Marathon Petroleum
Health Reimbursement Account Plan

IMPORTANT NOTICE:
This plan will terminate effective at the close of December 31, 2021. Additional details as to the plan's termination are provided in this document.

Amended and Restated
January 1, 2021

Health Reimbursement Account Plan

Table of Contents

Health Reimbursement Account Plan

This document serves as the Plan document and the Summary Plan Description ("SPD") for the Marathon Petroleum Health Reimbursement Account Plan (the "Plan").

I. Introduction

Marathon Petroleum Company LP (the "Company") is the Plan's sponsor. The Plan is frozen. Specifically, effective January 1, 2016, no additional amounts will be credited to Participants' Plan health reimbursement accounts ("HRA") after December 31, 2015, and only Employee and Retiree Participants with existing balances in their HRA as of that date are eligible to participate in this Plan. 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 (the "Code"), as well as a health reimbursement arrangement as defined in Internal Revenue Service Notice 2002-45 and related guidance published by the Internal Revenue Service. The expenses reimbursed under the Plan are intended to be eligible for exclusion from Participants' gross income under Code Section 105(b). The Plan is a limited scope excepted benefit plan within the meaning of 45 Code of Federal Regulations Section 146.145(b), such that only eligible dental and vision expenses may be reimbursed from Participants' HRAs; provided, however, that Retirees with HRA balances may also receive reimbursement for retiree health plan coverage premiums, the Retiree portion of the Plan is a retiree-only plan and not available to any current Employee.

The Plan will terminate effective at the close of December 31, 2021. Claim reimbursements will be permitted for eligible expenses incurred through December 31, 2021, provided Participants submit claims no later than May 31, 2022. No reimbursement will be made for any expenses incurred after December 31, 2021. The Plan will close following processing of final claims, and Participants' HRA balances, if any, will be forfeited.

II. Eligibility

The following classes of Employees and Retirees are eligible to participate in the Plan ("Participants"):

1. Employees with a balance in a Plan HRA as of January 1, 2016. This eligible group includes LTD Terminated Employees with a balance in a Plan HRA as of January 1, 2016, provided they remain eligible for long term disability benefits under the Marathon Petroleum Long Term Disability Plan.
2. Retirees with a balance in a Plan HRA as of January 1, 2016.

"Employee" means an individual employed by the Company.

"LTD Terminated Employee" means an individual receiving benefits under the Marathon Petroleum Long Term Disability Plan whose employment with the Company has been terminated.

"Retiree" means a former Employee eligible for benefits under the Marathon Petroleum Retirement Plan. "Retiree" shall not mean in any instance any current active employee, including rehires, of the Company.

III. Limited Scope Benefits

Participants with HRA balances can receive reimbursement from the Plan up to the remaining balance in their HRA for eligible dental and vision expenses incurred by the Participant and his or Covered Dependents.

"Covered Dependent" means a Participant's spouse to which he or she is legally married and also includes a Participant's child under age 26 who is considered a dependent under Code Sections 52 and/or 213(d)(5)). "Spouse" means the individual who is legally married to a Participant, and also includes a common law spouse established under the laws of a state in which common law marriage is legal and for which member can provide confirmation of such common law marriage as required in the Marathon Petroleum Affidavit of Common Law Marriage form.

Eligible expenses include dental and vision expenses that are not paid by an insurer, claims administrator, or other third party payer on the participant's behalf. Such expenses may include:

- Copayments for dentist and optometrist visits
- Coinsurance for dental or orthodontia services
- New eyeglasses
- Lasik surgery
- Dentures
- Teeth cleaning, fluoride treatments, sealants, x-rays, fillings, extractions, braces

Services or procedures performed purely for cosmetic purposes may not be reimbursed from the HRA, including teeth whitening. Eligible dental and vision expenses are defined in Code Section 213(d). A Participant may consult Internal Revenue Service Publication 502 for clarification, or seek advice from a tax advisor, as to which dental and vision expenses may be eligible for reimbursement under the Plan.

IV. Retiree Only Plan Benefit

Retiree Participants with positive balances in their HRA as of the date of retirement from the Company are additionally eligible to receive reimbursement from their HRA for the cost of retiree health plan coverage premiums (the "Retiree Only Plan Benefit"). If a Retiree is rehired by the Company, he or she will not be eligible for the Retiree Only Plan Benefit during the period of his or her employment with Company.

V. Other Plan Features

The Plan Administrator has established a recordkeeping account for each Participant, which is the Participant's HRA.

