Long Term Disability Plan

Marathon Petroleum
Long Term Disability Plan

January 1, 2020

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Long Term Disability Plan

I. Purpose

Recognizing the severe economic hardship that results from loss of earnings over a long period of time, the Company offers long term disability coverage as part of its employee benefits program.

Long term disability coverage provides the member with income during extended periods of disability, whether caused by accident or sickness, whether occupational or non-occupational, whether incurred inside or outside the United States.

The Marathon Petroleum Long Term Disability Plan (Plan) is a self-funded plan operated and governed in its entirety by the federal Employee Retirement Income Security Act of 1974 (ERISA). ERISA preempts state law pursuant to Section 514 of ERISA.

II. Eligibility

An employee is eligible to become a member of this plan provided the following are met:

1. The employee is a Regular employee who works on a “full-time” or “part-time” basis. For purposes of eligibility, Regular Full-time means the employee has a normal work schedule of at least 40 hours per week, or at least 80 hours on a bi-weekly basis.

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

2. The employee is not eligible to participate in another long term disability plan toward which the Company makes contributions, or for which the Company provides benefits.

3. Regular employees who work on a full-time or part-time basis must be specifically designated as such by the Company to be eligible to participate in the plan. Casual employees, any other employees not normally scheduled to work at least 40 hours per week, and all other common law employees who have not been designated by the Company as Regular employees who work on a full-time or part-time basis are excluded from eligibility to participate. Specifically excluded from eligibility to participate in the plan are any individuals who have signed an agreement, or have otherwise agreed to provide services to the Company as an independent contractor, regardless of the tax or other legal consequences of such an arrangement. Also specifically excluded are leased employees compensated through a leasing entity, whether or not the leased employee falls within the definition of “leased employee” as defined in Section 414(n) of the Internal Revenue Code.

III. Joining the Plan

Eligible employees hired or rehired on or after January 1, 2010, are automatically enrolled for coverage under this Plan.

Eligible employees hired prior to January 1, 2010, and enrolled in this Plan as of December 31, 2009 are insured for coverage.

Eligible employees hired prior to January 1, 2010, and not enrolled in this Plan as of December 31, 2009, may apply for membership and will be required to provide evidence of insurability.

IV. Effective Date of Coverage

An eligible employee shall become a member of this Plan on the applicable participation dates as outlined below, provided the employee is actively at work.

1. Initial Enrollment

Coverage will be effective on the first day of employment.

2. Late Enrollment

Employees who have previously waived participation must submit a completed evidence of insurability application to the Third Party Administrator and may need to undergo a physical examination before coverage can become effective. The evidence of insurability application must be returned within 30 days from the date it is mailed to the employee. Should an exam be deemed necessary, the Third Party Administrator will arrange for the exam to be performed by an approved examiner at no cost to the employee. Employees may be examined by a physician of their choice, but such exam will be totally at the employee's expense. If the Third Party Administrator approves the results of the physical examination, participation is effective on the date of the physical examination. To late enroll in the plan, the employee should call the Benefits Service Center (1-888-421-2199) for the necessary procedures to follow.

3. Actively At Work

If the employee is not actively at work on the date that coverage would normally become effective, coverage will become effective on the day the employee returns to work.

V. Waiver of Coverage

A member may waive coverage under the Plan at any time by contacting the Benefits Service Center at 1-888-421-2199. A member may rejoin the plan, subject to the procedures listed under Section III and IV above.

VI. Cost

The Company pays the full cost of the Plan.

VII. Definition of Disability

During the First Two Years of Disability — The member is wholly and continuously disabled to the extent that the member is unable to perform the essential functions pertaining to their own occupation with or without a reasonable accommodation.

After the First Two Years of Disability — The member is wholly and continuously disabled to the extent that the member is unable to engage in any occupation or perform any work for gainful compensation or profit for which they are, or may become, reasonably qualified by education, training, or experience.

