Marathon Petroleum Exchange Health Reimbursement Account Plan

Effective January 1, 2020

Exchange Health Reimbursement

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Exchange Health Reimbursement

This document serves both as the Plan document and the Summary Plan Description ("SPD") for the Marathon Petroleum Exchange Health Reimbursement Account Plan. To the extent not preempted by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the provisions of this document shall be construed and governed by the laws of the State of Ohio.

I. Purpose

The purpose of the Marathon Petroleum Exchange Health Reimbursement Account Plan ("the Plan" or "EHRA") is to reimburse eligible age 65 and over retirees and certain eligible disabled employees and their eligible spouses for Medicare Supplemental Plan premiums and Health Care Expenses, which are not otherwise reimbursed. The Plan is intended to qualify as a self-funded medical reimbursement plan for purposes of Sections 105 and 106 of the Internal Revenue Code of 1986, as amended ("Code"), as well as a health reimbursement arrangement as defined in Notice 2002-45 and related guidance of the Internal Revenue Service. The EHRA will be administered and interpreted at all times in a manner consistent with such intent.

II. Eligibility Requirements

You are eligible to participate in this Plan if you fall into one of these eligible categories:

A. Eligible Retiree

An Eligible Retiree is a former Company employee who:

1. Is eligible for Medicare due to age or disability; and
2. As of date of retirement was (a) eligible for coverage under the Marathon Petroleum Health Plan or Retiree Health Plan or International Medical Plan; (b) age 50 or over with 10 years or more vesting service in the Marathon Petroleum Retirement Plan and, if hired on or after January 1, 2002, had at least 10 years of accredited service under the Marathon Petroleum Employee Service Plan; and
3. Was hired as a regular part-time or full-time employee (not a Casual employee) prior to January 1, 2008, or was:
    a. a Speedway Grade 12 or above retiree who was hired prior to January 1, 2008, and who retired on or after January 1, 2014, but prior to January 2, 2019; or
    b. a Speedway Grade 12 or above retiree who was a Speedway Grade 12 or above employee as of December 31, 2018, and who maintained legacy Grade 12 or above status up to date of your retirement, was hired or acquired prior to January 1, 2008, and retired on or after January 2, 2019.*

An Eligible Retiree also includes a Legacy Western Retiree who is eligible for Medicare due to age or disability. Refer to the Glossary for the definition of Legacy Western Retiree.

* For a former Company employee in this category who retires after January 1, 2019, the Company credit will be based on points accrued and frozen as of December 31, 2018 with respect to that employee.

B. Eligible LTD Recipient

An Eligible LTD Recipient includes an individual receiving long term disability ("LTD") benefits under the Marathon Petroleum Long Term Disability Plan who:

1. Is eligible for Medicare due to disability rather than age; and
2. Is not considered to be in "current employment status" pursuant to the Medicare Secondary Payer rules at 42 U.S.C. Section 1395y(b)(1)(B)(i); and
3. If disabled due to end stage renal disease within the meaning of 42 U.S.C. Section 1395y(b)(1)(C)), has received LTD benefits for more than 30 months.

C. Spouse of an Eligible Retiree and Eligible LTD Recipient

A Spouse, provided the Spouse has been continuously married to the Eligible Retiree or Eligible LTD Recipient since the date active employment with the Company ended. A Spouse who was previously a "Domestic Partner" (as designated and defined pursuant to requirements established in the Marathon Petroleum Company Affidavit of Domestic Partner Relationship form) is also eligible to participate, provided there was a continuous domestic partner relationship since the date active employment with the Company ended, and the legal marriage occurred before the Spouse became eligible for Medicare due to age or disability.

In addition, Spouse eligibility also requires that the Eligible Retiree/Eligible LTD Recipient be enrolled in one of the following: (a) the Marathon Petroleum Health Plan or Retiree Health Plan; (b) an individual policy offered through a private exchange; or (c) an approved alternative plan such as Veteran's Administration (VA) or TRICARE plan.

