



Marathon Petroleum Retiree Health Plan

**Amended and Restated
January 1, 2023**

Retiree Health Plan



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Retiree Health Plan

Marathon Petroleum Company LP (Company) sponsors and maintains the Marathon Petroleum Retiree Health Plan (the “Plan” or “Retiree Health Plan”). This document amends and restates the Plan effective as of January 1, 2023. This document serves both as the plan document and the Summary Plan Description (SPD) for the Plan. To the extent not preempted by the Employee Retirement Income Security Act of 1974 (ERISA), the provisions of this instrument shall be construed and governed by the laws of the State of Ohio.

I. Purpose

Medical expenses can place sizeable financial burdens on individuals, especially in cases of long-term or other catastrophic illnesses. The Company therefore offers this group Retiree Health Plan to provide financial assistance for most medical expenses. Unless otherwise stated herein, coverage under the Plan ends when a Member becomes eligible for Medicare due to age. Plan Members may elect coverage under one of the following options:

- The Saver HSA Option is a self-funded high deductible health plan option with a lower monthly cost to participants. It works like a Preferred Provider Organization (PPO) with the ability to contribute to a Health Savings Account (HSA). The Saver HSA Option is available to all Members.
- The Classic Option is a self-funded lower deductible PPO option that provides higher levels of reimbursement for a higher monthly cost to participants and is available to all Members.

Coverage under the Medical/Surgical Program (which includes mental health and substance abuse), Managed Prescription Drug (Prescription) Program, and the Routine Physical and Preventive Services (Preventive Services) Program are provided to Members enrolled in each of the above Options.

- The Kaiser Permanente Traditional HMO Plan — Northern California Region is a fully-insured option available to Members who reside within the Kaiser northern California service area.
- The Kaiser Permanente Traditional HMO Plan — Southern California Region is a fully-insured option available to Members who reside within the Kaiser southern California service area.

The above-mentioned fully-insured HMO options through Kaiser Permanente (“Kaiser”) may provide benefits that differ from those available under the Saver HSA and Classic options. Refer to Appendices F and G for Evidence of Coverage documents which provide a comprehensive description of the terms of eligibility and description of benefits coverage under each of these HMO options. It should be noted that not all sections of this document are applicable to Kaiser enrollees; the Kaiser provisions shall supersede where applicable.

II. Helpful Terms

Here are some terms, as defined for purposes of the Retiree Health Plan, you may find helpful as you read through this document.

Age 65 — Throughout this document, the terms “age 65,” “post-65” and “over-age-65” mean “eligible for Medicare due to age.” The terms “pre-65,” “under-age-65” and “less than age 65” mean “not eligible for Medicare due to age.” An individual becomes Medicare eligible due to age on the first day of the month in which they turn age 65 or, if the individual turns age 65 on the first day of the month, then Medicare eligibility occurs on the first day of the month preceding the individual’s birth month. The terms are used to assist with readability and comprehension of provisions.

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Coinsurance — The percentage of covered costs the Plan or the Member pays after any required deductibles are met. Examples include the 20% coinsurance the Member pays for most in-network services under the Saver HSA and Classic Options.

Copay — A fixed dollar amount (for example, \$20) the Member pays for a covered health care service, usually at the time you receive the service. The amount can vary by the type of covered health care service, such as an office visit or purchase of prescription drug. With an emergency room copay, coinsurance will also be applied.

Deductible — The amount each covered individual pays toward most covered charges in a Plan Year before the Plan begins paying benefits. Deductible amounts are based on the Option you select. The Medical/Surgical Program and the Managed Prescription Drug (Prescription) Program each have separate deductibles under the Classic Option. Under the Saver HSA Option, the Medical/Surgical Program and the Prescription Program deductible is combined.

Charges under the Preventive Services Program are not subject to a deductible except for Preventive Services charges incurred out-of-network under the Classic or Saver HSA Options. Such out-of-network preventive services charges are subject to the applicable Option out-of-network medical/surgical deductible.

The deductible for the Classic Option works like this: Once the Classic Option's deductible under the Medical/Surgical Program has been met by an individual covered by the Plan, the Plan starts paying benefits under the Medical/Surgical Program for that individual. When any combination of two or more covered family Members meet the family deductible under the Medical/Surgical Program, the Plan will start paying benefits under the Medical/Surgical Program for all covered family Members. (This is called an "embedded" deductible.)

Once the Classic Option's deductible under the Prescription Program has been met by an individual covered by the Plan, the Plan starts paying benefits under the Prescription Program for that individual. When any combination of two or more covered family Members meet the family deductible under the Prescription Program, the Plan will start paying benefits under the Prescription Program for all covered family Members.

The deductible for the Saver HSA Option works like this: For Member Only coverage, the Plan starts paying benefits once the Member meets the individual deductible. For any Member Plus Dependent(s) coverage, the Plan starts paying benefits once one covered family Member or any combination of covered family Members meets the family deductible. (This is called an "aggregate" deductible.)

Emergency Care — Emergency care is treatment required immediately for the sudden, unforeseen onset of an illness or accidental bodily injury because permanent disability or endangerment of life could result if the condition were not immediately treated. Examples of emergency situations include: unconsciousness, lacerations requiring sutures, serious burns, fractures, automobile accident, ambulance/EMS/police-initiated visits to an emergency room, electric shock, eye injury, serious breathing difficulties, poisoning and inhalation of smoke or noxious fumes.

ERISA — The Employee Retirement Income Security Act of 1974, as amended.

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Exchange Health Reimbursement Account Plan (Exchange HRA) — A Company-sponsored health reimbursement arrangement, to which the Company credits notional dollar amounts, that is maintained for the benefit of certain Medicare eligible Marathon Petroleum retirees and their Medicare eligible spouses, or an employee or employee's dependent who is eligible for Medicare due to disability, who enroll in an individual Medicare supplemental health care policy offered and who participate in the Marathon Petroleum Exchange Health Reimbursement Account Plan. *Further information regarding the Exchange HRA is available in the Marathon Petroleum Exchange Health Reimbursement Account Plan document, which is separate from this Retiree Health Plan.*

Formulary — A list of preferred drugs. If no generic equivalent drug exists and you must purchase a brand name drug, your benefits will be maximized, and your out-of-pocket cost minimized when you purchase a name brand drug on the formulary. Express Scripts maintains the formulary list using an independent committee that meets regularly to review the drugs on the formulary based on safety, efficacy, and cost, and to decide whether any new drug should be added. The committee also helps to ensure that Express Scripts' policies are medically sound.

Health Savings Account (HSA) — Members who enroll in the Saver HSA Option and who meet the eligibility rules for an HSA will be able to establish an account with Fidelity associated with enrollment in the Saver HSA Option and may elect to contribute tax-deductible money to their HSA up to IRS limits. For 2023, the IRS contribution limits are \$3,850 for Member Only and \$7,750 for Member Plus Dependent(s), with \$1,000 in additional catch-up contributions allowed for those age 55 and over.

HSA funds can be used to pay deductibles and other IRS-recognized health expenditures and, unlike Health Care Flexible Spending Account (FSA) monies, can accumulate into future years. For specific information concerning HSA eligibility, benefits, administration, and Internal Revenue Service tax regulations, refer to Fidelity's materials at www.netbenefits.com or www.401k.com. Members who are enrolled in Medicare or who are receiving Social Security benefits (which means they are automatically covered in Medicare Part A) are not eligible to contribute to an HSA. Members are responsible for complying with HSA contribution rules and should consult with a tax advisor regarding individual tax concerns.

Hospital — A legally constituted and operated institution which has on-the-premises organized facilities (such as for diagnosis and major surgery) to care for and treat sick and injured persons. There must be a staff of doctors and a Registered Nurse on duty at all times. This term does not include an institution, or part of one, used mainly for rest or nursing care, convalescent care, care of the aged, care of the chronically ill, custodial care, or educational care.

Infertility — The condition of a presumably healthy Member who is unable to conceive or produce conception. This does not include conditions for men when the cause is a vasectomy or orchiectomy or for women when the cause is tubal ligation or hysterectomy.

Legacy Andeavor — Also known as "Andeavor-Acquired Employees" means active employees of Andeavor and its subsidiaries as of 11:59 p.m., September 30, 2018 (including employees of Andeavor and its subsidiaries who were on a Leave of Absence as of 11:59 p.m., September 30, 2018) and who on October 1, 2018, or soon thereafter, as a direct result of the Closing, became employees of the controlled group to which Marathon Petroleum Company LP belongs ("Controlled Group") and are such employees as of 12:01 a.m., January 1, 2019.

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In addition, former employees of Andeavor and its subsidiaries who as a result of being transferred, newly hired or rehired by Andeavor and its subsidiaries and who subsequently became employees of the Controlled Group are also considered Andeavor-Acquired Employees provided their transfer, hire or rehire dates were during the period from October 1, 2018, through the end of the day on December 31, 2018, and they are employees of the Controlled Group as of 12:01 a.m., January 1, 2019.

Legacy MPC — An employee who was eligible for the Marathon Petroleum Health Plan on or before December 31, 2018.

Marathon Petroleum Company LP — In this document, this can be referred to as MPC or Company. It means Marathon Petroleum Company LP and, as appropriate, includes members of the Marathon Petroleum Company LP controlled group which have become participating employers in the Retiree Health Plan. These other members are listed in Article XXII, “Participation by Associated Companies or Organizations,” and in Appendix A.

Maximum Allowed Amount — An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services (CMS). Unusual circumstances and complications are taken into consideration. The Medical/Surgical Program uses a Maximum Allowed Amount equal to 315% of the Medicare allowed rate.

Medically Necessary — Services or supplies that are provided for the diagnosis or treatment of a medical or mental health and substance abuse condition; are appropriate for the medical or mental health and substance abuse condition; are done within the proper setting or manner required for the medical or mental health and substance abuse condition; and meet generally accepted health care practices.

Member — An individual who meets eligibility requirements, participates in the Retiree Health Plan, and meets the criteria as contained in Article III, “Retiree Health Plan Participation,” of this document.

Negotiated Fee Schedule — The charge for a medical service or mental health and substance abuse service or treatment that providers have agreed to accept based on a contractual relationship between the Plan and the provider network in which the provider participates. Charges under the Plan will be limited by the Negotiated Fee Schedule depending on the Option elected.

Non-Employee Group — Members who make up the “Non-Employee Group” are Retiree Members, LTD Retiree Members, LTD Terminated Members, Spouse/Domestic Partner Members, Surviving Spouse Members and Child(ren) Members, along with Continued Members who were part of the Non-Employee Group on the date of their initial qualifying event.

Out-of-Pocket Maximum — This is the most each covered individual would pay including deductible and coinsurance in a Plan year. Once the out-of-pocket maximum has been met, the Plan pays 100% for covered health care services and supplies for the remainder of the calendar year. The out-of-pocket maximum is combined for the Medical/Surgical Program and the Managed Prescription Drug Program.

The following **do not** count toward satisfying out-of-pocket maximum limits:

- Charges above the Maximum Allowed Amount and Negotiated Fee Schedules; and

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- Non-covered charges, including charges incurred after benefit maximums (such as the benefit limit on manipulations) have been reached.

The out-of-pocket maximum works the same for the Saver HSA and Classic Options. Here's how it works: Once the individual out-of-pocket maximum has been met by an individual covered by the Plan, the Plan will pay 100% of covered benefits for that individual. (This is called an “embedded” out-of-pocket maximum.) When any combination of two or more covered family members meet the family out-of-pocket maximum, the Plan will pay 100% of covered benefits for all covered family members. (The Plan never pays non-covered charges or charges above the Maximum Allowed Amount, whether or not the out-of-pocket maximum has been met.)

Preferred Provider Organization or PPO — A network of health care providers (including, but not limited to physicians, hospitals, and providers of ancillary services such as diagnostics and therapy) which is managed by Anthem BC/BS, an organization with whom the Plan has contracted for Members to use their network of providers. The benefit level under the PPO depends on whether or not medical care is provided by a provider participating in the Anthem PPO Network and the Marathon Petroleum Retiree Health Plan Option chosen. The two benefit levels available under the Retiree Health Plan Options are **in-network** benefits and **out-of-network** benefits.

Provider — A licensed physician, a hospital, or other health care professional recognized by the Retiree Health Plan.

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

Smart90 Walgreens — A feature of the Managed Prescription Drug Program under the Plan, managed by Express Scripts. Instead of using Express Scripts Mail Order Home Delivery, with Smart90 Walgreens, Members may fill ninety-day supplies of long-term maintenance medications (drugs you take regularly for ongoing conditions) at all Walgreens retail pharmacies and affiliates (including Duane Reade pharmacies) without incurring a penalty for filling maintenance drugs at retail.

Urgent Care — Urgent care is treatment for a sudden illness or injury that demands immediate medical attention but is not life threatening. Examples of urgent situations include: sprains/strains, high fever, minor burns, vomiting, ear infections and urinary tract infections.