Successive Periods of Disability — Successive periods of disability are considered as one period of disability:

1. If they arise from the same or related causes and are separated by less than three months of continuous active employment, or
2. If they arise from different or unrelated causes and are not separated by return to active employment.

VIII. Claim and Appeals Procedure

The Plan has established procedures to handle claims for benefits from members as well as any appeal which a participant might file as a result of their claim being denied in whole or in part.

1. **Initial Claim** — The Third Party Administrator is retained by the Plan Administrator to interpret all initial claims for benefits under the Plan on behalf of the Plan Administrator. Claims must be submitted on forms provided by the Plan along with supporting documentation to the Third Party Administrator at the current address listed on the form.

   Determination of the claim will be based on the information provided in the claim form along with the supporting documentation, including medical documentation. The member is responsible for providing objective medical evidence of disability and must attach it to the Claim. Social Security disability determinations are not considered to be conclusive evidence of disability under this Plan and will not be given special weight in any Plan claim for benefits and/or appeal.

   All claims information, including the member's supporting documentation and other available data, will be forwarded to the Third Party Administrator who will notify the member of the decision made on their claim within 45 days of the day the Claim was initially received by the Plan. No application will be considered until all required completed forms are submitted to the Third Party Administrator. The Third Party Administrator may require more time to review a claim if necessary due to circumstances beyond its control. If this happens, the member will be notified in writing that the review period has been extended for up to two additional periods of 30 days. If the extension is needed because the member must provide additional information, these 30-day periods will begin when the additional information is received by the Plan. Members have 45 days to provide any requested additional data to the Plan.

During the review period, the Plan may require a medical examination of the member, at the Plan's expense; or the Plan may request additional information regarding the claim. If a medical examination of the member is required, the member will be notified of the name or names of the examining physician or physicians and the time and place of the examination. Failure to appear for, or submit to, a medical examination shall result in the termination of a Member's claim. As a result of a medical examination it may be necessary for a member who has filed a claim to provide supplementary information to fully complete the initial claim for benefits. The Third Party Administrator has 45 days from the date that the Plan receives the member's fully completed claim for benefits to render a decision as to whether benefits are payable under the Plan. Medical examinations may include psychological examinations.

If a claim is denied, in whole or in part, the member must receive a written notice from the Plan within the 45-day review period (or within 75 or 105 days if the review period was extended). The Plan's written notice must include the following information:

- The specific reason(s) the claim was denied, including an explanation of the basis for disagreeing with or not following the views presented by the claimant to the plan of health care professional treating the claimant and vocational professionals who evaluated the claimant, the views of medical or vocational experts whose advice was obtained on behalf of the plan, and any disability determination presented by the claimant to the plan made by the Social Security Administration.
- Specific reference to the Plan provision(s) on which the denial was based.
- Any additional information required for the member's claim to be reconsidered, and the reason this information is necessary.
- Identification of any internal rule, guideline or protocol relied on in making the claim decision (or that none exist), and an explanation of any medically-related exclusion or limitation involved in the decision.
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.
- A statement informing the member of his or her right to appeal the decision, and an explanation of the appeal procedure, as outlined below.

2. **Appeals Procedure** — Whenever a claim is denied, a Member has the right to appeal the decision to the Plan Administrator, who is the Plan's named fiduciary, or an Assistant Plan Administrator or another person or entity appointed by the Plan Administrator to act as fiduciary in reviewing appeals under this Plan. The member (or the member's duly authorized representative) must make a written request for appeal to the Plan within 180 days from the date the member received the denial. Members failing to make this request within 180 days waive their right to appeal. The appeals should be sent to the Plan Administrator as follows:

    Plan Administrator
    Marathon Petroleum Long Term Disability Plan
    539 South Main Street
    Findlay, OH 45840

Once the member's request has been received by the Plan, a prompt and complete review of the member's claim must take place. This review will give no deference to the original claim decision, and will not be made by the person or persons who made the initial claim decision. During the review, the member (or the member's duly authorized representative) has the right to review any documents that have a bearing on the claim, including the documents which establish and control the Plan. Any medical or vocational experts consulted by the Plan will be identified. The member may also submit issues and comments that he or she feel might affect the outcome of the review. The Plan Administrator shall provide the member, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan as soon as possible and sufficiently in advance of the date on which the final determination is made so that the member may have a reasonable opportunity to respond to such additional evidence. In addition, prior to issuing a final determination based upon a new or additional rationale, the Plan Administrator will provide the member, free of charge, with the rationale, also sufficiently in advance of the date on which the final determination is made so that the member may have a reasonable opportunity o respond.