D. Spouse of Pre-65 Retiree*

The legally married Spouse of a Pre-65 Retiree is eligible if the Spouse is eligible for Medicare due to age or disability, provided the Spouse has been continuously married to the Pre-65 Retiree since the date the Pre-65 Retiree retired from the Company. A Spouse who was previously a "Domestic Partner" (as designated and defined pursuant to requirements established in the Marathon Petroleum Company Affidavit of Domestic Partner Relationship form) is also eligible to participate, provided there was a continuous domestic partner relationship since the date the Pre-65 Retiree retired from the Company, and the legal marriage occurred before the Spouse became eligible for Medicare due to age or disability.

* Refer to the Glossary for the definition of Pre-65 Retiree.

E. Surviving Spouse of an Active Employee and Eligible Retiree

A Participant who was the Spouse of a Company retiree remains eligible for this Plan as a Surviving Spouse following the death of the Company retiree. The Spouse of a deceased active employee who was hired as a regular part-time or full-time employee (not a Casual employee) prior to January 1, 2008, becomes an eligible Participant when such Spouse is eligible for Medicare due to age or disability.

Eligibility terminates if and when a Surviving Spouse remarries.

Notwithstanding any other provision of the Plan to the contrary, the following classes of individuals are not eligible to participate in the Plan:

1. Employees, retirees, and spouses of employees and retirees, who were hired, rehired, or whose employment type changed from casual to regular part-time or regular full-time on or after January 1, 2008,
2. Former LTD Recipients who stop receiving LTD benefits for any reason,
3. A Surviving Spouse who remarries,
4. A rehired retiree who returns to active employment and is eligible for coverage under the Marathon Petroleum Health Plan due to current employment status,
5. Spouses of employees eligible for coverage under the Marathon Petroleum Health Plan, even if the spouse is over 65 or eligible for Medicare due to disability, and
6. Any other individual not specified as eligible under paragraphs A. through E. above in this Section II.

III. Enrolling in Coverage

Eligible individuals will be given the opportunity to enroll in an individual policy offered through a private exchange as of the first day of the month they become eligible for Medicare. An option available is obtaining an individual health insurance policy through Via Benefits ("Via Benefits"), which is a private Medicare marketplace through which you may purchase individual Medicare supplemental plans such as Medigap, Medicare advantage, and Medicare Part D prescription drug plans, as well as vision and dental plans. Upon enrollment in a private exchange policy, the individual will be eligible for a subsidy provided by MPC and funded through a health reimbursement account ("HRA") administered by Via Benefits. Eligible individuals may inquire about their account by contacting Via Benefits via telephone at 855-535-7152 or online at www.my.viabenefits.com/marathonpetroleum.

IV. Health Reimbursement Account ("HRA")

A. Account

Once you are enrolled in the Plan, a hypothetical account ("Account") will be established for you. If your spouse is also a Participant, you will share one combined Account. Annually, at the beginning of the Plan Year, or when first eligible, MPC will credit to your Account a certain number of credits for each Participant, which you can then use to reimburse yourself for Health Care Expenses, including premiums ("Benefit Credits"). You and your spouse, if both Participants, will each receive a certain number of Benefit Credits, which will be credited to a combined Account.

B. Benefit Credits

The amount of Benefit Credits will be determined in the same manner as the "Non-Employee Group" Member Company subsidy calculation in the Marathon Petroleum Health Plan and Retiree Health Plan, using the 4% accrual method. The final accrual percentage obtained by the retiree upon their date of retirement will be used to determine the amount of the Benefit Credit for this Account. The final accrual percentage will be multiplied by the maximum annual Company contribution to determine the annual Benefit Credit to the EHRA for each Participant. The 2020 Company contribution to the EHRA will be $219.86 per month ($2,638.32 for the year), per Participant, for Participants who have reached the 100% accrual level. Annual increases will be based on the U.S. City Average for Medical Care Expenditures as provided in Table 1. Consumer Price Index for All Urban Consumers.

(CPI-U): U.S. City Average, by Expenditure Category and Commodity and Service Group (Medical Care Expenditures), (unadjusted percent change from June to June), but not to exceed 4% annually.