Participant HRAs are credited entirely with Company contribution credits denominated in dollars. No additional Company contribution credits will be made to Participants' HRAs after December 31, 2015. No money shall actually be allocated to any Participant's HRA; all amounts credited to Participants' HRAs are of a memorandum nature, maintained by the Plan Administrator for accounting purposes, and shall not be representative of any identifiable trust assets or other funded amount. No interest will be credited to or paid on amounts credited to Participants' HRAs. In no event will any HRA credited amount be disbursed to a Participant in the form of additional, taxable compensation.

All amounts payable under the Plan will be paid from the general assets of the Company. No trust, fund, or other form of segregation of assets will be maintained for the benefit of any Participant.

A Participant's HRA will be debited as eligible expenses submitted for reimbursement are approved and reimbursed. Once a Participant's HRA balance equals zero, no additional claims will be reimbursed and the Participant's Plan participation will end.

Participants may review the status of their Account and/or any claims outstanding by logging on to www.payflex.com, the website of the Plan's record keeper, PayFlex Systems USA, Inc.

A Participant's HRA balance is carried over from year to year; provided, however, that the HRA balance will be canceled upon an Employee Participant's termination of employment, unless the Participant then becomes a Retiree Participant. Therefore, eligible expenses will first be reimbursed from the Marathon Petroleum Health Care Spending Account Plan account of a Participant, if any, until that account balance is reduced to zero. Eligible expenses will then be reimbursed from the Plan. Since the HRA balance carries over from year to year, the HRA balance can be used for current expenses or saved for future expenses if the Participant remains employed by the Company or retires from the Company. **Notwithstanding the foregoing, however, the Plan will terminate at the close of December 31, 2021. Claim reimbursements will be permitted for eligible expenses incurred through December 31, 2021, provided Participants submit claims no later than May 31, 2022. No reimbursements will be made for any expenses incurred after December 31, 2021. The Plan will close following processing of final claims, and Participants' HRA balances, if any, will be forfeited.**

Participants may elect to opt out of the balance of their HRA, as a balance may prevent the Participants from obtaining a premium assistance tax credit if they decide to purchase health coverage through the Health Insurance Marketplace.

VI. Participation While on a Leave of Absence

Participating Employees on a leave of absence during the Plan Year may continue participation in the Plan, as follows:

- Medical Leave — Coverage continues for up to two years.
- Family Leave — Coverage continues for the duration of the leave.
- Personal leave — Coverage continues for up to two years.
- Military Leave — Coverage continues for the duration of the leave.
- Educational Leave — Coverage continues for up to two years.

- Leave of absence for other reasons — Coverage is terminated unless approval to continue coverage is granted by the Company. If no approval to continue is granted, the remaining HRA balance is forfeited.

VII. Termination of Plan Participation

A Participant's participation in the Plan ends on the earliest to occur of the following events:

1. The date the Participant's HRA balance is exhausted (a zero dollar balance);
2. The date the Participant's employment with the Company (including any company in the Marathon Petroleum Company LP controlled group of companies) terminates, unless the Participant then becomes a Retiree; and
3. The date on which this Plan terminates.

VIII. Continuation of Coverage after Termination of Employment

Federal law (commonly known as "COBRA") requires that Plan Participants and their spouses and dependents be permitted to elect to continue coverage under the Plan when coverage terminates due to certain qualifying events. Such "qualifying events" include a Participant's death, termination of employment, divorce or legal separation, or reduction in hours. In the case of a dependent, the dependent's ceasing to qualify as an eligible dependent is also a qualifying event. If coverage ceases due to any such qualifying event, a Participant and his or her spouse and dependent will be offered COBRA continuation coverage. For information concerning these COBRA rights, contact Businessolver, Inc. at 1-844-408-2575 or review them as set forth in the Appendix at the end of this document.

IMPORTANT: As a practical matter, because the Plan is frozen, meaning that no additional amounts are credited to Employee and Retiree Participants' HRAs, COBRA coverage, while available as explained here, will likely offer no additional value to a qualified beneficiary.

A. Retirement

An Employee Participant who becomes a Retiree Participant will continue participant in the Plan until his or her HRA balance is exhausted (a zero dollar balance).

B. Death

If a Participant dies with a balance in his or her HRA the remaining balance may be used to reimburse eligible dental and vision expenses incurred by the Participant's surviving spouse or other surviving tax dependents. If there is no surviving spouse or eligible surviving tax dependents, the HRA balance is forfeited.