Workday Benefits — Workday Benefits is a site where retirees and other eligible members in certain MPC benefit plans can view their benefits information, as well as enroll or make changes to certain benefit elections, when applicable. For instructions on how to access Workday Benefits, visit www.mympcbenefits.com and click on the **Your Benefit Elections** tile. For assistance, view additional information at www.mympcbenefits.com or contact the MPC Benefits Service Center at 1-888-421-2199, option 1, then option 3.



III. Retiree Health Plan Participation

Coverage can be waived upon initial eligibility to participate in the Plan. In the event of such waiver, such individual will be permitted a one-time opportunity to enroll in the Plan at a future date, either during the Annual Enrollment period or due to a qualifying event, provided eligibility requirements are satisfied, and further, that such individual whose retirement date is on or after January 1, 2021, provides evidence of continuous creditable health coverage during the period of waived coverage.

A member who terminates participation in the Plan on or after January 1, 2021 will not be eligible to re-enroll unless participation was terminated to enroll in the Marathon Petroleum Health Plan (for active employees) and such enrollment is continuous until re-enrollment in this Plan.

A. Member Eligibility

Subject to Appendix A, you are eligible to participate in the Plan as a “Member” as follows. Coverage begins on the first day of retirement.

1. Retiree Member or LTD Retiree Member

- a. A retired employee is eligible to participate as a Retiree Member or LTD Retiree Member if they were, as of the date immediately preceding retirement:
 - i. A Regular Full-time or Regular Part-time employee who was eligible for coverage under either the active employee Marathon Petroleum Health Plan or the International Medical Plan, whose date of hire was prior to January 1, 2008, was at least age 50 but not eligible for Medicare due to age, had 10 years or more vesting service in the Marathon Petroleum Retirement Plan and had at least 10 years of accredited service under the Employee Service Plan; or
 - ii. A Casual employee who had a change in employment status from Regular Full-time or Regular Part-time employment to casual employment and immediately preceding the change in employment status was eligible for coverage under either the active employee Marathon Petroleum Health Plan or the International Medical Plan, whose date of hire was prior to January 1, 2008, was at least age 50 but not eligible for Medicare due to age, had 10 years or more vesting service in the Marathon Petroleum Retirement Plan and had at least 10 years of accredited service under the Employee Service Plan; or
 - iii. A Regular Full-time or Regular Part-time employee who was eligible for coverage under either the active employee Marathon Petroleum Health Plan or the International Medical Plan, whose date of hire or rehire was on or after January 1, 2008 but prior to January 1, 2019 (or prior to January 1, 2016 if a legacy Andeavor employee), was at least age 55 but not eligible for Medicare due to age, had 10 years or more vesting service in the Marathon Petroleum Retirement Plan and had at least 10 years of accredited service under the Employee Service Plan; or

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- iv. A Regular Full-time employee who was involuntarily separated from employment effective October 17, 2020, and who met the requirements of III.A.1.a.iii. on October 16, 2020, except for the age, vesting service or accredited service requirements, but who would have met such age, vesting service and accredited service requirements at any time during the period October 17, 2020 through December 15, 2020, assuming they had continued in active employment as a Regular Full-time employee during such time period; or
- v. A Casual employee who had a change in employment status from Regular Full-time or Regular Part-time employment to casual employment and immediately preceding the change in employment status was eligible for coverage under either the active employee Marathon Petroleum Health Plan or the International Medical Plan, whose date of hire was on or after January 1, 2008 but prior to January 1, 2019 (or prior to January 1, 2016 if a legacy Andeavor employee), was at least age 55 but not eligible for Medicare due to age, had 10 years or more vesting service in the Marathon Petroleum Retirement Plan and had at least 10 years of accredited service under the Employee Service Plan.

A member will be determined to be an LTD Retiree Member upon separation of employment that occurs prior to January 1, 2022 if, at that time, they otherwise meet the member eligibility requirements of this Plan, have earned less than 100% of the Company subsidy under the 4% accrual method (see Appendix C), and continue to remain eligible for disability benefits under the Marathon Petroleum Long Term Disability (LTD) Plan (if legacy MPC) or the fully-insured Long Term Disability Plan previously sponsored by Andeavor (if legacy Andeavor). An LTD Retiree Member and LTD Terminated Member are mutually exclusive. An individual cannot transition into LTD Retiree Member status from LTD Terminated Member status.

- b. Andeavor-Acquired Employees who were hired by Andeavor prior to January 1, 2016, and who retire on or after January 1, 2019, will have their actual Andeavor company service recognized for determining retiree coverage eligibility immediately upon retirement, as follows:
 - i. Andeavor-Acquired Employees hired prior to January 1, 2006, who meet one of these two minimum age and service requirements as of January 1, 2020, (1) age 55 with 5 years of service, or (2) age 50 with 80 points (“points” being the sum of age and years of service) will be eligible to participate in the MPC Retiree Health Plan at 100% of the Company subsidy (which is the same as 80% of the full premium) when they retire on or after January 1, 2019.
 - ii. All other Andeavor-Acquired Employees hired prior to January 1, 2016, who are at least age 55 and have at least 10 years of service at the time of their retirement, will be eligible to participate in the MPC Retiree Health Plan at a subsidy percentage that is determined under the MPC 4% subsidy accrual percentage calculation.

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- iii. Andeavor-Acquired Employees hired on or after January 1, 2016, which includes legacy Western and legacy NTI employees, are not eligible for retiree medical coverage under the MPC Retiree Health Plan. (Andeavor-Acquired Employees who are former MPC employees may be eligible for MPC Retiree Health coverage; each will be reviewed on a case-by-case basis.)
- c. Acquired retirees who were eligible for the Andeavor Retiree Health Plan:
 - i. On a subsidized basis, as of December 31, 2018 are eligible for coverage, as of January 1, 2019, at the same subsidy level as under the Andeavor Retiree Health Plan.¹
 - ii. On a non-subsidized basis (access only), as of December 31, 2018, will not be eligible, as of January 1, 2019.
- d. Notwithstanding III.A.1.a, b and c above, you are specifically not eligible for this Plan if:
 - i. You were hired or rehired on or after January 1, 2019 (and were not previously eligible to enroll in this Plan as a Retiree Member);
 - ii. You are a legacy Andeavor employee who was hired on or after January 1, 2016;
 - iii. You are a legacy Andeavor employee who was part of the June 1, 2013 BP acquisition and are eligible for post-retirement medical programs (including account-based programs) through BP;
 - iv. You are a legacy Andeavor employee who was part of the June 13, 2013 Chevron acquisition and are eligible for post-retirement medical programs (including account-based programs) through Chevron;
 - v. You were eligible for the Andeavor Post-Retirement Medical Plan (a constituent benefit program under the Andeavor Omnibus Group Welfare Benefits Plan) on a non-subsidized basis (access only), as of December 31, 2018;
 - vi. You are a legacy Andeavor employee who was part of the June 1, 2017 Western Refining acquisition²;
 - vii. You are a legacy Andeavor employee who was part of an acquisition that did not provide for post-retirement medical plan eligibility;
 - viii. You are an employee represented by a collective bargaining agreement that has not been specifically negotiated to participate in this Plan; or
 - ix. You are a separated employee whose coverage was terminated for failure to pay required member contributions in the Andeavor Medical Plan or its Andeavor Post-Retirement Medical Plan component (the Andeavor Medical Plan was a constituent benefit program under the Andeavor Omnibus Group Welfare Benefits Plan), Marathon Petroleum Health Plan or Marathon Petroleum Retiree Health Plan.

¹ Subsidies may be rounded up to the nearest whole MPC subsidy percentage.

² Except certain legacy Andeavor employees who were part of the June 1, 2017 Western Refining acquisition are eligible, as provided in Appendix B.

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Former Retiree Members and eligible retirees who are rehired and subsequently terminate employment again prior to completing one year of service will be able to return to their prior Retiree Member or eligible retiree status and Company subsidy level (no credit will be given for additional service for subsidy purposes).

Former Retiree Members and eligible retirees whose original hire date was prior to January 1, 2008 and who are rehired on or after January 1, 2008 but prior to January 1, 2019, and work one year or more, upon termination of employment again, have a choice of 1) returning to their prior Retiree Member (or eligible retiree status and prior Company subsidy level (no credit will be given for additional service for subsidy purposes) or 2) elect to instead receive credit for their additional service for subsidy purposes (resulting in a higher Company subsidy) as a Retiree Member under this Plan. **IMPORTANT:** Retirees who return to their prior Company subsidy under this Plan will continue to be eligible for a Company contribution into the Exchange HRA to be used toward the purchase of post-65 individual Medicare Supplement health care policy(ies) through participation in the Exchange HRA. Retirees who elect to receive credit for additional service (and increased Company subsidy under this Plan) will not be eligible for a Company contribution into an Exchange HRA.

Former Retiree Members and eligible retirees whose original hire date was January 1, 2008 or later and who are subsequently rehired prior to January 1, 2019 and work one year or more, upon termination of employment again, will be given credit for additional service for subsidy purposes under this Plan.

Former Retiree Members and eligible retirees who are rehired on or after January 1, 2019 and who subsequently terminate employment again will remain eligible; however, no credit will be given for subsidy purposes for service accrued on or after January 1, 2019 for subsidy purposes.

For purposes of determining eligibility for Retiree Member coverage, past service which has been granted to an acquired or merged employee under the Employee Service Plan as a result of an acquisition or merger supported by a definitive agreement signed on or after March 1, 2004, will count toward eligibility to be a Retiree Member provided the signed definitive agreement governing the merger or acquisition specifically provides for the recognition of service under the Employee Service Plan for these purposes. (Such past service will not, however, affect employee's date of hire.)

Employees transferred to Speedway LLC (Speedway) from Marathon Petroleum Company LP who terminate or retire on or after December 22, 1999, but prior to January 2, 2019, from employment with Speedway will be eligible for coverage under the Plan as Retiree Members provided they meet the necessary age, service, and acquisition date requirements described above for Retiree Members and LTD Retiree Members.



2. LTD Terminated Member

An under-age-65 former employee whose original date of hire is prior to January 1, 2019 (if a legacy MPC employee) or prior to January 1, 2016 (if a legacy Andeavor employee) and who was terminated prior to January 1, 2022 upon reaching the maximum 24 months of Medical Leave allowed under the Marathon Petroleum Medical Leave Policy, but who continues after the termination to remain eligible for disability benefits under the Marathon Petroleum Long Term Disability (LTD) Plan (if legacy MPC) or fully-insured Long Term Disability Plan previously sponsored by Andeavor (if legacy Andeavor) is eligible to participate as an LTD Terminated Member. Coverage begins as an LTD Terminated Member on the first day following termination. Notwithstanding the foregoing, a separated employee is not eligible if coverage was terminated for failure to pay required member contributions in the Andeavor Medical Plan or its Andeavor Post-Retirement Medical Plan component (the Andeavor Medical Plan was a constituent benefit program under the Andeavor Omnibus Group Welfare Benefits Plan), Marathon Petroleum Health Plan or Marathon Petroleum Retiree Health Plan.

Once an LTD Terminated Member is no longer eligible for disability benefits under the Marathon Petroleum Long Term Disability (LTD) Plan (if legacy MPC) or the fully-insured Long Term Disability Plan previously sponsored by Andeavor (if legacy Andeavor), the individual is no longer eligible for coverage in this Plan. An LTD Terminated Member and LTD Retiree Member are mutually exclusive, and an individual cannot transition into LTD Retiree Member status from LTD Terminated Member status.

3. Surviving Spouse Member

The under-age-65 surviving spouse of a deceased employee³, LTD Terminated Member or Retiree Member (including an LTD Retiree Member) on the date of the death may be eligible to participate as a Surviving Spouse Member. The spouse must satisfy the definition of a spouse under the Plan on the day of the employee's or retiree's death, and such employee or retiree must have been eligible for coverage in the active employee Health Plan or Retiree Health Plan, respectively, or have been eligible to participate in the Exchange HRA or in the International Medical Plan on the day of their death.

The surviving spouse's first date of eligibility under the Retiree Health Plan as a surviving spouse is the day after the date of death. Such surviving spouse must elect enrollment and provide required documentation through Workday Benefits within 31 days of the date of death (including date of death) and coverage will be effective on the day after the date of death.

³ Surviving Spouse is eligible if the employee death occurred a) prior to March 1, 2020, irrespective of whether employee would have been eligible for the Retiree Health Plan if employment had terminated on date of death, except that no spouse of an employee hired or rehired on or after January 1, 2019 shall be eligible, or b) on or after March 1, 2020, and employee, at time of death, would have been eligible for the Retiree Health Plan if employment had terminated on date of death.



4. Spouse Member

This definition is used for Plan administration purposes to cover an under-age-65 spouse under the Retiree Health Plan 1) when coverage under the Plan ends for the Retiree Member, LTD Retiree Member or LTD Terminated Member when eligible for Medicare due to age, or 2) when coverage under the active employee Health Plan ends when an employee retires at or after age 65 and, but for the fact the employee was age 65 or older at retirement, would have been otherwise eligible for this Plan.