An eligible MPC retiree Participant married to another MPC retiree Participant will receive one Benefit Credit; if the Benefit Credit is different than their retiree spouse's Benefit Credit, the greater Benefit Credit accrued by either of the married retirees will be applied to both.

No additional subsidy points will be earned for purposes of EHRA funding for any Company employee who has less than a 100% subsidy of EHRA funding and who was hired, rehired or acquired on or after January 1, 2019.

C. Carryover

If a Participant has a balance in his or her Account at the end of the Plan Year, the balance will be carried over to following Plan Years.

D. Funding

The benefits provided under the EHRA shall be provided by the Company out of its general assets. No assets shall be segregated or earmarked for the purpose of providing benefits under this Plan. Nor shall any person have any right, title, or claim to such assets prior to payment under the terms of the Plan. Each Account established pursuant to the Plan shall be a hypothetical account which merely reflects a bookkeeping concept and does not represent assets that are actually set aside for the exclusive purpose of providing benefits to the Participant under the terms of the Plan or that are protected from the reach of the Company's creditors.

E. Death

In the event a Participant dies, survived by a spouse who is also a Participant on the date of death and who shares a combined Account with the deceased Participant, the surviving Participant may continue to file claims in the normal course and the Account balance shall continue. If a Participant dies and is not survived by a spouse who is a Participant on the date of death sharing a combined Account, the Participant's Account shall be immediately forfeited. However, the deceased Participant's estate or representative may submit claims for Health Care Expenses incurred prior to his or her death. Claims must be submitted within 180 days of the date of death, or if earlier, within 90 days from the Plan's termination.

V. Receiving Reimbursement From Your EHRA

A. Health Care Expenses

When you incur a qualifying medical expense, or pay insurance premiums, you can receive reimbursement for that expense from your EHRA. Expenses that may be reimbursed from your EHRA are referred to as Health Care Expenses. Health Care Expenses are expenses incurred by you, your spouse, or a dependent for medical care as defined in Code Section 213(d) and the rules, regulations and IRS interpretations thereunder. Health Care Expenses include premiums for health care insurance coverage and premiums for long-term care insurance coverage. See Appendix A for a list of some qualifying and non-qualifying medical expenses.

However, Health Care Expenses shall not include expenses reimbursed or reimbursable under any private, employer-provided, or public health care reimbursement or insurance arrangement or any amount claimed as a deduction on the federal income tax return of the participant or the participant's dependent, or any expenses excluded in Appendix A. In addition, Health Care Expenses shall include an expense incurred for a medicine or drug only if such medicine or drug is a prescribed drug (without regard to whether such medicine or drug is available without a prescription) or is insulin.

B. How to Receive Reimbursement

When you incur Health Care Expenses, you pay for the expenses directly to your health care provider and then submit a reimbursement request to Via Benefits. Health Care Expenses are incurred when the medical care is provided, not when you receive a bill, are charged for, or pay the expenses.

Health Care Expenses will be reimbursed from your Account if incurred after you became a member of this Plan and before your participation ends. Health Care Expenses up to the unused amount of Benefits Credits in your Account will be reimbursed.

You can activate direct deposit to receive reimbursements directly into your bank account. Otherwise, reimbursement will be made via check sent by regular mail. No benefits under this Plan shall be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement of Health Care Expenses.

You can also set up, through Via Benefits, automatic premium payments from your EHRA.

C. Submitting Claims for Reimbursement

You will need to provide Via Benefits with requested information to verify the Health Care Expense you seek to have reimbursed from your EHRA. Via Benefits may require that you submit a bill, receipt, cancelled check, or other written evidence of certification of payment or proof of your obligation to pay the Health Care Expense. The Plan Administrator reserves the right to verify to his/her satisfaction all claimed Health Care Expenses prior to reimbursement.