The Plan has 45 days from the date it receives the member's request to review the claim and notify the member of its decision. Under special circumstances, the Plan may require more time to review the claim. If this should happen, the Plan must notify the member, in writing, that its review period has been extended for an additional 45 days. Once its review is complete, the Plan must notify the member, in writing, of the results of the review and indicate the Plan provisions upon which it based its decision. In the case of a denial of benefits after an appeal to the Plan Administrator, such written notification will also include the same information listed above for a denial upon initial review.

The Plan Administrator has the final authority in resolving questions concerning benefits under the plan. Members retain the right to seek remedies through a civil action under Section 502(a) of ERISA in the event the member's appeal is denied by the Plan.

3. **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.

IX. Time Limit for Filing an LTD Claim

All claims for injury or illness must be filed by the first anniversary of the date of disability for any benefits to be paid. Members who file claims after the deadline are not eligible for benefit payments.

X. Mandatory Rehabilitation Assessment

Eligibility for benefits under this plan is conditioned upon the member taking part in, and successfully completing, a mandatory Rehabilitation Assessment conducted by individuals or organizations designated by the Third Party Administrator.

The initial component of the mandatory Rehabilitation Assessment will consist of the Third Party Administrator reviewing each claim for benefits to determine potential for vocational rehabilitation training. If, in the opinion of the Third Party Administrator, a potential claimant is not a candidate for vocational rehabilitation, no further action will be taken, the potential claimant will not be contacted, and the Rehabilitation Assessment will be considered complete.

If, in the opinion of the Third Party Administrator, a potential claimant is a candidate for vocational rehabilitation training, they will be contacted by a representative of the Third Party Administrator for their active completion of the mandatory Rehabilitation Assessment process. Participation in the plan will be permanently denied (for the purpose of the claim under review) if the member refuses to take part in, or complete, the Rehabilitation Assessment.

XI. Benefits During Rehabilitation

A member receiving Long Term Disability (LTD) benefits may be eligible for employment in a rehabilitative status. Rehabilitative status is voluntary and must have the written approval of the Third Party Administrator. While the member is in rehabilitative status, monthly benefits will be reduced by 50% of any earnings received for each month. The rehabilitative status is initially approved as a three-month period, but may be extended by the Third Party Administrator for not more than a total of twelve months for one period of disability. Employment on rehabilitative status is limited only to non-participating employers in the Marathon Petroleum Company LP benefit plans.

XII. Basic Disability Benefits

For LTD benefit payments commencing on or after January 1, 2002, the amount of the gross monthly benefit shall be 60% of the member's monthly base pay.

Monthly base pay as used in this plan shall mean the compensation paid to an employee by the Company at the basic rate for their Regular Full-time or Regular Part-time principal occupation while a member of this plan, under rules uniformly applicable to all employees similarly situated. Base pay includes scheduled overtime and Geographic Pay Differential. Unscheduled overtime, shift differential, premium pay, commissions, bonuses, Success Through People (STP) payments, Annual Cash Bonus (ACB) payments, suggestion awards, military pay, travel pay, signing payments made as a result of the collective bargaining process, or similar payments shall be excluded.

Monthly base pay shall include contributions to the Thrift Plan's Pre-Tax Account, contributions made under the Contribution Conversion Plan (CCP), and contributions to the Health Care Flexible Spending Account (HCFSA).

This benefit is subject to a maximum monthly limit of $12,000 and will be reduced by the sum of the following:

1. Any disability payments from any other benefit plan toward which the Company has made contributions or provided the benefit. This does not include benefits from the Accidental Death and Dismemberment Insurance Plan.