A Spouse Member is the under-age-65 spouse of the following:

- a. An over-age-65 retiree, LTD retiree, or LTD terminated employee. Coverage begins:
 - i. On the first day of the month in which the retiree, LTD retiree or LTD terminated employee becomes eligible for Medicare due to age (age 65), as long as the spouse was eligible to participate in the Plan as a dependent on the day prior to the Retiree Member, LTD Retiree Member or LTD Terminated Member attaining age 65; or
 - ii. On the date an employee retires at or after age 65, as long as the spouse was eligible to participate in the active employee Health Plan as a dependent on the day prior to the retirement date.
- b. An under-age-65 disabled retiree, LTD retiree, or LTD terminated employee who participates in the Exchange HRA. For further information refer to Article VIII, "Special Provisions for Under-Age-65 Disabled/ESRD Individuals," of this document.
- c. A retiree, LTD retiree or LTD terminated employee eligible for coverage under this Plan or the Exchange HRA who has waived coverage in order to participate in an approved alternative plan (such as the Veteran Administration's health care plan or TRICARE). Coverage begins for the spouse on the effective date of the waiver of coverage.

5. Domestic Partner Member

This definition is used for Plan administration purposes to cover an under-age-65 domestic partner, who was already covered as a domestic partner dependent under this Plan, 1) when coverage under this Plan ends for the Retiree Member, LTD Retiree Member or LTD Terminated Member when eligible for Medicare due to age, or 2) when coverage under the active employee Health Plan ends when the employee retires at or after age 65. In addition, the retiree, LTD retiree or LTD terminated employee must participate in the Exchange HRA (or other approved alternative plan such as the Veteran Administration's health care plan or TRICARE) in order for the under age 65 domestic partner to continue coverage.

A Domestic Partner Member is the under-age-65 domestic partner of the following:

- a. An over-age-65 retiree, LTD retiree, or LTD terminated employee. Coverage begins:
 - i. On the first day of the month in which the retiree, LTD retiree or LTD terminated employee attains age 65, as long as the domestic partner was a participant in the Plan as a dependent on the day prior to the Retiree Member, LTD Retiree Member or LTD Terminated Member attaining age 65; or

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- ii. On the date an employee retires at or after age 65, as long as the domestic partner was a participant in the active employee Health Plan as a dependent on the day prior to the employee's retirement date.
- b. An under-age-65 disabled retiree, LTD retiree, or LTD terminated employee who participates in the Exchange HRA. For further information refer to Article VIII, "Special Provisions for Under-Age-65 Disabled/ESRD Individuals," of this document.
- c. A retiree, LTD retiree or LTD terminated employee eligible for coverage under this Plan or eligible to participate in the Exchange HRA who has waived coverage in order to participate in an approved alternative plan (such as the Veteran Administration's health care plan or TRICARE). Coverage begins for the domestic partner on the effective date of the waiver of coverage. Domestic partner children of the retired employee are not eligible as dependent of the Domestic Partner Member when a Retiree Member, LTD Retiree Member or LTD Terminated Member elects to waive coverage to participate in approved alternative plan.

6. Child Member

Child Member is a term used for Plan administration purposes to cover an eligible dependent child where:

- Both parents are deceased; or
- The former Member of this Plan or of the active employee Health Plan participates in the Exchange HRA and the other parent also participates in the Exchange HRA, is deceased, or is not eligible to join the Plan; or
- The former Member of this Plan or of the active employee Health Plan is deceased and the other parent is either a participant in the Exchange HRA or not eligible to participate in the Exchange HRA.

The child(ren) may participate in the Plan on the day following the death of the child's parent who was an employee⁴ or retiree, provided the employee or retiree was eligible to participate in either the active employee Health Plan, the International Health Plan or the Retiree Health Plan on the day of their death and the child's other parent is not eligible to join the Retiree Health Plan or is deceased.

Coverage may begin or continue on the date indicated below, provided the child(ren) was covered under the active employee Health Plan or Retiree Health Plan as a dependent on the day:

- Prior to the day the child's parent, who was a Spouse Member under the Plan, becomes divorced;

⁴ A surviving dependent is eligible if the employee death occurred a) prior to March 1, 2020, irrespective of whether the employee would have been eligible for the Retiree Health Plan if employment had terminated on date of death, except that no dependent of an employee hired or rehired on or after January 1, 2019 shall be eligible, or b) on or after March 1, 2020, and the employee, at time of death, would have been eligible for the Retiree Health Plan if employment had terminated on the employee's date of death.

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- Prior to the first day of the month in which the child's parent who was an employee member under the active employee Health Plan retires at age 65 or older, provided the child's other parent is either not eligible to join the Retiree Health Plan or is deceased;
- Prior to the first day of the month in which the child's parent who was a Spouse Member, Surviving Spouse Member or Retiree Member, LTD Retiree Member or LTD Terminated Member attains age 65, provided the child's other parent is either not eligible to join the Plan or is deceased;
- Prior to the day the child's parent, who was a Surviving Spouse Member, loses coverage due to remarriage, provided that no other coverage is available and assuming that all other child eligibility criteria are met.

Eligible Children and Dependent Disabled Children of employees transferred to Speedway LLC from MPC or other participating employer will be eligible for coverage under the Plan as a Child Member if their parent dies and at the time of death would have met the definition of a Retiree Member as defined in Section III.A.1. above, and the other parent is either also deceased or not eligible to join the Plan.

7. Continued Member

An individual who has continuing coverage under COBRA is a Continued Member.

B. Dependent Eligibility

Your eligible dependents may be covered under the Plan, provided such dependents were not acquired by you (for example, by marriage, birth or adoption) on or after your date of retirement or were enrolled in the Plan as of December 31, 2020. They include:

1. Spouse

The under-age-65 spouse of a Retiree Member, LTD Retiree Member, or LTD Terminated Member is an eligible dependent under the Plan.

2. Children

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

- a. Natural children of the first degree;
- b. Legally adopted children, and children placed with you for adoption;
- c. Stepchildren;



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

(In order to be an eligible dependent, any child born to (or adopted by) a Surviving Spouse member after the death of the Retiree Member of this Plan or death of the Employee Member of the Marathon Petroleum Health Plan must also be an eligible child of (or a child who was placed for adoption with) the deceased Retiree Member of this Plan or the deceased Employee Member of the Marathon Petroleum Health Plan.)

3. Domestic Partner

The under-age-65 qualified domestic partner of a Retiree Member, LTD Retiree Member, or LTD Terminated Member is an eligible dependent under the Plan. Employees must meet the requirements established in the *Marathon Petroleum Domestic Partner Certification* form prior to benefit enrollment.

4. Children of Domestic Partner

Children through end of the month during which they turn age 26 of a qualified under-age-65 domestic partner, who is enrolled in the Plan, are eligible dependents under the Plan. Members must meet the requirements established in the *Marathon Petroleum Company Domestic Partner Certification* form prior to benefit enrollment.

5. Dependent Disabled Child

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

- a. became disabled before reaching age 19 and was covered under the Plan when they reached age 19; or
- b. became disabled between the ages of 19 and end of the month during which they turn age 26 and was covered under the Plan when they became disabled; and
- c. the Disabled Dependent Child is primarily dependent on Member for support. Primarily dependent means child depends on you for more than 50% of their support, and the child qualifies as a dependent under the Internal Revenue Code as evidenced by you claiming the child as a dependent on your federal income tax return.



6. Children Covered by Qualified Medical Child Support Order

If you become divorced or legally separated, certain court orders could require that you provide health care coverage for your child(ren), even if you do not have custody. The Plan will determine if a “medical child support order,” as that term is defined under ERISA Section 609, is a “qualified medical child support order” (QMCSO), as that term is also defined under ERISA Section 609, in accordance with the Plan’s QMCSO procedures. Administration of the QMCSO by the Plan will be in accordance with the terms of the Plan and the Plan’s QMCSO procedures adopted by the Plan Administrator. If you would like a copy of the Plan’s QMCSO procedures, contact the Benefits Service Center at 1-888-421-2199, option 1, then option 3, to request a copy. The procedures are also posted online at www.mympcbbenefits.com, under “Notices & Plan Documents,” then “Legal Notices,” or can be found directly at <http://www.mympcbbenefits.com/documents/mpc-qualified-medical-child-support-order-procedures.pdf>.

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

Note: You and your covered dependents must be covered under the same Option of the Plan.

C. When Coverage Ends or May be Continued

The following are instances of when coverage under the Plan is terminated or may be continued. In most instances, if coverage may be continued, contributions are required to be paid.

1. The Member fails to pay the required Member contributions on a timely basis;
 - Coverage terminates on the last date for which contributions were paid.
2. If Retiree Member dies;
 - Coverage for the surviving spouse and other dependents may be continued thereafter as long as they are eligible and pay the required Member contributions.
3. If the spouse of a Retiree Member becomes eligible for Medicare due to age (age 65) before the retiree;
 - Coverage for the spouse terminates the first of the month in which spouse turns age 65.
4. If the Retiree Member, Surviving Spouse Member, or Spouse Member becomes eligible for Medicare due to age (age 65);
 - Coverage for the Member terminates the first of the month Member turns age 65. Coverage for eligible children may be continued under the Retiree Health Plan. In addition, coverage for an under-age-65 spouse of a Retiree Member who attains age 65 may continue under the Retiree Health Plan.
5. If a retiree waives coverage under this Plan or under the Exchange HRA in order to participate in an “approved alternative plan,” such as the Veteran Administration’s health care plan or TRICARE, coverage under this Plan for the spouse may be continued. Coverage for eligible children terminates.

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6. If a Retiree Member and spouse die simultaneously;
 - Coverage for eligible children is continued at Company expense for 60 days following the date of death. Children or the legal guardian may continue the children's coverage as long as they remain eligible by paying the required contributions.
7. If a Member becomes divorced;
 - Coverage for the spouse terminates at the effective date of the divorce. Coverage for eligible children may be continued.
8. If a Surviving Spouse Member remarries;
 - Coverage for the Member and children terminates at the end of the month in which the marriage occurs. Coverage for the children may be reinstated provided that evidence is provided that no other coverage is available and the child(ren) pay the retiree contribution at the retiree rate (if one child) or retiree with children rate (if two or more children) to continue as Members.
9. When a child reaches first of month following month in which they turn age 26;
 - Coverage for the child terminates.
10. If a dependent becomes a regular full-time employee of the Company;
 - Coverage normally terminates since the dependent can join the active employee Health Plan as an employee member. However, if the dependent is a spouse or child, continued coverage as a dependent is permitted.
11. When LTD Terminated Member is no longer eligible for disability benefits under the Marathon Petroleum Long Term Disability (LTD) Plan (if legacy MPC) or fully-insured Long Term Disability Plan previously sponsored by Andeavor (if legacy Andeavor);
 - Coverage for Member and any dependents terminates.

IV. Cost of Coverage

The Plan is designed so the Company pays approximately 80% of the cost of the Plan and Members pay 20% of the Plan cost through contributions.

See Article II, "Helpful Terms," of this document for the Member types that are part of the "Non-Employee Group."

Member contributions for the Non-Employee Group are listed in Appendix C. Members will be advised of changes in monthly contributions prior to the start of each calendar year. Members pay for coverage by submitting monthly payments in advance.

A. "Non-Employee Group" Member Contributions

The total cost for the "Non-Employee Group" is determined annually based on past claims experience for Members of that group. The Company subsidy for the group is then calculated such that the Company will be paying approximately 80% of the cost. Thus, the Member cost for those individuals who are eligible for 100% of the Company subsidy is approximately 20% of the total cost for the Non-Employee Group.

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However, the amount of Company subsidy for a Member of the “Non-Employee Group” may be less than 100% and is currently determined using the “4% accrual method.” Under this provision, an employee age 30 or older earns 1% of the eventual retiree subsidy for each calendar quarter in which they are either actively employed or on one of the approved leave statuses on the last day of the quarter. Generally, this means that an employee earns 4% of the eventual retiree subsidy per year. If an employee works continuously from age 30, they will be entitled to 100% of the eventual retiree subsidy by age 55. The amount of subsidy earned for each individual is frozen at their retirement and will then be used to determine all future Retiree Health Plan Member contributions for the Retiree Member and any covered spouse and children.

Refer to Appendix C for actual rates based on the possible accrued percentage of Company subsidy.

Retiree Health Plan Member contributions for Spouse/Domestic Partner Members, Surviving Spouse Members, and Surviving Child(ren) Members of retirees are determined using the percent of Company subsidy earned by their respective Retiree Member and frozen at the time of the Retiree Member’s retirement.

Retiree Health Plan Member contributions for eligible Surviving Spouse Members and eligible Surviving Child(ren) Members of employees who died while actively employed with the Company (prior to retirement) are determined using 100% of the Company subsidy for the Non-Employee Group.