Each request for reimbursement shall include the following information:

1. The amount of the Health Care Expense for which reimbursement is requested;
2. The date the Health Care Expense was incurred;
3. A brief description and the purpose of the Health Care Expense;
4. The name of the person for whom the Health Care Expense was incurred and, if such person is not the Participant requesting reimbursement, the relationship of the person to such Participant;
5. The name of the person, organization or other provider to whom the Health Care Expense was or is to be paid;
6. A statement that the Participant has not been and will not be reimbursed for the Health Care Expense by insurance or otherwise, and has not been allowed a deduction in a prior year (and will not claim a tax deduction) for such Health Care Expense under Code Section 213; and
7. A written bill from an independent third party stating that the Health Care Expense has been incurred and the amount of such expense and, at the discretion of the Plan Administrator, a receipt showing payment has been made.

D. Timing of Reimbursements

Once Via Benefits receives and approves your Health Care Expense, reimbursement will generally be processed within approximately three to five business days. However, under federal regulations, reimbursements are permitted to take up to 30 days, with an additional 15 days if needed to conduct a review. Via Benefits will notify you if the additional 15 day period is needed. If this extension is needed because information was not provided that is necessary to review the claim, Via Benefits will describe the information needed. You will have up to 45 days from the date you receive the request for information to submit it. Once you provide the requested information, a determination will be made within 15 days from the date the Plan receives your information, or, if earlier, the deadline to submit your information.

If you are set up for direct deposit, you will generally receive reimbursement within three days of approval. If you receive reimbursement by check, you should receive it within 14 days.

E. Deadline for Submitting Claims for Reimbursement

Participants must submit claims for reimbursement for Health Care Expenses incurred prior to the date his or her participation in the Plan ends, within 180 days of the date participation in the Plan ceases.

VI. Appeal Procedures

Claims that are partially or wholly denied may be appealed to the Plan Administrator. Also, if you or your spouse has been denied eligibility to participate in this Plan, and you wish to request a review of the eligibility denial decision, you may appeal that decision to the Plan Administrator as well.

You or your duly authorized representative may appeal a denial of a claim by submitting a written request for review no later than 180 days after you receive notice of the denial to:

Plan Administrator
Marathon Petroleum Exchange Health Reimbursement Account Plan
539 South Main Street
Findlay, OH 45839

In furtherance of your appeal, you or your duly authorized representative may request to receive and review pertinent documents; and may submit issues and comments in writing. All such requests and written comments must be directed to the Plan Administrator.

A decision on review of a denied claim shall be made by the Plan Administrator not later than 60 days after the Plan Administrator's receipt of a request for review. The decision on review shall be in writing and shall include the specific reason(s) for the decision, including:

- The specific reasons for the adverse determination;
- Reference to specific plan provisions upon which the determination was made;
- State that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- Describe any voluntary appeal procedures offered by the plan and your right to obtain information about such procedures;
- Disclose any internal rule, guidelines, or protocol relied on in making the adverse determination (or state that such information will be provided free of charge upon request);
- If the denial is based on a medical necessity or experimental treatment or similar limit, explain the scientific or clinical judgment of the determine (or state that such information will be provided free of charge upon request; and
- Include a statement regarding your right to bring an action under Section 502(a) of ERISA.

You will also receive a notice if your claim on appeal is approved. Questions regarding any the procedures discussed above may be directed to the Plan Administrator.

VII. 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.

VIII. Finality of Decision and Legal Action

You 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.

IX. Termination of Coverage

Participation in the Plan continues until:

1. The Participant's death.
2. The Participant ceases to be eligible for Medicare.
3. A Spouse becomes divorced from an Eligible Retiree or Eligible LTD Recipient or Company Retiree.
4. A Surviving Spouse remarries.

5. An Eligible Retiree or Eligible LTD Recipient returns to current employment status and is eligible for group health plan coverage through employment.

6. Termination of the Plan.

   When participation ends, Participants receive no further Benefit Credits and any Health Care Expenses incurred thereafter will not be reimbursed under this Plan, even if unused credits remain in the Participant's Account. Participants may, however, submit claims for reimbursement for Health Care Expenses incurred prior to the date his or her participation ceased, provided such claims are filed within 180 days of the date participation in the Plan ceased.

X. COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), you or your eligible Spouse may be entitled to continuation of coverage under the Plan as a result of certain events that would otherwise cause you and/or your Spouse to lose EHRA coverage. Qualifying events would include divorce or legal separation, or a bankruptcy filing by the Company.