C. Termination

An Employee Participant whose participation terminates in 2021 due to employment separation, and who does not become a Retiree Participant, may continue to submit claims until May 31, 2022 for eligible expenses incurred prior to his or her 2021 separation date. Any balance in the Participant's HRA will be forfeited. Expenses are incurred on the date the dental or vision service is performed, not when the bill for the service is received or paid.

Terminating Employee Participants will also be offered the opportunity to extend coverage under COBRA provisions for expenses incurred after their termination date but not later than December 31, 2021.

Notwithstanding the foregoing, however, the Plan will terminate at the close of December 31, 2021. Claim reimbursements will be permitted as explained above. The Plan will close following processing of final claims, and Participants' HRA balances, if any, will be forfeited.

IX. General Tax Treatment

It is intended that the amounts credited by the Company the Plan HRA of a Participant will not result in taxable income to the Participant and that all benefits provided under the Plan to the Participant will not be included in the Participant's taxable income, all as provided under Code Sections 105 and 106 and other applicable regulations. In the event that a benefit provided under the Plan does not satisfy the requirements of Code Sections 105 and 106, and therefore becomes taxable to the Participant, the reimbursement will be paid no later than the last day of the taxable year following the taxable year in which the expense was incurred.

X. Reimbursement Procedures; How to Submit a Claim

A Participant who has incurred an eligible expense may seek reimbursement under the Plan from his or her HRA by submitting a claim for reimbursement.

Mailed Claims: PayFlex Systems USA, Inc.
P.O. Box 4000
Richmond, KY 40476-4000

Faxed Claims: 855-703-5305

Customer Service: 844-PAYFLEX (844-729-3539)

Claim forms are available online at www.payflex.com after the Participant registers on the site, or by calling PayFlex. The forms are also available at www.myMPCbenefits.com.

The Plan will terminate at the close of December 31, 2021. Claim reimbursements will be permitted for eligible expenses incurred through December 31, 2021, provided Participants submit claims no later than May 31, 2022. No reimbursements will be made for any expenses incurred after December 31, 2021. The Plan will close following processing of final claims, and Participants' HRA balances, if any, will be forfeited.

Claims should contain such information as may be required by PayFlex to comply with the terms of the Plan. At a minimum, any claim submitted should include the Participant's name, address, and other identifying information as determined by PayFlex in its administration of claims, the name and relationship to the Participant of the person on whose behalf eligible dental and vision expenses were incurred, the amount and date of the claim, the name of the person, organization or entity to which the expense was or is to be paid, the specific basis for the claim, and any additional information submitted to support the claim or which may be required. The claim will not be deemed to be effectively made until the claim, as filed, satisfies the requirements established by the Plan and PayFlex.

If a claim for a Plan benefit is wholly or partially denied by PayFlex, notice of the decision shall be furnished to the Participant within a reasonable period of time after receipt of the claim in accordance with the Plan's claim procedures.

PayFlex can be reached at 844-PAYFLEX (844-729-3539).

The participant's account can be accessed at www.payflex.com.

First time users must register as a new user.

XI. Recovery of Overpayments

If it is later determined that a Participant received an overpayment or a payment in error (for example, the Participant was reimbursed for an expense under the Plan that is later paid for by the Marathon Petroleum Dental Plan or Vision Plan or some other plan), the Participant will be required to refund the overpayment or erroneous reimbursement to the Company.

If the overpayment or erroneous payment is not refunded, the Plan reserves the right to debit the Participant's HRA by the amount of the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from the Participant's pay, to the extent allowed by applicable law. If these options are unsuccessful, the Plan Administrator may decide to treat the amount of the overpayment as taxable income. In addition, if the Plan Administrator determines that a fraudulent claim was submitted, the Plan Administrator may terminate the Participant's coverage under the Plan and the Participant's remaining Account balance will be forfeited.

XII. Claim Procedures

The following claim procedures apply to the Plan, provided, however, that to the extent any additional procedures are required by the claim procedure regulations under ERISA, those additional procedures shall apply and, upon request from a Participant or his or her authorized representative, shall be provided to the Participant/authorized representative.