Retiree Health Plan Member contributions for LTD Retiree Members and LTD Terminated Members are determined using 100% of the Company subsidy for the Non-Employee Group. Spouse Members, Surviving Spouse Members, and Surviving Child(ren) Members of LTD Retiree or LTD Terminated Members also qualify for 100% of the Non-Employee Group subsidy.

Retiree Members who retired prior to January 1, 2016, (and their dependents if applicable) who worked more than 50% of their total service as Regular Part-time employees will receive 50% of the Company contribution that the Retiree Members are otherwise entitled to. (This provision does not apply to LTD Retiree Members or LTD Terminated Members.) Retiree Members who retired January 1, 2016 or later who worked more than 50% of their total service as Regular Part-time employees will receive 100% of the Company contribution to which Retiree Members are entitled.

Rehired Regular employees receive credit for any previously earned percentage and begin to earn additional percentages immediately. Rehired Regular employees who had previously retired with less than 100% of the Company subsidy begin to earn additional percentages immediately, but they cannot be applied unless the Rehired Regular employee works at least a full year. However, if the rehired retiree was rehired January 1, 2008, or later, additional service credit can only be applied to coverage under the Marathon Petroleum Retiree Health Plan. (See further clarification under Member Eligibility — Retiree Member or LTD Retiree Member.)



Important Note: *At one point a different method, the “Age and Service Point System,” was used to determine the amount of retiree’s Retiree Health Plan Company subsidy. Those individuals who were employed at the time the Age and Service provision was in effect earned the per cent of subsidy using this method. Appendix C explains how this method worked, and also certain “grandfather” provisions that are used when an individual has earned percentages under both methods.*

IMPORTANT NOTE: The Company reserves the right to modify the Company subsidies described above, and to make corresponding changes to the manner in which the Retiree Health Plan Member contributions are to be paid by members of the Non-Employee Groups, as the Company may, in its sole discretion, determine to be necessary or desirable.

B. Tax Treatment

Plan coverage is not taxable, except with respect to certain Domestic Partner Members and their covered children who are not tax dependents of the Retiree Member, LTD Retiree Member or LTD Terminated Member. Where the Domestic Partner Member or their covered child is not a tax dependent, the fair market value of the coverage not paid for by the Retiree Member, LTD Retiree Member or LTD Terminated Member will be taxable to them. The Company will report this taxable amount to the Internal Revenue Service and to the affected member and to other taxing authorities as required by the Internal Revenue Code and other applicable laws, and the affected member is responsible for paying any resulting taxes on the amount. The Company shall determine whether a Domestic Partner or a child of same is a tax dependent of the affected member and may require such information from the affected member and implement such procedures as it may in its discretion deem appropriate to make such determination.

V. Enrolling in the Plan

A. Annual Enrollment

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

B. Member Enrollment

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

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A retiree may waive coverage in order to enroll in an “approved alternative plan” (such as the Veteran Administration’s health care plan or TRICARE) and cover their under-age-65 spouse under the Plan. For further information, refer to “Spouse Member” in Article III, “Retiree Health Plan Participation,” Section (A)(5) of this document.

1. Enrollment When First Eligible for Coverage

a. Retiree Member, LTD Retiree Member and LTD Terminated Member Coverage

- i. Prospective Retiree Members, LTD Retiree Members, and LTD Terminated Members may, within 31 days of the effective date of their retirement (including the retirement date), elect to enroll through Workday Benefits in order to be covered as a Member under the Plan. If the enrollment election is submitted in Workday Benefits within 31 days of the first date of eligibility (including the eligibility date), participation is effective on the first date of eligibility.

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

b. Spouse Members, Surviving Spouse Members, and Child Members

- i. Prospective Spouse Members, Surviving Spouse Members, and Child Members who **are enrolled** in the Plan as a dependent of a Member on the day immediately prior to their first date of eligibility under the Plan as a Member will have their coverage automatically continued under the Option of the Plan they were most recently enrolled in as a dependent. Such Members will not be required to make an election through Workday Benefits in order to continue coverage.
- ii. Prospective Spouse Members, Surviving Spouse Members, and Child Members who **are not enrolled** in the Plan as a covered dependent of a Member on the day prior to their first date of eligibility as a Member must elect to enroll and provide any required documentation through Workday Benefits in order to be covered as a Member under the Plan. If the election is submitted in Workday Benefits within 31 of the first date of eligibility, participation is effective on the eligibility date.

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

2. Late Enrollment

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



- a. your loss of eligibility for coverage under another employer's group health plan providing medical coverage or under other health insurance coverage providing medical coverage that was obtained through self-employment; or
- b. the exhaustion of COBRA continuation of coverage by you under another employer's group health plan providing medical coverage.

All enrollments or election changes due to the above events must be made within 31 days of the event (including the event date) through Workday Benefits. Any required documentation also must be submitted within 31 days of the event. If the enrollment is received on, before or within 31 days of any of the above events (including the event date), participation is effective on the date of the event. Enrollment elections or changes submitted after the 31-day election period will not be accepted.

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

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

In addition, under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIP) you may enroll in the Plan within 60 days of either (1) termination of Medicaid or CHIP coverage due to loss of eligibility or (2) becoming eligible for a state premium assistance program under Medicaid or CHIP coverage.

3. Enrollment for Continued Member Coverage

See Article XIX, "Your Legal Right to Continue Coverage Under COBRA."

C. Dependent Enrollment

1. If the enrollment (including any required documentation) for an eligible dependent or dependents is submitted in Workday Benefits on, before or within 31 days of an event described below (including the event date), participation is effective on the date of the event.
 - a. the first date of eligibility of the Member;
 - b. the first date of eligibility of the dependent;
 - c. the loss of eligibility for coverage by an eligible dependent of a Member under another employer's group health plan providing medical coverage or under other health insurance coverage providing medical coverage that was obtained through self-employment;



- d. the exhaustion of COBRA continuation of coverage under another employer's group health plan providing medical coverage by a prospective Member and/or by an eligible dependent of either a prospective Member or a Member; provided, however that dependents of Spouse Members, or Surviving Spouse Members are not eligible to be enrolled due to this event (d).

For purposes of this section, the phrase "loss of eligibility for coverage" does not include a loss of coverage due to any individual's failure to make timely premium payments (or other required contributions) for any reason.

Under CHIP, dependents may be enrolled in the Plan within 60 days of either (1) termination of Medicaid or CHIP coverage due to loss of eligibility or (2) becoming eligible for a state premium assistance program under Medicaid or CHIP coverage.

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

VI. Changing Coverage Options While Enrolled

If a current Plan Member wishes to make a change between the available Options of coverage under the Retiree Health Plan, the change may be made during the Annual Enrollment Period designated by the Plan Administrator each year, by using the procedures set up by the Plan Administrator to make such changes. See Article I, "Purpose," of this document for an explanation of available Options. Such a change will be effective for both the Member and any covered dependents on January 1 of the following year.

VII. Waiver of Coverage

A Member may waive coverage under the Retiree Health Plan for the Member and/or dependents at any time. The waiver is effective the day the election is submitted in Workday Benefits. Subject only to the exceptions described in Sections VII.A. and VIII., if Member coverage is waived, all dependent coverage must also be waived.

A. In certain instances, a Retiree Member, LTD Retiree Member, or LTD Terminated Member may waive coverage under the Retiree Health Plan for themselves and cover their under-age-65 spouse and, in some cases, eligible children. An example is:

1. Member elects to enroll in an "approved alternative plan" such as the Veteran Administration's health care plan or TRICARE.

A member who terminates participation in the Plan on or after January 1, 2021 will not be eligible to re-enroll unless participation was terminated to enroll in the Marathon Petroleum Health Plan (for active employees) and such enrollment is continuous until re-enrollment in this Plan.



VIII. Special Provisions for Under-Age-65 Disabled/ESRD Individuals

If you or your covered spouse are under age 65, covered by Medicare due to disability or end stage renal disease (ESRD) and have Medicare as the primary payer of benefits, you or they may choose to change your or their coverage from the Retiree Health Plan to an individual Medicare supplemental policy and participate in the Exchange HRA, if eligible.

(Children are not eligible to participate in the Exchange HRA.) If you make this choice, you may continue to cover your eligible under-age-65 dependents under the Retiree Health Plan.

You or your covered spouse may elect to change coverage to an individual Medicare supplemental policy and participate in the Exchange HRA, if eligible, to be effective on the first date of coverage by Federal Medicare, where Medicare is the primary payer of benefits, provided your change in election, including submission of any required documentation, is made through Workday Benefits within 31 days of the first date of coverage by Medicare (where Medicare is the primary payer of benefits).

For information on making changes from the Retiree Health Plan to an individual Medicare Supplemental policy and participation in the Exchange HRA, contact the Benefits Service Center at 1-888-421-2199, option 1, then option 3. For information on Medicare eligibility and your rights to Social Security benefits, contact your local Social Security office.

A. Offset Provision

The offset provision applies to you if you or a covered dependent are disabled or have ESRD and “eligible for Medicare Benefits” and have (or would have if Medicare were elected) Medicare as your primary payer of benefits (with the Retiree Health Plan as the secondary payer of benefits). Under the offset provision, your benefits under the Retiree Health Plan will be reduced (offset) by the benefits payable under Medicare Parts A and B (or that would have been payable had Medicare been elected). “Eligible for Medicare Benefits” means the individual is or could be covered under Medicare Part A, or Part A and B, because of 1) the entitlement to Social Security benefits for themselves or for one of their parents (in the case of a child) or 2) ESRD.

IX. Overview of How the Plan Works

A. Plan Options

If you are eligible to enroll for Retiree Health Plan coverage, you and any eligible dependents can enroll in the following options as indicated below:

- **Classic or Saver HSA (Options)** — Both Preferred Provider Organization (“PPO”) Options are available to all Members and are subject to in-network and out-of-network benefit levels, depending upon the Option chosen.

The PPO (Preferred Provider Organization) network offered will be:

- The Anthem BC/BS BlueCard PPO Network



Prescription drug benefit levels differ based on the Option in which the employee is enrolled. The Managed Prescription Drug Program is administered by Express Scripts.

- Kaiser Permanente Northern or Southern California HMO (Options) — These HMO Options are available to Members residing in the respective California service area and are subject to the provisions and benefit levels of the option selected. Refer to Appendices E and F for benefit information.

B. Types of Programs

Benefits under the Plan are provided by the following three programs:

- 1. Medical/Surgical Program** — Covers services and supplies relating to a medical diagnosis, mental health and substance abuse, and other services which are not covered by the Managed Prescription Drug Program or the Routine Physical and Preventive Services Program.
- 2. Managed Prescription Drug (Prescription) Program** — Covers “outpatient prescription drugs.” For a definition of “outpatient prescription drugs,” see Article XIII, “Managed Prescription Drug Program.” of this document.
- 3. Routine Physical Examination and Preventive Services (Preventive Services) Program** — Covers a routine physical examination, and designated preventive screening tests and designated preventive immunizations. Coverage is limited to one covered service each calendar year or as recommended by the U.S. Preventive Services Task Force pursuant to provisions of the Patient Protection and Affordable Care Act (PPACA). See Article XI, “Physical Examination and Preventive Services (Preventive Services),” of this document.
- 4. Teladoc Medical Experts** — Members are eligible to voluntarily utilize this third-party service to gain access to expert physicians to help with making medical decisions and to locate specialists. Members can contact Teladoc Medical Experts at 1-855-380-7828 or visit www.teladoc.com/medical-experts. Teladoc Medical Experts provides the services summarized below. (Not available to Kaiser enrollees.)

Expert Medical Opinion — A leading physician expert reviews a Member’s diagnosis and/or treatment plan and provides a detailed recommendation. Teladoc Medical Experts reviews everything in great detail and creates a comprehensive report, either confirming what the Member has been told or recommending a change. Members can share the report with their treating physician as a basis for further discussion of treatment options. **(Note:** As with other medical/surgical treatments, procedures or prescriptions drugs which may be recommended by a health care provider for a Member, coverage under the Plan is governed by the terms of the Plan, and a recommendation by Teladoc Medical Experts is not a decision regarding approval of coverage for such treatment under the Plan.)

Critical Case Support — Receive expert medical guidance if Member has been admitted into the hospital.

Mental Health Navigator — Receive guidance on a mental health condition or treatment that isn’t improving.



Ask the Expert — Members can get answers to basic questions about a diagnosis, treatment options or a health condition from an expert. Teladoc Medical Experts will discuss your concerns with you and deliver your questions to the most appropriate specialist. Teladoc Medical Experts will also help you determine what questions to ask.

Find A Doctor — If you need to find a specialist in your local area who is approved by the Plan, Teladoc Medical Experts has a database of more than 53,000 medical experts in over 450 specialties and subspecialties to help find the doctor who's right for you.