Continuation of coverage pursuant to COBRA requires payment of a monthly premium equal to 102% of the cost of the coverage, as determined by the Plan Administrator. The Plan Administrator will notify qualified beneficiaries of the applicable premium at the time of a qualifying event.

In the event of a divorce or legal separation, the Plan Administrator must be notified within 60 days of the qualifying event. Such notice must be provided to:

Marathon Petroleum Benefits Service Center
539 South Main Street
Room M-09-090
Findlay, OH 45840
1-888-421-2199 (phone)
1-419-421-3057 (fax)
benefits@marathonpetroleum.com

Also, please keep the Company apprised of any address changes for you and your spouse.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to the qualified beneficiary. COBRA continuation coverage is a temporary continuation of coverage, generally lasting for up to 36 months. However, coverage may end earlier upon the occurrence of any of the following events:

- The date the qualified beneficiary notifies the Plan Administrator that he or she wishes to discontinue coverage;
- The date any required monthly premium is not paid when due or during the applicable grace period;
- The date, after the date of the qualified beneficiary's election to continue coverage, that he or she becomes covered under another group health plan; or
- The date the Company ceases to provide any group health plan.

XI. Privacy

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. More information can be obtained regarding the use of PHI under HIPAA and the establishment of a security officer at http://www.mympcbenefits.com/Documents/MPC-HIPAA-Notice-of-Privacy-Practices.pdf.

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.

XII. Plan Administration

Important Plan Administration Information	
Plan Name	Marathon Petroleum Exchange Health Reimbursement Account
Effective Date	Plan commenced January 1, 2013
Plan Administrator (Agent for service of legal process)	Jonathan M. Osborne 539 South Main Street Findlay, OH 45839 Phone: (419) 422-2121
Employer Identification Number	31-1537655
Type of Plan	Welfare Benefit Plan
Plan Sponsor	Marathon Petroleum Company LP ("MPC") 539 South Main Street Findlay, OH 45840
Plan Number	572
Inspection of Plan Documents	Plan documents may be inspected by making a request at any Company Human Resources office or by writing to: Marathon Petroleum Company LP Benefits Administration 539 South Main Street Findlay, OH 45840
Plan Year	Ends on December 31, and its records are kept on a calendar year basis.
Plan Funding	Benefits are provided from the Company's general assets.
Third Party Administrator	Via Benefits P.O. Box 981155 El Paso, TX 79998-1155 Phone: (855) 535-7152 www.my.viabenefits.com/marathonpetroleum
Claims Submission Agent	Via Benefits P.O. Box 981155 El Paso, TX 79998-1155 Fax: (888) 211-9900

The Plan Administrator shall be responsible for the administration and interpretation of the Plan. In determining the eligibility of participants for benefits and in construing the Plan's terms, the Plan Administrator has the power to exercise discretion in the construction or interpretation of terms or provisions of the Plan, as well as in cases where the Plan instrument is silent, or in the application of Plan terms or provisions to situations not clearly or specifically addressed in the Plan itself. In situations in which 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 written administrative rulings, which, until revoked, or until superseded by Plan amendment or by a different administrative ruling, shall thereafter be followed in the administration of the Plan.

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

XIII. Legal Notices

A. Newborn's and Mothers Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

B. Notice regarding Women's Health and Cancer Rights Act

To the extent the Plan provides benefits with respect to mastectomy, it will provide, in the case of an individual who is receiving benefits in connection with a mastectomy and who elects reconstruction in connection with such mastectomy, coverage for all stages of reconstruction of the breast on which a mastectomy was performed, surgery and reconstruction of the other breast to provide a symmetrical appearance, prostheses, and coverage of physical complications at all stages of the mastectomy, including lymphedemas.

XIV. Further Information

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

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

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

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

E. Facility of Payment. If the Plan Administrator deems any person incapable of receiving benefits to which he or she is entitled by reason of minority, illness, infirmity, or other incapacity, it may direct that payment be made directly for the benefit of such person or to any person selected by the Plan Administrator to disburse it, whose receipt shall be complete acquittance therefor. Such payments shall, to the extent thereof, discharge all liability of the Plan Administrator, Plan Sponsor and the Company.