A. Initial Review of Claim

If a claim for a Plan benefit is wholly or partially denied by the Plan, notice of the decision shall be furnished to the Participant/claimant (or, for all purposes under these claim procedures, the Participant's authorized representative) by the Plan or Plan Administrator within a reasonable period of time, but not later than 30 days after receiving the claim. If more time is needed to review the claim, the Plan may extend the time period up to an additional 15 days, explaining the reason for the extension and will notify the participant of the extension before the end of the first 30-day period. If an extension is necessary because of the Participant's failure to submit the information necessary to decide the claim, then the Plan Administrator will notify the Participant regarding what additional information the Participant is required to submit, and this Participant will be given at least 45 days after such notice to submit the additional information. If the Participant does not submit the additional information, the Plan Administrator will make the decision based on the information that it has. If the claim is denied, the notice shall include the following information:

- The specific reason or reasons for the denial;
- Specific reference to the Plan provisions on which the denial is based;
- A description of any additional material or information necessary to complete the claim and an explanation of why this material or information is necessary; and
- An explanation of the steps to be taken to submit the claim for review.
- A description of the Plan's internal review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA following a denial on review;
- If the Plan Administrator relied on an internal rule, guideline, protocol, or similar criteria in making its determination, either a copy of the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criteria was relied upon in making the determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to the Participant free of charge upon request.

B. Appeal of Denied Claim

A Participant may appeal a denial of a claim by requesting a review by written application to the Plan Administrator or its designee no later than 180 days after receipt by the Participant of written notification of denial of a claim. Failure to make written request for appeal within the 180-day period after the receipt of the Plan Administrator's notice of denial of the claim shall render the Plan Administrator's decision regarding the claim final, binding and conclusive on all parties. The Participant:

- May review pertinent documents; and
- May submit issues and comments in writing as well as other relevant documents, records, or other information; and
- May request from the Plan copies of all documents, records, and other information related to the claim.

If the Plan Administrator receives new or additional evidence that it considered, relied upon, or generated in connection with the claim, other than evidence that the Participant has provided, the Participant will be provided with this information and given a reasonable opportunity to respond to the evidence before the due date for the notice of final adverse benefit determination.

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.

Written notice will be provided to the Participant, advising if the appeal was granted or denied. If the appeal is denied, the notice will describe the specific reason for the denial; a reference to the specific Plan provision(s) on which the denial is based; a statement providing that the Participant is required to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Participant's claim for benefits; if an internal rule, guideline, protocol, or similar criterion was relied upon in make the determination, a copy of such rule, guideline or similar criterion; and a statement of the Participant's right to seek judicial review of the Plan's decision under ERISA.

Questions regarding any of the procedures discussed above may be directed to the Plan Administrator.

C. Appointment of Authorized Representative

An authorized representative may act on behalf of a claimant with respect to a benefit claim or appeal under the Plan's claim procedures. No person will be recognized as an authorized representative until the Plan receives an *Appointment of Authorized Representative* form signed by the claimant.

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 at 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.

D. 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.

XIII. Administration of the Plan

Important Plan Administration Information	
Plan Name	Marathon Petroleum Health Reimbursement Account Plan
Plan Administrator (Agent for service of legal process)	Jonathan M. Osborne P.O. Box 1 539 South Main Street Findlay, OH 45839-0001 Phone: (419) 422-2121
Employer Identification Number	31-1537655
Type of Plan	Employee welfare benefit plan
Plan Sponsor	Marathon Petroleum Company LP 539 South Main Street Findlay, OH 45840
Plan Number	556
Inspection of Plan Documents	Plan documents may be inspected by making a written 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	The Plan Year is January 1 through December 31. Records are kept on a calendar year basis.
Recordkeeper	PayFlex Systems USA, Inc (PayFlex) P.O. Box 4000 Richmond, KY 40476-4000

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 it is deemed 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 the Plan Administrator's authority shall be final and binding upon all persons, including, but not limited to, the Company and all Participants. 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. Any discretionary acts taken under this Plan by PayFlex, the Plan Administrator or the Company, shall be uniform in their nature and shall be applicable to all participants similarly situated, and shall be administered in a nondiscriminatory manner in accordance with the provisions of ERISA and the Code.

The records of the Plan Administrator and the Company shall be conclusive in respect to all matters involved in the administration of the Plan except as otherwise provided herein or by law.

The Company shall pay all costs and expenses incurred in administering the Plan.

XIV. Additional Terms

A. Governing Law

The Plan shall be administered and interpreted in conformity with the requirements of the Employee Retirement Income Security Act of 1974, as amended ("ERISA") and the Internal Revenue Code of 1986, as amended (the "Code"). To the extent not in conflict with the preceding sentence, the construction of the Plan shall be governed by the laws of the State of Ohio.