C. Comparing the Plan's Options

Refer to Appendix D for the comparison of the Plan's Options, deductibles and out-of-pocket maximum amounts.

X. Medical/Surgical Program

A. Plan Deductible

The Medical/Surgical Program has a deductible amount that must be met each calendar year before the Plan pays for any medical/surgical covered expenses. Deductible amounts incurred during a plan year under a Marathon Petroleum Health Plan option will be transferred to a Marathon Petroleum Retiree Health Plan option, if enrolled, provided such enrollments occur within the same plan year.

- 1. In-Network:** Once the in-network medical/surgical deductible is met, in-network benefits are paid under the Medical/Surgical Program of the Plan. Only in-network covered charges and eligible out-of-network emergency room coinsurance apply toward the in-network deductible. Out-of-network covered charges **do not** apply toward the in-network deductible, with the exception of eligible out-of-network emergency room coinsurance.
- 2. Out-of-Network:** Once the out-of-network medical/surgical deductible is met, out-of-network benefits are paid under the Medical/Surgical Program of the Plan. Out-of-network covered charges apply toward the out-of-network deductible. In-network covered charges **do not** apply toward the out-of-network deductible.

Charges under the Routine Physical Examination and Preventive Services (Preventive Services) Program are not subject to the medical/surgical deductible except for preventive services obtained out-of-network.

Under the Classic Option, charges under the Managed Prescription Drug (Prescription) Program cannot be applied toward the Medical/Surgical Program deductible. Under the Saver HSA Option, the deductible is combined for the Medical/Surgical Program and the Prescription Program.

You can refer to Article II, "Helpful Terms," of this document for more information about how the Plan deductible works under the Classic and Saver HSA Options.



B. Out-of-Pocket Maximum Limit

The out-of-pocket maximum is the most each covered individual would pay in the form of deductible, coinsurance and copays each calendar year, subject to the Maximum Allowed Amount and other plan limitations as further described in Article II, “Helpful Terms,” of this document. Once the appropriate out-of-pocket maximum has been met, the Plan pays 100% of all covered expenses for the remainder of the calendar year. Out-of-pocket maximum amounts incurred during a plan year under a Marathon Petroleum Health Plan option will be transferred to a Marathon Petroleum Retiree Health Plan option, if enrolled, provided such enrollments occur within the same plan year.

Once the in-network out-of-pocket maximum is met, most covered charges under the in-network level of benefits of the Plan are paid at 100% for the rest of the calendar year. Once the out-of-network out-of-pocket maximum is met, most covered charges under the out-of-network level of benefits of the Plan are paid at 100% for the rest of the calendar year. Any copays or coinsurances you pay by obtaining preventive services out-of-network (under the Preventive Services Program) are applied toward the out-of-network out-of-pocket maximum.

In-network and exception benefit level coinsurances apply toward meeting the in-network out-of-pocket maximum limit. Out-of-network coinsurances apply only toward meeting the out-of-network out-of-pocket maximum. However, out-of-network emergency room copays apply toward meeting the in-network out-of-pocket maximum. In-network emergency room copays do not apply toward the out-of-network out-of-pocket maximum. See Article XII, “Classic & Saver HSA Options,” Section G for more information on exception benefit levels.

Under both the Classic Option and the Saver HSA Option, covered charges under the Prescription Program are paid at 100% after the in-network out-of-pocket maximum is reached.

You can refer to Article II, “Helpful Terms,” of this document for more information about how the out-of-pocket maximum limit works.

C. Covered Expenses

Expenses must be medically necessary in order to be covered by the Plan. They are also limited to the Maximum Allowed Amount, negotiated fee schedules, and other Plan limitations. **See the Article XIV, “Expenses Not Covered Under the Plan,” in this document for a list of specific types of expenses which are not covered,** even though they may otherwise be considered medically necessary.

The Retiree Health Plan includes (but is not limited to) coverage for the following services at the coinsurance amounts indicated on the chart in Article X, “Medical/Surgical Program,” Section F. Refer to the separate sections for further requirements which may affect the level of coinsurance (in-network vs. out-of-network).

See Article X, “Medical/Surgical Program,” Section D, for specific pre-certification requirements which may apply.

There may be significant penalties applied to the Member for not following the pre-certification requirements.



Required Notice Under the Women’s Health and Cancer Rights Act of 1998

(Women’s Health Act): If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the deductibles and coinsurance as shown in Appendix D will apply.

If you would like more information on WHCRA benefits, call Anthem at 1-855-698-5676.

1. Hospital Inpatient Charges

Covered hospital charges include:

- a. Room and board charges.
- b. Intensive care unit charges.
- c. Ancillary charges which include charges for diagnostic expenses (laboratory tests and X-rays); medicines; use of operating and recovery rooms; private nursing fees; and other items prescribed as medically necessary by a doctor.

2. Physician and Surgeon Charges

Covered physician and surgeon charges include physician, surgeon, physician specialists, anesthetist and other physician fees for services performed in the hospital. (For physician charges in the emergency room, see “3. Emergency Room Charges” below.)

Classic and Saver HSA Options. If a covered individual uses an in-network facility and the facility uses an out-of-network Radiologist, Anesthesiologist, Pathologist, and/or Assistant Surgeon, coverage for the provider will be at the in-network level (80% under both Options) and the charges will be subject to the Maximum Allowed Amount (which means the Member will be responsible for both the coinsurance of 20% as well as any charges in excess of the Maximum Allowed Amount).

Independent Medical Evaluations/Second Surgical Opinions. You may be required to obtain an Independent Medical Evaluation (IME)/Second Surgical Opinion by the pre-certification review agency if there are any questions as to medical necessity, appropriateness, and cost effectiveness of a hospital admission, surgery, or diagnostic procedure. You will be advised if you are required to obtain an IME/Second Surgical Opinion and the charges for the approved evaluation will be covered by the Plan without being subject to the medical/surgical deductible or coinsurance provisions.



3. Office Visits — Primary Care

Standard Primary Care Physicians include:

- Advance Registered Nurse Practitioners
- Nurse Practitioners
- Nurse Practitioner Pilot Program
- Obstetricians
- Gynecologists
- General Practice
- Family Practice
- Internal Medicine
- Physician Assistants
- Pediatricians
- Clinical/Multi Specialty Groups

Office visits include telehealth visits and telephonic visits (exclusive of LiveHealth Online) that are appropriate for telehealth and telephonic care.⁵

⁵ Covered services include a medical consultation using the internet via a webcam, chat or voice. Non-covered services include, but are not limited to, communications used for: reporting normal lab or other test results; office appointment requests; billing, insurance coverage or payment questions; requests for referrals to physicians outside of the online care panel; benefit precertification; and physician to physician consultation.

Classic Option. The Member copay for covered physician office visits is \$20 if an in-network provider is used. If Member uses an out-of-network provider, Member cost is 40% coinsurance after meeting the out-of-network deductible, as well as any charges in excess of the Maximum Allowed Amount.

Saver HSA Option. The Member pays 100% of charges until the deductible is met. If an in-network provider is used, once the in-network deductible has been met, Member cost is 20% coinsurance. If Member uses an out-of-network provider, once the out-of-network deductible is met, Member cost is 40% coinsurance, as well as any charges in excess of the Maximum Allowed Amount.

4. Office Visits — Specialist Care

Specialist Physicians include cardiologists, oncologists, chiropractors, pulmonologists, urologists, rheumatologists and neurologists. In general, specialists are those who provide medical care in a specialized medical field and who are not listed above as a standard primary care physician.

Office visits include telehealth visits and telephonic visits (exclusive of LiveHealth Online) that are appropriate for telehealth and telephonic care.⁶

Classic Option. The Member copay for all covered physician office visits is \$50 if an in-network provider is used. If Member uses an out-of-network provider, Member cost is 40% coinsurance after meeting the out-of-network deductible, as well as any charges in excess of the Maximum Allowed Amount.

⁶ Covered services include a medical consultation using the internet via a webcam, chat or voice. Non-covered services include, but are not limited to, communications used for: reporting normal lab or other test results; office appointment requests; billing, insurance coverage or payment questions; requests for referrals to physicians outside of the online care panel; benefit precertification; and physician to physician consultation.



Saver HSA Option. The Member pays 100% of charges until the deductible is met. If an in-network provider is used, once the in-network deductible has been met, Member cost is 20% coinsurance. If Member uses an out-of-network provider, once the out-of-network deductible is met, Member cost is 40% coinsurance, as well as any charges in excess of the Maximum Allowed Amount.

5. Office Visits — LiveHealth Online

Using LiveHealth Online, Members have access to board-certified doctors 24 hours a day, seven days a week, via an online video visit with a doctor or therapist by using a smartphone, tablet or computer with a webcam. LiveHealth Online physicians can provide medical care for common conditions including the flu, colds, pink eye, sinus infections, bronchitis and more and can send prescriptions to the pharmacy of your choice, if needed. For more information on how to use or sign up, Members should go to www.livehealthonline.com. LiveHealth Online is not for emergencies.

Classic Option. The Member copay for a LiveHealth Online visit is \$10, and the copay is applied to your in-network out-of-pocket maximum.

Saver HSA Option. Member cost for a LiveHealth Online visit is \$59, and the cost is applied to your in-network deductible and out-of-pocket maximum.

6. Urgent Care Facility

Urgent Care facilities are not emergency rooms and not meant to provide treatment of life threatening or serious conditions. Urgent care facilities are often open for extended hours in the evenings and on weekends and can provide treatment for common conditions such as upper respiratory infection, earache, fever, and minor injuries, cuts and burns.

Classic Option. The Member copay for a visit to an urgent care facility is \$50 if an in-network provider is used. If a Member uses an out-of-network provider, the Member cost is 40% coinsurance after meeting the out-of-network deductible, as well as any charges in excess of the Maximum Allowed Amount.

Saver HSA Option. The Member pays 100% of charges until the deductible is met. If an in-network provider is used, once the in-network deductible has been met, the Member cost is 20% coinsurance. If Member uses an out-of-network provider, once the out-of-network deductible is met, the Member cost is 40% coinsurance, as well as any charges in excess of the Maximum Allowed Amount.

7. Emergency Room Charges

Covered emergency room charges include emergency room facility charges, physician charges, and ancillary charges.

Under the Classic Option, all emergency room visits that do not result in a hospital admission will be subject to a \$200 copay. Additionally, the Member pays any amount remaining toward meeting the deductible and then 20% coinsurance. The emergency room copay does not apply toward the deductible, but it does apply toward the out-of-pocket maximum.



Under the Saver HSA Option, the Member pays 100% of charges until the deductible is met. Once the deductible has been met, the Member is subject to a \$200 copay (copay waived if the Member is admitted to the hospital) and then 20% coinsurance. The emergency room copay applies toward the out-of-pocket maximum.

8. Ambulance Services

Covered ambulance services include emergency local ambulance service or public carrier, to and from the residence or place of disability and nearest adequate facility for treatment, as prescribed by a doctor. Ambulance services to or from the patient's home or other location for convalescence care are generally not covered. Refer to Article XIV, "Expenses Not Covered Under the Plan," for further information.

9. Diagnostic Tests

Diagnostic tests must be recommended by a doctor for the diagnosis of an illness or injury. Covered diagnostic tests include X-rays or tests performed in a doctor's office, laboratory, or at a hospital as an outpatient. Hearing tests are covered if medically necessary and performed for diagnostic purposes in connection with an illness or injury. See Article X.C.22 regarding coverage for diagnostic testing and related services for COVID-19.

10. Therapeutic Treatment

The following therapeutic treatments are covered.

- a. Physical therapy, occupational therapy, and non-educational speech therapy.
- b. Manipulations, regardless of provider type or specialty, are limited to 20 visits per person per year, while the individual is not confined to a hospital or other covered institution as an admitted inpatient.

11. Immunizations, Injections, and Allergy Shots

Expenses for immunizations, allergy shots, and other injectable drugs which are not covered under any other provision of the Plan, are covered by the Plan under this provision if they are prescribed by a physician for treatment of an illness or injury. (Insulin and certain specialty medications — injectable medications administered either by the Member or a health care professional — are covered under the Managed Prescription Drug Program of the Plan.)

12. Treatment for TMJ

Charges for the treatment of Temporomandibular Joint Dysfunction (TMJ) are covered by the Plan.



13. Hearing Aids

Coverage for hearing aids and certain related charges are covered, subject to deductible and coinsurance, only if services are obtained through an in-network provider. Coverage is limited to one hearing aid per ear every 36 months (three years). Covered expenses include conformity exam, placement exam and hearing aid assessment exam, each limited to one per 36 months, not included with any other exam. Hearing exams/testing are covered with no visit limit, batteries, repairs and additional charges are not covered.

14. Coverage for Autism Spectrum Disorder and Rett Syndrome

Treatment includes Applied Behavior Analysis (ABA) therapy, as well as speech and occupational therapy within the limits of the Plan.