F. Lost Distributees. Any benefit payable hereunder shall be deemed forfeited if, after reasonable efforts, the Plan Administrator is unable to locate the Participant to whom payment is due.

G. Status of Benefits. Neither the Company nor the Plan Administrator makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state, or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state, and local income tax purposes and to notify the Plan Administrator or Company if the Participant has any reason to believe that such payment is not so excludable. Any Participant, by accepting a benefit under this Plan, agrees to be liable for any tax that may be imposed with respect to those benefits, plus any interest as may be imposed.

H. Applicable Law. The Plan shall be construed and enforced according to the laws of the state of in which the Plan Sponsor is domiciled, to the extent not preempted by any Federal law.

XV. Participation by Affiliates

Upon specific authorization and subject to such terms and conditions as it may establish, Marathon Petroleum Company LP may permit subsidiaries and affiliated companies to participate in the Plan. Currently, these participating companies include Marathon Petroleum Service Company, Marathon Petroleum Logistics Services, Marathon Refining Logistics Services LLC, and Treasure Card Company LLC.

For purposes of the Plan: (i) the term "Company" and other similar terms means Marathon Petroleum Company LP and, where the context requires, such participating affiliates; and (ii) the term "Employee" and other similar terms mean an eligible employee of Marathon Petroleum Company LP, and, where the context requires, an eligible employee of a participating affiliate.

XVI. Modification and Termination of the Plan

Marathon Petroleum Company LP reserves the right to modify 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 Marathon Petroleum Company LP for any reason.

XVII. Your Rights Under Federal Law

As a participant in the Marathon Petroleum Exchange Health Reimbursement Account Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended ("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 plans, 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 a 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 coverage 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 plans. The people who operate your plans, called "fiduciaries" of the plans, 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 plans, you should contact the respective 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.

Glossary

Legacy Western Refining Retiree means an individual who was a participant in, or eligible to be a participant in, the "Retiree Medical Plan Feature" of the Western Refining & Affiliated Companies Benefit Trust ("Western Refining Retiree Medical Plan") as of October 1, 2018, on account of having been either (a) a eligible ChevronTexaco Corporation transferee, or (b) a Giant Yorktown, Inc. retiree, each as further defined in the applicable plan document for the Western Refining Retiree Medical Plan as in effect on October 1, 2018.

Medicare means the Hospital and Supplemental Medical Insurance Plan established by Title XVIII of the Social Security Act of 1965, as amended.

Participant means any Eligible Retiree, Eligible LTD Recipient, or Spouse who has elected to purchase individual insurance coverage through a private exchange and receive Benefit Credits in an Account.

Pre-65 Retiree means former Company employees hired before January 1, 2008, and who are eligible for and enrolled in the Marathon Petroleum Retiree Health Plan.

Spouse means the legally married spouse of an Eligible Retiree or Eligible LTD Recipient who is eligible for Medicare due to age or disability and who was married to the Eligible Retiree/Eligible LTD Recipient as of the date of his or her retirement/disability.

Surviving Spouse means a Spouse of a deceased Eligible Retiree.

Appendix A

Qualifying and Non-Qualifying Medical Expenses

The following is not intended to be a complete list of Internal Revenue Service Qualifying Medical Expenses and non-Qualifying Medical Expenses. It is the Company's intention to allow such expenses according to IRS guidelines and as interpreted by Via Benefits. If you have questions concerning eligibility of medical expenses, contact your tax advisor and/or Via Benefits.