2. Any disability payments which the member or the member's family is currently entitled to receive because of the member's disability under any Governmental, Social Security, (for Social Security only, disability payments currently received by the member's family are not offset), Workers' Compensation, or any other disability act, including the Federal Jones Act and Longshore and Harbor Workers' Compensation Act. For purposes hereof, the member's Social Security retirement benefit at age 65 or older replaces the member's Social Security disability benefit.
3. Any Social Security retirement benefits which are voluntarily received by the disabled member in lieu of Social Security disability benefits.
4. 50% of any earnings the member receives from employment while in a rehabilitative status as discussed under "Benefits During Rehabilitation."
5. Amounts paid to the member because of loss of earnings or earning capacity through settlement, judgment, arbitration or otherwise, regardless of whether liability is determined.

For LTD benefit payments commencing prior to January 1, 2002, the amount of the gross monthly benefit shall be either:

1. 60% of the member's monthly base pay, or
2. 70% of the member's base pay, if the disabled member has a child or children entitled to Social Security child's benefits by reason of the member's disability.

This benefit is subject to a maximum monthly limit of $6,000 and will be reduced by the sum of the following:

1. Any disability payments from any other benefit plan toward which the Company has made contributions or provided the benefit. This does not include benefits from the Accidental Death and Dismemberment Insurance Plan.
2. Any disability payments which the member or the member's family is currently entitled to receive because of the member's disability under any Governmental, Social Security, Workers' Compensation, or any other disability act, including the Federal Jones Act and Longshore and Harbor Workers' Compensation Act. For purposes hereof, the member's Social Security retirement benefit at age 65 or older replaces Social Security disability payments.
3. Any Social Security retirement benefits which are voluntarily received by the disabled member in lieu of Social Security disability benefits. This reduction of LTD includes any Social Security retirement benefits voluntarily received by dependents whose eligibility for such benefits is contingent upon the Social Security record of the disabled member.
4. 50% of any earnings the member receives from employment while in a rehabilitative status as discussed under "Benefits During Rehabilitation."
5. Amounts paid to a member because of loss of earnings or earning capacity through settlement, judgment, arbitration or otherwise, regardless of whether liability is determined.

When any of the above offsetting payments are made in the form of a lump sum (including those under the Federal Jones Act, and the Longshore and Harbor Workers' Compensation Act), the below applies.

Members must furnish immediate notice to the Plan of their receipt of retroactive lump sum awards, and return to the Plan such amounts that would have been offset under the Plan had payments been awarded in a timely manner to be offset from LTD benefit payments. In no event, however, will the amount requested for return to the Plan exceed the lump sum award received. Such amounts must be returned to the Plan within 90 days of the member's receipt of the award. Failure to do so will result in the employee being permanently denied participation in the LTD Plan.

XIII. Recovery of Overpayments

Whenever payments have been made by the LTD Plan in excess of the maximum amount of payment authorized by the terms of the LTD Plan, or when a Plan participant has refused to reimburse the Plan the amount of any overpayments, the Plan or its designee has the right to recover these excess payments or withhold payment of future benefits to offset such excess payments, and the member has the obligation to refund to the LTD Plan any such amount.

An overpayment occurs when it is determined that the total amount paid on a member's claim is more than the total of the benefits due under the Plan. This includes any overpayments resulting from:

- Retroactive awards received from sources shown in Section XII above;
- Fraud; or
- Any error made in processing a claim.

The LTD Plan or its designee may withhold or offset future benefit payments, sue to recover such overpayment, or use any other lawful remedy to recoup any such overpayment.