Applied Behavior Analysis (ABA) Therapy:

- Precertification is required prior to services being rendered.
- A diagnosis of Autism Spectrum Disorder or Rett Syndrome is required. Evaluation and diagnosis must have been completed by a psychiatrist, developmental behavior pediatrician, psychologist or neurologist.
- Ongoing reviews for medical necessity take place at specific intervals throughout the child's treatment. These typically occur every six months. However, intervals may vary based on the child's needs and the target behaviors that are being addressed through therapy.
- ABA providers must be independently licensed professional such as clinical social workers, clinical psychologists or masters level therapists; or they must be behavior analysts certified by the Behavior Analyst Certification Board.
- ABA may be provided in an office setting, in the home or in another community setting outside of the classroom. Services provided in the classroom setting are not covered.

Members or their ABA provider must contact Anthem's Autism Spectrum Disorders (ASD) Program at 1-844-269-0538 prior to engaging in ABA services to request pre-certification and to ensure services are covered. The ASD Program provides clinical review of ABA assessment and treatment requests to ensure that appropriate and medically necessary care is being delivered. The Program also offers autism-focused case management services to support members with coordination of care, resource referrals and educational information.



15. Infertility Treatment

With a diagnosis of infertility, covered treatment includes one attempt (or cycle) per Member per lifetime combined all treatments, at an in-network provider, for either in vitro fertilization (IVF) or artificial insemination (AI). IVF includes gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT). Labs, X-rays, ultrasounds or diagnostic procedures do not count toward the one attempt (or cycle), but will be covered as well. Although not required, the provider should submit a pre-determination to Anthem to verify the treatment sought is a covered procedure at an in-network provider or facility, as well as to provide the Member with an estimate of covered expenses. Treatment provided by an out-of-network provider is not covered.

There is an individual lifetime maximum of \$15,000 in prescription drug coverage to treat infertility. Any fertility drugs covered under the Plan prior to January 1, 2020, will not be counted toward this lifetime maximum.

16. Mental Health Parity and Substance Abuse Equity

The Plan has been designed to be in compliance with the Mental Health Parity and Addiction Equity Act of 2008 (the MHPAEA) and will provide inpatient and outpatient benefits, including emergency care and prescription drug coverage, for mental health conditions and substance use disorders without quantitative or non-quantitative treatment limitations more restrictive than those applied to equivalent medical/surgical benefits for other conditions covered by the Plan. To the extent that the Plan does not otherwise satisfy the requirements of the MHPAEA, the Plan will be interpreted under this paragraph in the manner which complies with the requirements of the MHPAEA.

Charges for the following expenses are covered by the Plan:

Substance Abuse Disorders

- a. Inpatient institutions and ancillaries and residential treatment centers, including detoxification. Methadone clinics are covered.
- b. Outpatient institutions and outpatient therapy. Methadone clinics are covered.
- c. Outpatient office visits.

Mental Health and Eating Disorders

- a. Inpatient institutions and ancillaries and residential treatment centers.
- b. Outpatient institutions and outpatient therapy.
- c. Outpatient office visits.



Programs — Partial Hospitalization and/or Intensive Outpatient

In order for treatment to be eligible for coverage through a partial hospitalization program or intensive outpatient program, the program must be licensed and operated as required by law and be fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA). Additionally, such service must be provided by a program that provides:

Partial Hospitalization Program:

Structured, multidisciplinary behavioral health treatment that offers nursing care and active individual, group and family treatment in a program that operates no less than six hours per day, five days per week.

Intensive Outpatient Program:

Structured, multidisciplinary behavioral health treatment that provides a combination of individual, group and family therapy in a program that operates no less than three hours per day, three days per week.

Residential Treatment Center

In order for treatment to be eligible for coverage at a residential treatment center (RTC) or facility, the RTC must be licensed and operated as required by law, which includes:

- a. Room, board, and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight hours daily with 24-hour availability;
- b. A staff with one or more doctors available at all times;
- c. Residential treatment takes place in a structured facility-based setting;
- d. The resources and programming to adequately diagnose, care and treat a psychiatric and/or substance use disorder;
- e. Facility is designated residential, subacute, or intermediate care and may occur in care systems that provide multiple levels of care; and
- f. Is fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA).

The term residential treatment center/facility does not include a provider, or that part of a provider, used mainly for:

- a. Nursing care
- b. Rest care
- c. Convalescent care
- d. Care of the aged
- e. Custodial care
- f. Educational care



17. Other Covered Expenses

Charges for the following expenses are covered by the Plan:

- a. Charges made by a registered nurse when recommended by a doctor to perform skilled nursing procedures on an intermittent basis.
- b. Charges for radiation therapy and chemotherapy whether performed as a hospital inpatient or an outpatient.
- c. Charges for intravenous (IV) and intramuscular injectable drugs. (Certain specialty medications — injectable medications administered either by the Member or a health care professional — are covered under the Managed Prescription Drug Program of the Plan.)
- d. Charges for durable medical equipment and prosthetic/orthopedic devices. These charges include plastic molds, splints, trusses, crutches, braces, artificial limbs or eyes, insulin pump (as well as tubing and needles for the pump) and rental of respirator, wheelchair, hospital-type bed, or special mechanical equipment for treatment of an illness.
- e. Charges for acupuncture provided by a licensed or certified physician, chiropractor, or acupuncturist acting within the scope of that license or certification. (Does not include acupuncture coverage for smoking cessation treatment.)
- f. Contraceptive diaphragms and IUDs.
- g. Weight Reduction surgery is covered under the Retiree Health Plan under the “Centers of Excellence” concept. Qualifying Retiree Health Plan Members will receive coverage for the procedure if they have the procedure done at a facility that has been identified as a Center of Excellence by Anthem BC/BS. Reimbursement will be at the 80% level under both Options. ***If the procedure is done at a facility that has not been designated as a Center of Excellence, there will be no reimbursement.***

In order to qualify for this surgery, you must have a Body Mass Index of at least 40, or a BMI of 35 or greater with complicating morbidities, directly related to or exacerbated by obesity. There are other requirements that you may have to meet. In order to see if you qualify, you will need to contact Anthem. They will also be able to provide you with the list of Centers of Excellence.

18. Hospitalization Alternatives

a. Skilled Nursing Facility

Skilled nursing facility means an institution that provides room, board and skilled nursing services for medical care around-the-clock. It must comply with legal requirements and keep daily medical records of all patients. The term does not include institutions used mainly for substance abuse, rest care, educational care, custodial care or care of the aged.



Coverage for skilled nursing facility is subject to the following restrictions:

If confinement begins after:

- discharge from a hospital confinement of at least three days; or
- discharge from an extended care facility where confinement began as described immediately above;

then payment will be made up to the 180th day of confinement for covered charges made by the facility.

If the Member is readmitted to a skilled nursing facility within 72 hours, no new hospital stay is required.

Payments for all skilled nursing facility confinements are limited to 365 days in each covered person's lifetime.

b. Home Health Care

Home Health Care Agency means a public or private agency or organization, or part of one, which provides skilled nursing and other therapeutic services. It must keep clinical records of all patients. The services must be supervised by a doctor or Registered Nurse, and they must be based on policies set by associated professionals, which include at least one doctor and one Registered Nurse.

Charges made by a qualified home health care agency for home health services that have been prescribed by a doctor in place of hospital services are covered by the Plan. Covered services include:

- Part-time nursing care given in the covered person's home by a Registered Nurse, a Licensed Practical Nurse, a Licensed Public Health Nurse, or Licensed Vocational Nurse, if under the supervision of a Registered Nurse;
- Part-time home health aide visits for personal care of the patient and light household tasks (four hours allowed per visit);
- Physical, occupational, or non-educational speech therapy provided in the covered person's home; and
- Physical, occupational, or non-educational speech therapy, or the use of medical equipment and prescription drugs provided on an outpatient basis by a home health agency, or if arranged with a home health agency, a hospital or other facility.

Services performed by a Member of the covered person's immediate family or by a person who normally lives in the home are excluded. Also excluded are services not needed for the treatment of an injury or illness.



c. Hospice Care

Hospice care is a coordinated system of medical, psychological and nursing care for terminally ill patients given at an approved hospice facility or at home.

A Member is eligible for hospice care if the Member's physician and the hospice medical director certify the Member is terminally ill and likely to have less than twelve (12) months to live. The Member may access hospice care while participating in a clinical trial or continuing disease modifying therapy, as ordered by the treating provider. Disease modifying therapy treats the underlying terminal illness.

The services and supplies listed below are covered when given by a hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms, but is not meant to cure a terminal illness. Covered Services include:

- care from an interdisciplinary team with the development and maintenance of an appropriate plan of care;
- short-term Inpatient Hospital care when needed in periods of crisis or as respite care;
- skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse;
- social services and counseling services from a licensed social worker;
- nutritional support such as intravenous feeding and feeding tubes;
- physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist;
- pharmaceuticals, medical equipment, and supplies needed for the palliative care of Your condition, including oxygen and related respiratory therapy supplies; and
- bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death.

The Member's physician must agree to care by the hospice and must be consulted in the development of the care plan. The hospice must keep a written care plan on file and provide it to the claims administrator upon request.

Benefits for services beyond those listed above that are given for disease modification or palliation, such as but not limited to, chemotherapy and radiation therapy, are available to a Member in hospice.



19. Case Management

If you or a covered dependent suffer a catastrophic illness or injury, you'll likely have many decisions to make regarding medical care. Case Management is designed to help manage the care of patients who suffer a catastrophic illness or injury while covered under the Plan.

The primary objective of Case Management is to identify and coordinate alternative medical treatments that are cost effective and meet accepted standards of medical practice. Case Management also monitors the care of the patients, and coordinates communication among the health care providers, patients, and others.

You or your covered dependent may be offered the chance to participate in Case Management after the Case Management team reviews your medical status, talks to the attending physician, and determines that an alternative treatment program or other special assistance would be in your best interest and is cost effective to the Plan.

If you accept the offer to participate in Case Management, the Plan pays after the deductible 100% of expenses which are not covered expenses under any other provisions of the Plan. All of these expenses must be incurred while you are covered under the Plan and are participating in Case Management. Custodial care (except for respite care) is not covered under the Case Management provision.

The patient may terminate participation in Case Management, or the Plan may terminate the patient's participation in Case Management at any time. Expenses incurred after such a termination are not covered under these Case Management provisions.

Anthem BC/BS is the third party administrator of the Plan who makes the Case Management decisions on behalf of the Plan.

20. Transplant Management Program

The Transplant Management Program is administered by Anthem BC/BS. Your coverage is higher if you participate in the Transplant Management Program.

You must agree to have the procedure performed at one of the designated Transplant Centers of Excellence facilities offered by Anthem BC/BS, and they must have a center of excellence that is for the required transplant.

If the above requirements are met, coverage will be at 100% for health care expenses related to the specialized procedure performed at the designated Transplant Centers of Excellence facility. The hospital expenses of a donor or prospective donor which are related to the covered individual's organ or tissue transplant are covered at 100%. The Transplant Management Program covered expenses are in place of all other benefits under any other provision of the Plan for the same charges. There is a maximum benefit allowance of \$30,000 per occurrence for the National Bone Marrow Donor Search. In addition, the approved transportation and approved lodging for one accompanying individual (two individuals if patient is minor child) will be reimbursed at 100%. Lodging is limited to \$50/day; maximum travel reimbursement is \$10,000 per transplant.



a. If you choose not to participate in the Transplant Management Program

The designated facilities under the Transplant Management Program are considered participating providers/in-network providers. If you choose not to participate in the Program and choose not to use a designated facility, your procedure will be subject to the out-of-network provisions of the Classic and Saver HSA Options. You will also be subject to the out-of-network provisions if you use an otherwise participating provider. Eligible donor or prospective donor expenses will be covered at the out-of-network level of benefit.

b. Other Transplant Information

The choice of physician and facility under this Plan is that of the patient. “Transplant Centers of Excellence” is a term of Anthem BC/BS and its use does not constitute an endorsement by MPC or the Plan. The Plan offers these “Transplant Centers of Excellence” in an effort to broaden Member choices, but does not endorse any provider over another.

21. Clinical Trials

The Plan pays for routine care costs incurred during your participation in a qualifying clinical trial. Benefits include coverage for services given to a participant in an approved clinical trial if the services are covered services under this Plan. Covered expenses will be covered at the in-network level if provided by an in-network provider or at the out-of-network level if provided by an out-of-network provider.

An “approved clinical trial” means a phase I, phase II, phase III or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

- a. Federally funded trials approved or funded by one of the following:
- The National Institutes of Health
 - The Centers for Disease Control and Prevention
 - The Agency for Health Care Research and Quality
 - The Centers for Medicare & Medicaid Services
 - Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs
 - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants



- Any of the below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
 - a. The Department of Veterans Affairs
 - b. The Department of Defense
 - c. The Department of Energy
- b. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;
- c. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

When a requested service is part of an approved clinical trial, it is a covered service even though it might otherwise be Investigational as defined by this Plan. All other requests for clinical trials services that are not part of approved clinical trials will be reviewed according to Anthem Clinical Coverage Guidelines, related policies and procedures.