Expenses Allowed by the IRS

- Acupuncture
- Alcoholism or drug addiction treatment center, including meals and lodging
- Ambulance
- Artificial limbs
- Birth control products (male and female)
- Body scan
- Braille books and magazines
- Breast Reconstruction Surgery
- Chiropractic expenses
- Christian Science practitioner expenses
- Contact lenses
- Cost of medically necessary operations and related treatments
- Crutches
- Deductibles, coinsurance, co-payments and amounts exceeding medical and dental plan limits
- Dental expenses, including preventive, diagnostic, restorative, orthodontic, and therapeutic care
- Dentures
- Diagnostic fees
- Fees for healing services
- Fees of licensed osteopaths
- Health plan/benefit insurance premiums, including long-term care insurance premiums
- Hearing expenses, including examinations, hearing aids, and batteries

Exchange Health Reimbursement

- Home improvements motivated by medical consideration
- Hospital bills
- Insulin
- Laboratory fees
- Lead base paint removal for children with lead poisoning
- Life fee to retirement home for medical care
- Medical information plan
- Medical supplies
- Medicine and other drugs (prescribed), including birth control pills
- Membership fees in associations furnishing medical services, hospitalization, and clinical care
- Nurses' fees, including nurses' board and Social Security tax where paid by taxpayer
- Obstetrical expenses
- Orthopedic shoes
- Over-the-Counter products that ***do not*** *require a doctor's statement* or prescription may include wound care products such as bandages and gauze, thermometer, heating pad, and contact lenses solution.
- Over-the-Counter medications and products, which ***do*** require a doctor's prescription for treatment of a medical condition and which must be filled at pharmacy may include antacids, antibiotics, antifungals, antihistamines, cough medicines, decongestants, pain relievers, smoking cessation aids, homeopathic remedies, naturopathic remedies, dietary supplements, hair growth products, sleeping aids and weight loss products.
- Oxygen
- Physician fees
- Practical nurse fees
- Psychiatric fees and psychiatric care, including the cost of supporting a mentally ill dependent at a specially equipped medical center
- Psychoanalysis and psychologist fees
- Routine physicals and other non-diagnostic services and treatments
- Special communication devices for the hearing-impaired (telephone/television)
- Special education for the blind
- Special plumbing for the handicapped
- Sterilization fees
- Surgical fees

- Therapy received as medical treatments
- Transplants
- Transportation essential to obtain medical care (mileage, tolls, parking, taxi, bus, etc.)
- Tuition at special school for disabled person
- Tuition fees (part), if college or private school furnishes breakdown of medical charges
- Vaccines
- Vision correction surgery
- Vision expenses Examinations, eyeglasses, contact lenses, and seeing-eye dogs (and their upkeep)
- Weight-loss or stop-smoking program prescribed by a doctor
- Well baby and well child care
- Wheelchair and maintenance
- X-rays

Expenses NOT Allowed by the IRS

- Before-tax contributions to a medical or dental plan
- Cosmetic surgery-related expenses including doctor, surgical, hospital, supplies, etc.
- Diaper service
- Divorce expense (even if recommended by physician)
- Funerals and burials
- General counseling (e.g., family, marital or couple)
- Hair transplants and hair removal
- Health club dues/memberships
- Household and domestic help expenses (even though recommended by a physician due to an employee's or dependent's inability to perform physical housework)
- Lens replacement insurance
- Lessons (swimming, dancing, gymnastics, aerobics, etc.)
- Liposuction
- Maternity clothes
- Medical procedures performed solely for cosmetic reasons
- Nutritional supplements (without doctor's statement)

Exchange Health Reimbursement

- Over-the-counter medications (unless prescribed by a doctor and filled at a pharmacy) which may include antacids, antibiotics, antifungals, antihistamines, cough medicines, decongestants, pain relievers, smoking cessation aids, homeopathic remedies, naturopathic remedies, dietary supplements, hair growth products, sleeping aids and weight loss products
- Physical therapy treatments for general well-being
- Supplements prescribed by a naturopath or chiropractor (even if the services are covered)
- Teeth whitening
- Toiletries such as toothpaste, shampoo, etc.
- Vitamins (without doctor's statement)
- Expenses claimed as a deduction or credit for federal or state income tax purposes
- Expenses reimbursed under another flexible spending account program
- Expenses reimbursed through another benefit program or another employer
- Expenses reimbursed through Medicare or another government program

Contact Via Benefits if you have any questions.
1-855-535-7152