pays*[2]
Diagnostic and Preventive Services — exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Emergency Palliative Treatment — to temporarily relieve pain	100%	100%	100%
Sealants — to prevent decay of permanent teeth	100%	100%	100%
Radiographs — X-rays	100%	100%	100%
Periodontal Maintenance — cleanings following periodontal therapy	100%	100%	100%
Minor Restorative Services — fillings and crown repair	80%	80%	80%
Endodontic Services — root canals	80%	80%	80%
Periodontic Services — to treat gum disease	80%	80%	80%
Oral Surgery Services — extractions and dental surgery	80%	80%	80%
Other Basic Services — misc. services	80%	80%	80%
Relines and Repairs — to bridges and dentures	80%	80%	80%
Major Restorative Services — crowns	50%	50%	50%
Prosthodontic Services — bridges and dentures	50%	50%	50%

[1] This summary is a brief outline of maximum benefits which may be payable. For a full description of each benefit, refer to the "Covered Services" section of this Plan.

[2] When you receive services from a Delta Dental Premier Dentist or Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's PPO Dentist Schedule that will be paid for those services. This amount may be less than what the Dentist charges or Delta Dental approves, and you are responsible for that difference.

Maximum Payment — $1,000 annual maximum per person total per year on all services. No orthodontia coverage.

Deductible — $50 Deductible per person total per year. Deductible does not apply to diagnostic and preventive services, emergency palliative treatment, X-rays, and sealants and periodontal maintenance.

Pre-65 Retiree Dental Plan

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year. Periodontal maintenance procedures are also payable twice in the same calendar year. Full mouth debridement is payable once per lifetime.
- Members with specific at-risk health conditions may be eligible for eligible for additional services. Member should talk with their provider about treatment.
- Fluoride treatments are payable twice per calendar year with no age limit.
- Benefits for space maintainers are unlimited for Members through age 18.
- Bitewing X-rays are payable twice per calendar year. Full mouth X-rays (which include bitewing X-rays) are payable once in any three-year period.
- Sealants are payable for any tooth for Members through age 18. The surface must be free from decay and restorations.
- Composite resin (white) restorations are covered services on posterior teeth.
- Periodontal surgery and root planing are covered services.
- Crowns over implants are payable once per tooth in any five-year period.
- Antibiotic drug injections are covered services.
- Implants and related services are ***not*** covered services.
- Occlusal guards are ***not*** covered services.

Appendix B

Eligible Retiree Subsets (or Dependents) of Current and Former Participating Companies

- Marathon Petroleum Corporation
- Marathon Petroleum Company LP
- Marathon Petroleum Service Company
- Marathon Petroleum Logistics Services LLC
- Marathon Refining Logistics Services LLC
- Treasure Card Company LLC (a former participating company)
- Speedway LLC (a former participating company effective May 14, 2021)
  - Regular employees in Salary Grades 12 and above who retired on or after January 1, 2014, but prior to January 2, 2019
- Speedway Prepaid Card LLC (a former participating company effective May 14, 2021)
  - Regular employees in Salary Grades 12 and above who retired on or after January 1, 2014, but prior to January 2, 2019