The Plan is not required to provide benefits for the following services and reserves its right to exclude any of the following services:

- The experimental/investigative item, device, or service, itself; or
- Items and services that are given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; or
- Any item or service that is paid for, or should have been paid for, by the sponsor of the clinical trial.

22. COVID-19 Diagnostic Testing

In accordance with the Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief and Economic Stimulus (CARES) Act, the Plan covers diagnostic testing for COVID-19 with no cost sharing (including deductibles, copayments and coinsurance) requirements or prior authorization or other medical management requirements applied to the Member. This provision applies to services obtained January 1, 2020 through the end of the public health emergency related to COVID-19. Coverage includes costs associated with the diagnostic product, administration of the diagnostic product, and items and services provided during office visits (including LiveHealth Online visits), urgent care center visits and emergency room visits that result in an order for COVID-19 testing or administration of the test, to the extent those items and services relate to COVID-19 testing. Out-of-network services are subject to the Maximum Allowed Amount to the extent permitted by the FFCRA and CARES Act and any guidance issued thereunder.



D. Pre-Certification Requirements

Pre-certification is required for certain services. All inpatient admissions (including observation care), almost all outpatient surgeries, and certain diagnostic procedures must be pre-certified. Your provider will work with you to obtain pre-certification. However, you or the covered Member is ultimately responsible for making sure that pre-certification is received. **Any care that is not certified as medically necessary by the appropriate pre-certification review agency is not covered by the Plan.**

1. Pre-Certification Review Unit and Contact Information

To receive pre-certification or if you have questions about pre-certification, call the number below. You are required to call the pre-certification review unit for all in-network and out-of-network care.

- Pre-certification Review Unit: Telephone number 1-866-776-4793

2. Inpatient Admissions and Outpatient Services Requiring Certification

Refer to Appendix E for a list of inpatient admissions and outpatient services that require pre-certification with the pre-certification review unit.

3. Time Frame for Making the Certification

You are required to call the pre-certification review unit prior to an admission or procedure under the time frames stated below.

a. Hospital inpatient admissions, including observation care

- Elective Admissions** — You are required to notify the pre-certification review unit at least seven days prior to an elective admission. In cases where this is not possible, notify them as soon as you know about the intended hospital admission.
- Maternity Admissions** — Although pre-certification is not required for maternity admissions, you are encouraged to notify Anthem BC/BS of such admissions since it is helpful for Anthem BC/BS to monitor treatment for both the mother and newborn.

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



iii. Emergency Admissions — Call the pre-certification review agency within two working days following an emergency admission. An emergency admission is defined as a condition which, unless treated at once on a hospital inpatient or observation basis would either jeopardize the patient's life or cause serious impairment to the patient's body functions.

b. Outpatient Services

You are required to call the pre-certification review agency at least seven days before the scheduled surgery or diagnostic procedure. In cases where this is not possible, notify them as soon as you know about the surgery or procedure.

E. Assistance from 24/7 NurseLine and ConditionCare

1. All Plan Members have access to a registered nurse 24 hours a day, 7 days a week. 24/7 NurseLine is available to offer reliable and timely information to:
 - Assess and understand symptoms.
 - Find additional help to make informed healthcare decisions.
 - Locate a doctor, hospital or other practitioner.
 - Get information about an illness, medication or prescription.
 - Find information about a personal health issue such as diet, exercise or high blood pressure.

The Program is administered by Anthem and can be reached by calling **1-888-596-9473**. Bilingual nurses are also available.

2. Anthem BC/BS has also been engaged to provide ConditionCare for employees who have chronic conditions involving asthma, chronic heart failure (CHF), chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD) or diabetes. If you have a chronic condition, you may be contacted by a nurse specifically qualified to help you: learn to recognize your symptoms and lessen their affect, understand which treatments and medications may work best for you, help to follow your doctor's plan of care, and live healthier and feel your best every day.

The ConditionCare Program is voluntary. Plan Members can get more information on the ConditionCare Program by calling **1-866-387-8827**.



F. Medical/Surgical Program — Member Coinsurance and Copay Chart

(Chart information is subject to limitations described in other parts of this document.)

Expense Type	Saver HSA (After Deductible, Member Pays)		Classic (After Deductible, Member Pays)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
1. Hospital Inpatient Charges				
a. Room and board (semi-private room)	20%	40%	20%	40%
b. Ancillary charges	20%	40%	20%	40%
2. Physician and Surgeon Charges				
a. Physician charges for inpatient surgery, maternity, and medical consultation	20%	40%	20%	40%
b. Physician charges for outpatient surgery:				
– In physician's office	20%	40%	20%	40%
– Other than physician's office	20%	40%	20%	40%
c. Office visit to primary care physicians	20%	40%	\$20 copay ⁷	40%
d. Office visit to specialists	20%	40%	\$50 copay ⁷	40%
e. Virtual office visit via LiveHealth Online	\$59	Not covered	\$10 copay ⁷	Not covered
f. Office visit at Urgent Care facility	20%	40%	\$50 copay ⁷	40%
g. Independent medical evaluation/second surgical opinion (if required and approved)	\$0	\$0	\$0	\$0
h. Radiologists, anesthesiologist, pathologists services and assistant surgeon	20%	40%	20%	40%
3. Mental/Behavioral Health and Substance Use Disorder				
a. Outpatient services	20%	40%	\$20 copay ⁷	40%
b. Virtual office visit (licensed psychologist or therapist via LiveHealth Online)	\$59	Not covered	\$10 copay ⁷	Not covered
c. Inpatient services	20%	40%	20%	40%
4. Emergency Room (ER) Charges, Including Physician Charges	20% (after deductible is met, 20% after member pays \$200 ER copay; copay waived if admitted)	20% (after deductible is met, 20% after member pays \$200 ER copay; copay waived if admitted)	20% (after member pays \$200 ER copay ⁷ ; copay waived if admitted)	20% (after member pays \$200 ER copay; copay waived if admitted)

⁷ Copay not subject to deductible.

(continued)

Retiree Health Plan



Expense Type	Saver HSA (After Deductible, Member Pays)		Classic (After Deductible, Member Pays)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
4a. Non-Emergency Use of Emergency Room (ER), including Physician Charges	40% (after deductible is met, 40% after member pays \$200 ER copay)	40% (after deductible is met, 40% after member pays \$200 ER copay)	40% (after member pays \$200 ER copay ⁷)	40% (after member pays \$200 ER copay)
5. Ambulance Services				
a. Emergency	20%	20%	20%	20%
b. Non-emergency (subject to medical necessity)	20%	20%	20%	20%
6. Diagnostic Tests (that are not preventive)⁸	20%	40%	20%	40%
7. Therapeutic Treatments				
a. Physical, occupational and non-educational speech therapy	20%	40%	20%	40%
b. Manipulation (subject to 20 visits per year per covered member limit)	20%	40%	\$50 copay ⁷	40%
8. Immunizations (which are not preventive), Injections, and Allergy Shots	20%	40%	20%	40%
9. Treatment for TMJ	20%	40%	20%	40%
10. Other Covered Expenses	20%	40%	20%	40%
11. Hospital Alternatives: Home Health Care and Hospice Care	\$0	\$0	\$0	\$0
12. Skilled Nursing (limited to 180 days maximum per year/365 days lifetime, combined in- and out-of-network)	\$0	40%	\$0	40%
13. Case Management	\$0	\$0	\$0	\$0
14. Transplant Management Program (using Center of Excellence)	\$0	n/a	\$0	n/a
15. Transplant (not using Center of Excellence)	40%	40%	40%	40%

⁷ Copay not subject to deductible.

⁸ See Article X.C.22 for coverage of COVID-19 testing and related services.



XI. Physical Examination and Preventive Services (Preventive Services)

A. Eligibility

All Members covered by this Plan, either as a Member or a dependent, are eligible for the benefits under Preventive Services.

B. Deductible

There is no separate deductible under the Preventive Services Program. Benefits are or are not subject to the medical/surgical deductible as follows:

1. In-Network Level of Benefits

Benefits for in-network covered services **are not** subject to the medical/surgical in-network deductible.

2. Out-of-Network Level of Benefits

Benefits for out-of-network covered services **are** subject to the medical/surgical out-of-network deductible.

C. Out-of-Pocket Maximum Limit

There is no separate out-of-pocket maximum under the Preventive Services Program.

The Preventive Services Program is subject to the out-of-pocket maximum limit. Since designated preventive services are covered at 100%, except for out-of-network preventive services, the Preventive Services Program is generally not affected by the out-of-pocket maximum limit.

D. Covered Expenses

Coverage for the preventive services designated below is at the coinsurance amounts indicated on the chart in Article XI, "Physical Examination and Preventive Services (Preventive Services)," Section E. For individuals enrolled in either the Classic or Saver HSA Options, the coinsurance amount depends on if the preventive service is obtained using a network provider (in-network) or a non-network provider (out-of-network). Pursuant to provisions of the Patient Protection and Affordable Care Act (PPACA), the Plan will cover, at no cost to Member, preventive services as recommended by the U.S. Preventive Services Task Force, provided that such services are provided by an in-network provider. To access the federal government's website listing of Recommended Preventive Services (which may be updated from time to time), go to <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations>. For other preventive services that are not on the Recommended Preventive Services list, but are nonetheless deemed a preventive service, such expenses are generally covered at 100%, limited to the Maximum Allowed Amount, Negotiated Fee Schedules, and other Plan limitations. Questions concerning specific preventive services and coverage under the Plan should be directed to Anthem BC/BS at 1-855-698-5676.



The preventive services coverage is generally limited to preventive screening services and immunizations for wellness purposes. The purpose of preventive services is to provide early detection before you become aware that you have an illness or injury. Your visit to the physician is no longer considered preventive if you are having symptoms of an illness or injury — such a visit is considered diagnostic and is not covered under the Preventive Services Program. In addition, coverage is not to treat a condition you currently have. While those expenses are not covered under this Preventive Services Program, the expenses may be covered under the Medical/Surgical Program provisions of the Plan.

Routine visits to your physician are important to assist you in maintaining your health. However, not every individual needs the same preventive screening tests every year or at the same interval. Your need for certain tests depends upon several factors including your age, gender and heredity, as well as your lifestyle. You should discuss the purpose of your visit as a routine preventive examination when scheduling the appointment with your physician.

1. Well-Baby and Well-Child Care

Covered are charges incurred by a covered individual through 18 years of age for routine physical examinations, designated screening tests, and designated preventive immunizations.

2. Adults — Routine Physical Examination, Preventive Screening Tests and Preventive Immunizations

Covered are charges for a routine physical examination, designated screening tests and designated preventive immunizations for individuals age 19 and older. Coverage is limited to one such service per individual per year or as recommended by the U.S. Preventive Services Task Force pursuant to provisions of PPACA. (For example, one routine physical exam, one screening mammogram, one prostate specific antigen (PSA) test, etc., per individual per year.)

a. Routine Physical Exam

To assure that procedures are age and gender appropriate, Anthem BC/BS, working together with your physician and pursuant to the provisions of the Patient Protection and Affordable Care Act, will determine which tests should be performed and their recommended frequency.

b. Preventive Immunizations

The Plan will also rely on Anthem BC/BS or Express Scripts, as applicable, to follow the preventive care recommendations of the U.S. Preventive Services Task Force to determine what preventive immunizations will be covered. In general, most common preventive immunizations (including those required for international travel) will be covered at 100%. Note that if your physician requires you to purchase a vaccine at the pharmacy prior to administration, the Managed Prescription Drug (Prescription) Program through Express Scripts will cover the vaccine at 100%. Charges to administer the vaccine would still be covered by the Medical/Surgical Program portion of the Retiree Health Plan.



3. Claims for Covered Preventive Services

In order for a claim for covered preventive services to be paid properly, the provider must use standard procedure and diagnostic codes for preventive/routine services when billing. If the claim is submitted for services that are not covered by the Preventive Services Program or with a diagnosis or procedure code that is not normally used for a wellness/routine service, the claim will be subject to the Medical/Surgical Program provisions of the Plan. A routine chest X-ray is not a covered preventive service.

E. Preventive Services Program Coinsurance and Coverage Chart

Expense Type	Classic and Saver HSA In-Network (No Deductible)	Classic Out-of-Network (After Med/Surgical Out-of-Network Deductible)	Saver HSA Out-of-Network (After Med/Surgical Out-of-Network Deductible)
1. Well Baby/Child Care (through age 18)	100%	60%	60%
2. Physician Charges for Routine Physical Exam (only designated services covered)	100%	60%	60%
3. Preventive Screening Tests (only designated services)	100%	60%	60%
Radiologist and Pathologist Services Rendered for Preventive Screening Tests	100%	60%	60%
4. Preventive Immunizations (only designated immunizations covered)	100%	60%	60%

Note: County health departments and similar government agencies are not PPO Network participating providers. However, for purposes of this Preventive Services Program only, county health departments and similar government agencies will be considered as if they were “network providers” for benefit payment purposes and coverage will be at the in-network level of benefits when immunizations are obtained at such facilities.