B. Limitation Regarding Employment

Neither the existence of the Plan nor the fact that an Employee has become a Participant of the Plan shall give any person any right to continued employment. Further, the Company may make decisions relating to an Employee's employment without regard to the effect that such decisions may have on the Employee's rights under the Plan.

C. 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 Participant under the Plan.

D. Severability

In case any Plan provision shall be held illegal or invalid for any reason, such illegality or invalidity shall not affect the remaining provisions, and the Plan shall be interpreted and administered without regard to such illegal or invalid provision.

E. Eligible Expenses Must Meet Code Requirements

Each Participant is responsible for ensuring that the expenses submitted for reimbursement under the Plan constitute eligible expenses as determined under the Code. A Participant who obtains reimbursement under the Plan of an ineligible expense will be solely responsible and liable for any resulting federal, state and local taxes, penalties and interest.

F. Missing Participant

If, five years after any amount becomes payable by the Plan to a Participant, and the payment has not been claimed, provided due and proper care has been exercised by the Plan Administrator or its delegate in attempting to make such payment by providing notice at the Participant's last address of record with the Company, the amount of the payment shall be forfeited and shall cease to be a liability of the Plan. In such case, the amount forfeited shall be retained by the Company in its general assets.

G. Non-Assignability

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

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 and Marathon Refining Logistics Services 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

The Company reserves the right to amend, 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. Amendment, modification or termination may be made by the Company for any reason.

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

As a participant in the Marathon Petroleum Health Reimbursement Account 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 other specified locations, such as worksites, all documents governing the Plan, including insurance contracts 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 operation of the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report, as required by law.

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 obligations upon the individuals 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 the Plan participants and their beneficiaries. No one, including the Company or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit under the Plan or from exercising your rights under ERISA.

Enforcement of 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 that 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 Federal court. In such a case, the court may require the Plan Administrator to provide the materials and to 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 Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in 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 the 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 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 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 Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in telephone directories 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 participant rights and responsibilities under ERISA by calling the publications hotline for the Employee Benefits Security Administration.

XVIII. Use and Disclosure of Protected Health Information (PHI)

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 Code of Federal Regulations Parts 160 and 164 ("HIPAA Privacy Standards"), the incident shall be reported to the Plan's privacy officer.

The privacy officer shall take appropriate action, including:

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

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

- Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law, including HIPAA privacy standards;
- Implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of EPHI that the Company creates, receives, maintains or transmits on behalf of the Plan;
- Ensure that the adequate separation between the Plan and the Company described above is supported by reasonable and appropriate security measures;
- Ensure that any agents, including a subcontractor, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Company with respect to such PHI;

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

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

Appendix A

COBRA Continuation of Coverage

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

IMPORTANT: As a practical matter, because the Plan is frozen, meaning that no additional amounts are credited to Employee and Retiree Participants' HRAs, COBRA coverage, while available as explained here, will likely offer no additional value to a qualified beneficiary.

I. Group Covered

All Participants of the Plan (other than nonresident aliens with no U.S.-source earned income), including their covered eligible dependents, are subject to these COBRA provisions.

II. Qualifying Events and Maximum Length of Continuation Periods

A. If an **Employee Participant** loses coverage:

1. Due to termination of employment (including retirement), either voluntary or involuntary, for reasons other than gross misconduct,
2. or due to layoff;

then the Participant and his or her eligible dependents will be entitled to elect continuation of coverage for a maximum of 18 months from the date of the qualifying event.

B. If the covered **Spouse** of a Participant loses coverage:

1. Due to the death of a Participant, or
2. Due to the divorce or legal separation from a Participant;

then the Spouse, and any other currently covered eligible dependents that lose coverage, will be entitled to elect continuation of coverage for a maximum of 36 months from the date of the qualifying event.

C. If an eligible **Child** of a Participant loses coverage:

1. Due to the death of a Participant,
2. Due to the dependent no longer meeting the Plan's definition of a Covered Dependent;

then the eligible Child will be entitled to elect continuation of coverage for a maximum of 36 months from the date of the qualifying event.

III. Extension of Maximum Length of Continuation Periods

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

Eligible dependents of a Participant who are entitled to a maximum 18-month period will have that period extended to a maximum of 36 months from the date of the first qualifying event if any of the following subsequent qualifying events occur during the maximum 18-month period (or during the maximum 29-month period, if applicable):

1. The death of the Participant;
2. The divorce or legal separation of the Participant; or
3. The dependent child no longer meets the Plan's definition of a Covered Dependent.