XIV. Subrogation Rights and Member Obligation to Reimburse

By submitting a claim for benefits under the Plan, a member also agrees to give immediate written notice to the Plan Administrator of any legal proceeding against a third party relating to the injury or illness for which benefits are paid. In the event benefits are paid by the Plan and the member who received the benefit receives a recovery (whether by settlement, judgment or otherwise) for lost employment compensation from any person or entity as a result of the injury or illness, then the Plan shall have a lien upon that recovery to the extent such recovery represents lost compensation upon which the Plan's benefit payments were based. A member by submitting a claim for benefits under the Plan agrees to reimburse the Plan for any recovery the individual received from a third party up to the amount of benefits paid by the Plan; provided however, that in no event shall the member be required to make reimbursement in an amount exceeding the recovery made by the member against the person or entity from whom the recovery was obtained. Participation in the Plan will be permanently denied if a member refuses to make reimbursement to the Plan.

The Plan reserves the right to assert a subrogation claim in such a legal proceeding or bring an independent action directly against the third party believed to be responsible for the injury or illness.

XV. Special Benefit Adjustment Rules

1. For an LTD recipient who became disabled on or after January 1, 1989:

   a. the amount by which the recipient's LTD benefit is reduced for Social Security is the Social Security amount in force at the time LTD benefits commence and is not adjusted to reflect any future Social Security cost-of-living increases or decreases, and

   b. no adjustments will be made to the recipient's LTD benefit to reflect general economic increases or decreases made by the Company.

2. The member should complete the process for obtaining a Social Security disability award. If an employee does not apply for Social Security disability benefits, the Plan may offset LTD benefits payable from the Plan by the estimated maximum amount of Social Security payments to which the member would be entitled if the member applied for Social Security disability benefits and the application was approved.

   Retroactive adjustments will be made to the benefit payable from the Plan based on Social Security's approval or denial of payments.

3. The member is required to file an appeal or file a new application with Social Security if Social Security benefits are denied and the Third Party Administrator believes that an appeal may be successful. If the member does not file an appeal, the amount of the member's benefit will be offset by the amount of Social Security payment to which the member would have been entitled if the member had filed an appeal and the appeal had been successful.

   Expenses incurred for engaging outside firms, independent of the Third Party Administrator, and attorney fees incurred by the Third Party Administrator, to pursue Social Security filings, appeals and awards are included in the approved administrative costs for operating the plan.

XVI. Duration of Benefit

A member's LTD disability date is effective and benefits commence as of the earlier of the following dates:

- Six months following the date that the employee is or was no longer able to perform his or her own occupation or work a reduced leave schedule; or
- The first day following an accumulated six (6) months of disability absence within a nine-month period immediately preceding the last full day worked [considered four (4) or more hours], provided that the absence has been for the same or related disability in accordance with the Successive Periods of Disability provision of the LTD Plan. If six (6) months of disability absence has not been accumulated over the previous 9-month period as of the last day worked, the benefit start date will be delayed until a total of six (6) months of disability absence has been accumulated.

The benefit continues until the first of the following occurs:

1. The member dies.

2. The member ceases to be disabled as defined in this plan, and has been given advanced notice of the upcoming claim closure. If the member ceases to be disabled as defined in this plan and is unaware that the claim is closing for reasons other than those below, then the member will receive an additional two weeks of benefits beyond the effective closing date of the claim.
3. The member ceases to furnish adequate medical proof of the continuance of disability or fails to meet any other requirements under the plan including, but not limited to, those described in Articles XII, XIII and XIV above.
4. The member refuses to submit to medical or psychological examination requested by either the Third Party Administrator or the Plan Administrator.
5. The member fails or refuses to take steps to expedite their recovery.
6. The member is no longer under the direct care of a legally qualified physician to treat the sickness or injury for which the claim is made under the Plan.
7. The member is no longer following the recommended course of treatment.
8. The member engages in work for gainful compensation or profit (other than employment while in a rehabilitative status as discussed under “Benefits During Rehabilitation”).
9. The member fails to make reimbursement to the Plan for an overpayment, therefore LTD participation coverage ceases.
10. The end of the month in which the member reaches age 65, provided they become disabled prior to their 60th birthday.
11. The member receives benefits for five years, provided they become disabled on or after their 60th birthday, but before their 66th birthday.
12. The member receives benefits for the period of time specified in the following chart:

Disabled	Length of Benefit
On or after their 66th birthday, but before their 67th birthday	4 years
On or after their 67th birthday, but before their 68th birthday	3 years
On or after their 68th birthday, but before their 69th birthday	2 years
On or after their 69th birthday	1 year

For LTD benefit payments commencing prior to January 1, 2010, although the months during which an employee member is receiving benefits under the terms of the LTD Plan are counted toward the 24-month maximum duration under the Sick Leave Policy, this maximum duration of sick leave is not applied while an employee member is receiving benefits under the terms of the LTD Plan (including the time while an employee is appealing the denial of such benefits).

For members of the Plan with dates of disability on or after January 1, 2010, upon termination of employment, payments will continue for the duration as described above, provided the member remains wholly and continuously disabled and otherwise satisfies the requirements, as stated above.

An individual on a Sick Leave receiving LTD benefits, or an individual whose LTD benefits are terminated, is not guaranteed re-employment with the Company. If no suitable work is available, the individual will be considered for retirement or termination.

XVII. Limitations

No benefits are payable for disabilities resulting from any of the following:

1. Self-inflicted injuries if intentional or inflicted while insane; or
2. Participation in committing a felony; or
3. War in which the United States is a participant.

In addition, a member may be disqualified from benefits under this plan during any period of time when, in the absence of a disability, they are otherwise unable to work due to other reasons (such as confinement in a jail, prison, etc.).

No benefits are payable if the employee separates employment, regardless of reason, prior to an LTD effective date and submission of required completed forms.

XVIII. Continuation of Coverage

If a member is granted a Sick Leave the member may continue coverage for six months.

If a member is granted a Military Leave to perform "service in the uniformed services" as defined under the Uniformed Services Employment and Re-employment Rights Act of 1994, participation for coverage in the LTD Plan may be continued during the Military Leave subject to the provisions of the Act. If an employee chooses not to retain coverage while on a Military Leave, upon the employee's return to work, the employee's coverage must be restored to at least the same level and terms as were provided when the Military Leave began, subject to any changes in benefit levels that may have taken place during the Military Leave affecting the entire workforce, unless otherwise elected by the employee. Therefore, the restored employee shall not be required to meet any qualification requirements such as passing a medical examination.

If a member is granted a Family Leave or Personal Leave, participation for coverage in the LTD Plan may be continued during the Family Leave or Personal Leave. If an employee chooses not to retain coverage during the leave, upon the employee's return to work, the employee's coverage must be restored to at least the same level and terms as were provided when Family Leave began, subject to any changes in benefit levels that may have taken place during the Family Leave affecting the entire workforce, unless otherwise elected by the employee. Therefore, the restored employee shall not be required to meet any qualification requirements such as passing a medical examination.

If a member is granted an Educational Leave, participation for coverage in the LTD Plan will be suspended during the Educational Leave. Upon the employee's return to work, the employee's coverage must be restored to at least the same level and terms as were provided when the Educational Leave began, subject to any changes in benefit levels that may have taken place during the Educational Leave affecting the entire workforce, unless otherwise elected by the employee. Therefore, the restored employee shall not be required to meet any qualification requirements such as passing a medical examination.

If a member is granted a leave of absence for other reasons, the Company may permit the member to continue coverage in accordance with the administrative provisions applicable to such leave of absence.

XIX. Participation in Other Benefit Plans

The member's participation in other Company-sponsored benefit plans while receiving benefits under this Plan is governed by the specific terms of those plans. For benefit participation, please refer to the following link at www.myMPCbenefits.com: http://www.mympcbenefits.com/Documents/MPC-BenStat-For-Lvs.pdf.

XX. Termination of Coverage

The member's coverage under this Plan will terminate when the first of the following occurs:

1. The member ceases to be a Regular employee who works on a "full-time" or "part-time" basis, or retires.
2. The member begins participating in another long term disability plan toward which the Company makes contributions or provides the benefit.
3. The member can no longer continue coverage under the provisions of a particular leave of absence.