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

IV. Termination of Continued Coverage

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

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

B. The date on which the HRA is exhausted.

V. Notification Procedure

A. If coverage terminates due to the Participant's layoff, reduction in work hours, or termination of employment (for reasons other than gross misconduct:

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

B. In the event of the divorce or legal separation of the Participant and spouse, or in the event that a dependent child no longer meets the Plan's definition of Covered Dependent:

   1. The Participant or dependent must notify the Plan Administrator in writing of the effective date of that event within 60 days after that date. (This notification can be submitted to the Plan Administrator through the Company's local Human Resources office or Benefits Administration in Findlay, Ohio); and

   2. The Plan Administrator or representative will inform the Participant/dependent of their rights under COBRA at the time of such notification, or mail the information within 14 days. Notification to the spouse will serve as notification for all dependents residing with the spouse.

C. The Participant/dependent must elect to continue coverage within a specified election period. This period begins on the **earlier** of:

   1. The date notification is given to the Employee Member/dependent, or

   2. The date of termination of coverage;

   and ends on the **later** of 60 days from:

   1. The date of the notice from the Plan Administrator, if applicable, or

   2. The date of termination of coverage.

D. If an election is not made within the election period described above, coverage ceases at the time of the qualifying event.

E. The first premium payment must be made within 45 days of the election and, if the premium payment is made after the qualifying event, the payment must be sufficient to cover not only the advance premium amount but also the premium amount for the period beginning on the date coverage would have otherwise ceased and ending on the first date covered by the advance premium amount.

VI. Special COBRA Election Period Under the Trade Act of 2002

In addition to the regular 60-day election period indicated in the "Notification Procedure" section immediately above, the Trade Act of 2002 provides for an additional "special" election period for individuals deemed eligible for trade adjustment assistance (TAA) benefits and a health COBRA tax credit. This "special" election period is 60 days in length and applies to those who had not previously elected COBRA coverage during the election period indicated in the "Notification Procedure" section immediately above, and are deemed eligible for the tax credit provisions, but only if the tax credit eligibility determination occurs within six months of the loss of group health coverage (qualifying event date.) If COBRA coverage is elected under this special COBRA election period, it begins on the first day of that special period and continues for the applicable 18, 29 or 36 months (depending on the circumstances) from the date of the initial loss of group health coverage. There is no coverage for the period between the initial loss of group health coverage and the beginning of the additional special election period. The Department of Labor anticipates that information on the right to an additional "special" election period, together with other information on trade adjustment assistance and the health coverage tax credit, will also be made available to potentially eligible individuals through the State Workforce Agencies in connection with the certification process for trade adjustment assistance. To find the State Workforce Agency for your state go to us.jobs/state-workforce-agencies.asp.

VII. Type of Coverage

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

VIII. Cost

Those electing continued coverage under these COBRA provisions will not be charged a premium in order to continue to utilize the remaining balance in their Account.

IX. Administration

The continuation coverage under the Marathon Petroleum Health Reimbursement Account Plan is administered in part by Marathon Petroleum Company LP and in part by Businessolver, Inc., P.O. Box 310512, Des Moines, IA 50331-0512. The toll-free number for BenefitSolver is 1-844-408-2575 or website www.myMPCbenefits.com/mybenefits.

X. Special Continuing Circumstances

A. General

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

B. Change in Control

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

Eligible terminated employees (including those eligible to retire at the time of termination) and their eligible dependents who immediately prior to termination were participants in the Health Reimbursement Account Plan have the opportunity to continue coverage under the terms and conditions of the Plan as applied to active employees for a period of 18 months provided the terminated employee is eligible for and timely elects continuation of such coverage in accordance with COBRA.

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

The period of coverage provided under this section shall constitute continuation coverage required by COBRA.

Appendix B

Extended Timeframes Due to National Emergency

Due to the COVID-19 pandemic, regulatory guidance was issued to provide relief to employees and qualified beneficiaries in certain situations. This relief includes an extended deadline to make benefit elections for some qualifying events, an extension for providing supporting documentation and other relaxed requirements. The relief also provides an extended deadline to file a claim and appeal a denied claim. The third-party administrator of the Plan or the Company's Benefits Service Center will administer extended deadlines as required. Where applicable, these changes are retroactive to March 1, 2020 and will remain in effect through 60 days after the COVID-19 National Emergency ends.

Additional information is available here or members can contact the Marathon Petroleum Benefits Service Center by calling 1-888-421-2199, Option 1, then Option 3, or by email at benefits@marathonpetroleum.com.