A member may rejoin the Plan, subject to the procedures listed under Section III and IV above.

XXI. Miscellaneous

Assignment of Benefits — No assignment by a member of any of the benefits under this Plan will be valid or recognized by the Company, the Plan Administrator, or Third Party Administrator.

Payments in Case of Incompetency — If any member entitled to any benefit under the Plan shall be legally, physically, or mentally incapable of receiving or acknowledging payment of such benefit, the Third Party Administrator may, upon receipt of satisfactory evidence of such incapacity, in its discretion, cause such benefits to be paid to some other person, persons or institution on behalf of the person entitled to such benefit.

Unclaimed Payment — If within 5 years after any amount becomes payable hereunder to a Participant, (including time under the predecessor Plan, the Long Term Disability Plan of Marathon Oil Company) the same shall not have been claimed, provided due and proper care have been exercised by the Third Party Administrator and the Corporation in attempting to make such payments by providing notice at the Participant's last known address, the amount thereof shall be forfeited and shall cease to be a liability of the Plan. In such case, the amount thereof shall be retained by the Plan and used to pay other Plan benefits and expenses. Provided that the claimant initially made a timely claim, the claimant shall have the right and responsibility to re-establish their claim for payment with the Corporation by providing due proof that such amount is owed to the Participant.

XXII. Participation by Other Companies and Employees

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

The term “Company” and other similar words shall include Marathon Petroleum Company LP and such affiliated organizations. The term “employee” and other similar words shall include any eligible employee of these companies.

XXIII. Modification and Discontinuance of 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.

XXIV. Further Information

This text is intended to describe the Long Term Disability 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 Third Party Administrator will make determinations concerning eligibility for benefits under this plan.

Important Plan Administration Information	
Plan Name	Marathon Petroleum Long Term Disability Plan
Plan Administrator (Agent for service of legal process)	Jonathan M. Osborne P.O. Box 1 539 South Main Street Findlay, OH 45839-01 Phone: (419) 422-2121
Employer Identification Number	31-1537655
Type of Plan	Disability Benefits Plan
Plan Sponsor	Marathon Petroleum Company LP 539 South Main Street Findlay, OH 45840
Plan Number	559
Inspection of Plan Documents	Plan documents may be inspected by making a request at any Company Human Resources office or by writing: 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 made from the Company's general assets.
Third Party Administrator	Matrix Absence Management

The Company, as the Plan Sponsor, has appointed Jonathan M. Osborne as Plan Administrator and Named Fiduciary. The Company shall appoint assistant administrators as may be deemed necessary.

In determining the eligibility of a participant for benefits and in construing the Plan's terms, the Plan Administrator (or the Third Party Administrator in cases where it has the authority to make determinations concerning eligibility for benefits) has the power to exercise discretion in the construction of doubtful, disputed, or ambiguous terms or provisions of the plan, 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 evidence (i) the exercise of such discretion, or (ii) any other type of decision, directive, or determination they may make 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 the Third Party Administrator in cases where it has the authority to make determinations concerning eligibility for benefits) made on all matters within the scope of their authority shall be final and binding upon all persons, including the Company, any trustee, 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.

XXV. Participant Rights Under the Employee Retirement Income Security Act of 1974 (ERISA)

As a participant in the Marathon Petroleum Long Term Disability 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 the Plan 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 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 operation of the plan, including insurance contracts, and copies of the latest annual reports (Form 5500 Series) and updated summary plan descriptions. The administrator may make a reasonable charge for the copies.

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

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 employee benefit plan. The individuals who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

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

Assistance With Questions

If a plan participant has any questions about the plans, such participant should contact the respective plan administrator. If a plan participant has any questions about this statement or about rights under ERISA, or needs assistance in obtaining documents from the plan administrator, a plan participant should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in a 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. Certain publications about rights and responsibilities under ERISA can be obtained by calling the publications hotline of the Employee Benefits Security Administration.