Immunizations obtained at a drug store, grocery store, or other similar locations will be covered at the in-network benefit level if the provider is a participating provider in the Express Scripts network of participating pharmacies.



XII. Classic and Saver HSA Options

A. How Do the PPO Options Work?

The Classic Option and the Saver HSA Option (the PPO Options) offer you the freedom to choose the benefit level you will receive each time you access medical care. The benefit level depends on whether or not medical care is provided by a provider participating in the Anthem BC/BS PPO Network. The two benefit levels available under the PPO Options are **in-network** benefits and **out-of-network** benefits.

If medical care is provided by a provider participating in the PPO Network, the Member receives in-network benefits which offer a higher benefit level. In addition to higher benefits, Members using a PPO Network provider will benefit from having lower out-of-pocket costs (in the way of coinsurances) because the PPO Network providers generally charge lower fees to PPO Option Members than to non-Members.

The PPO Network is a network of health care providers (including, but not limited to physicians, hospitals, and providers of ancillary services such as diagnostics and therapy) which is managed by Anthem BC/BS, with whom the Plan has contracted for PPO Option Members to use their network of providers.

If medical care is not provided by a PPO Network provider, the individual is subject to out-of-network benefits which result in higher out-of-pocket expenses.

It is important that you show your Anthem BC/BS I.D. card to your provider.

B. How to Locate a Provider Who Participates in the PPO Network

You can obtain information on participating Providers by contacting Anthem as follows:

Anthem Member Services Phone Number: 1-855-698-5676
(Specify you are looking for PPO providers.)

Anthem's website: www.Anthem.com

C. General PPO Coverage

Fees for services provided by a provider participating in the PPO Network are subject to the Negotiated Fee Schedule of the PPO Network. The Network Negotiated Fee Schedule is the maximum allowable reimbursement for services rendered by a provider participating in the PPO Network. Providers accept the lesser of the charged fee or the Network fee as payment in full for covered services. Fees for services provided by a provider not participating in the PPO Network are subject to the Maximum Allowed Amount regardless of the level of coverage paid under the PPO Option.

D. Using the PPO Options

Here are the basic guidelines for receiving health care through the PPO Options.



1. To be eligible to receive in-network benefits for covered services, all medical care must be obtained from a PPO Network participating provider. PPO Network providers will generally try to refer patients to other PPO Network providers. **However, it is your responsibility to make sure the provider from whom you or your covered dependent is receiving health care services participates in the PPO Network before care is given.**
2. If medical care is not obtained from a PPO Network participating provider, you are subject to the provisions of the out-of-network benefit level.

PPO Network

The Anthem BC/BS PPO Network (the PPO Network) includes both primary and specialty care physicians. Primary care physicians include general and family practitioners, pediatricians, general internists, OB/GYNs, certified nurse midwives, nurse practitioners, physician assistants, geriatrics and clinical/multi-specialty groups. Examples of specialists include surgeons, cardiologists, allergists, chiropractors and oncologists. Both primary and secondary hospitals are included in the PPO Network. Providers of ancillary services, such as diagnostic services (X-ray and laboratory) and therapy services (physical, speech, and occupational) are also included in the PPO Network.

E. Obtaining Medical Care in the Anthem PPO Network Area

1. Routine or Urgent Care in the Anthem PPO Network Area

When you utilize a provider in the PPO Network for routine or urgent care, you will receive the in-network level of benefits for covered charges that are medically necessary. If you do not use a provider in the PPO Network, you will be subject to the provisions of the out-of-network level of benefits.

2. Emergency Care in the Anthem PPO Network Area

- a. When the covered individual is in an Anthem Network Area and emergency care is required, they should seek health care treatment immediately and go directly to the nearest emergency facility. If a provider is used who is participating in the PPO Network, they will receive the in-network level of benefits for covered charges.
- b. If a provider is used in an emergency who is not participating in the PPO Network, the individual will receive the in-network level of benefits for covered charges provided Anthem determines the requirements have been satisfied to receive the in-network level of benefits.
- c. If follow-up treatment after the emergency is required and provided by a physician or other provider who is not participating in the PPO Network, the individual will receive the in-network level of benefits for covered follow-up treatment for up to 90 days after the date of the emergency facility visit, provided Anthem determines the medical condition treated in the emergency facility was an emergency.

For more detailed explanation of what is an emergency or urgent situation, see Article II, "Helpful Terms," of this document.



F. Obtaining Medical Care When Temporarily Out of the Anthem Network Area

Covered charges for emergency and urgent medical care received when temporarily away from an Anthem Network Area due to business, vacation, or when a child is away at college will be covered at the in-network benefit level provided Anthem determines the requirements have been satisfied to receive the in-network benefit level. For purposes of this section, “vacation” is used to include Non-Employee Members who reside part of the year in another part of the country (such as Florida), although they maintain their permanent address in an Anthem Network Area. It is expected that non-emergency and non-urgent medical care will be obtained upon the Member’s return to their Anthem Network Area.

For emergency care, seek health care treatment immediately and go directly to the nearest emergency facility.

Anthem has broad networks including both emergency and urgent care facilities. When you are temporarily away from your local network area and need emergency or urgent care, if you have the opportunity call the number on your Health Care ID for a list of participating providers in the area. However, if you are not able to check network status before seeking care at a facility, do not hesitate to seek the care you need. It is probable the facility you choose will be an Anthem PPO Network participating facility anyway. However, if Anthem receives an emergency or urgent claim from an out-of-network facility and processes it as out-of-network, call their number to have the claim reconsidered for payment at the in-network level of benefits.

1. Living Outside of the United States

Unless Anthem has special international relationships, Non-Employee Members and others who choose to live outside the United States will be required to return to the United States to seek coverage in the Anthem Network or work with Anthem to file the claims as out-of-network. Anthem BC/BS has a Blue Cross Blue Shield Global Core benefit that may be explored by calling their service center at 1-800-810-2583, or call collect 1-804-673-1177 before you travel or move internationally. BlueCross Blue Shield Global Core can provide you with access to medical assistance, doctors and hospitals in more than 200 countries around the world.

G. Exception Benefit Level

An Exception Benefit level exists in place of the out-of-network level of benefits for certain covered expenses when care is obtained from a provider not participating in the PPO Network. In rare instances the PPO Network may not have a physician specialty or ancillary service available within the PPO Network. An Exception Benefit level covers specialties or covered services not available through the PPO Network at 80%, subject to the in-network deductible, provided both of the following requirements are satisfied:

- Prior approval is obtained from Anthem. You will need to advise your referring physician that they must initiate this prior approval request. The phone number is: Anthem BC/BS PPO Option – Anthem BC/BS Precertification at 1-866-776-4793.



- There is no network provider who can perform the service within a 100-mile radius (as the crow flies) from the covered individual's permanent residence. (If there is a network provider who can perform the service within a 100-mile radius of the covered individual's permanent residence, the covered individual must use a network provider in order to receive the in-network level of benefits. If the covered individual in this situation does not use a network provider, they will receive the out-of-network benefit level.)

XIII. Managed Prescription Drug Program

The Managed Prescription Drug (Prescription) Program applies to all Members covered under the Plan. Prescription drug benefit levels differ based on the Option the Member enrolls in. The Prescription Program has a Retail Pharmacy component and a Mail Order component. You can also use the Smart90 Walgreens component in lieu of mail order for purchase of maintenance prescriptions at Walgreens retail pharmacies and affiliates (including Duane Reade pharmacies) without incurring penalty for filling maintenance drugs at retail. These components are administered by Express Scripts. All coverage under the Prescription Program is subject to medical necessity determination and other Plan limitations.

The Plan excludes coverage of certain drugs, as administered and managed by Express Scripts. The Member is responsible for paying the full cost of excluded medications, which does not count toward annual deductible or out-of-pocket maximums. If a prescribed drug is excluded from coverage, you may want to discuss alternatives with your doctor, including preferred brands and generics. A list of the excluded medications, which is periodically updated, is available at www.mympcbenefits.com/Your-Health/Prescription-Drug.aspx, or you can call Express Scripts at 1-877-207-1357.

Individual and family deductibles and out-of-pocket maximum amounts are listed in Appendix D at the back of this document. Deductibles and out-of-pocket maximums incurred during a plan year under the Marathon Petroleum Health Plan will be transferred to the Marathon Petroleum Retiree Health Plan, if enrolled, provided such enrollments occur within the same plan year.

Pursuant to provisions of the Patient Protection and Affordable Care Act (PPACA), the Plan will cover, at no cost to Member, vaccines, supplements and over-the-counter products (prescribed by a physician or other appropriate provider) which are recommended by the U.S. Preventive Services Task Force, provided that such vaccines, supplements and OTC products are provided by an in-network provider. To access the federal government's website listing of Recommended Preventive Services (which may be updated from time to time), go to <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations>. Questions concerning specific preventive services and coverage under the Plan should be directed to Express Scripts at 1-877-207-1357.



A. Coverage

1. To Receive Coverage

To receive coverage under the Plan, outpatient prescription drugs (see below for explanation of what are outpatient prescription drugs) must be purchased through the Retail Pharmacy component (through a participating Express Scripts retail pharmacy) or through the Mail Order component (from Express Scripts' Mail Order pharmacy) of the Prescription Program. Network pharmacies (both Retail and Mail Order pharmacies) offer discounted drug prices, drug utilization review to protect individuals from potentially dangerous drug interactions, and no claim forms to submit.

Except for certain exception situations explained in the Plan document, there is no coverage for outpatient prescription drugs that are not purchased through a Retail or Mail Order Network pharmacy.

Coverage levels vary depending on whether you use the Retail or Mail Order component.

Smoking cessation drug therapy is limited to 180 days of therapy (consisting of one or more prescriptions — including prescribed over the counter medications) per year per individual.

2. Outpatient Prescription Drugs

- a. Outpatient prescription drugs are prescription drugs which are:
 - i. Prescribed to be administered when the patient is not confined to a hospital as an inpatient (includes certain specialty medications — injectable medications administered either by the Member or a health care professional).
 - ii. Not billed by a home health agency, hospice agency, or sub-acute care facility (extended care facility).
 - iii. Federal legend drugs (prescription drugs), state restricted drugs, some compounded drugs, and oral contraceptives.
 - Compound drugs: For compound drugs to be covered under the Plan, they must satisfy certain requirements. In addition to being medically necessary and not experimental or investigative, compound drugs must not contain any ingredient on a list of excluded ingredients. Furthermore, the cost of the compound must be determined by Express Scripts to be reasonable (e.g., if the cost of any ingredient has increased more than 5% every other week or more than 10% annually), the cost will not be considered reasonable. Any denial of coverage of a compound drug may be appealed in the same manner as any other drug claim denial under the Plan.
 - iv. Insulin, insulin pump and continuous glucose monitor (CGM) with a prescription only, and covered diabetic supplies, with a prescription only.
 - Test strips and CGMs: Can be filled as a 30-day supply at any in-network pharmacy, Smart90 Walgreens Program or Express Scripts Mail Order. Test strips and CGMs are not subject to the retail maintenance third fill penalty.

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- Glucometers, lancets and syringes: Members must use Smart90 Walgreens Program or Express Scripts Mail Order and will be subject to the retail maintenance third fill penalty if filled as 30-day supply at in-network retail pharmacies.

CGMs are not covered for members who do not use insulin.

An insulin pump, as well as tubing and needles for the pump, can be covered under either the durable medical equipment provisions of the Medical/Surgical Program portion of the Plan or the Managed Prescription Drug Program portion of the Plan.

- b. Not covered under the Prescription Program but subject to the provisions of the Medical/Surgical Program are:
 - i. Supply items (other than diabetic supplies), therapeutic devices, and durable medical equipment; and
 - ii. Prescription drugs and covered diabetic supplies billed by a home health agency, hospice agency, or sub-acute care facility (extended care facility).

B. Saving Yourself and the Plan Money When You Buy Prescription Drugs

You can save yourself and the Plan money by following three guidelines when you purchase your prescriptions:

1. Purchase generics instead of brand name drugs;
2. If no generic is available, purchase brand name drugs on the Express Scripts Preferred Prescriptions Formulary list instead of brand name drugs not on the formulary; and
3. Purchase your maintenance prescriptions from Express Scripts Mail Order or from a Walgreens retail pharmacy instead of other retail network pharmacies.

C. Prescription Drug Benefit Levels

1. Prescription drug benefit levels differ based on the Option in which the Member is enrolled.

Under the Classic Option: When you use a participating retail pharmacy or Express Scripts Mail Order, you will first pay the prescription drug deductible amount. After the prescription deductible amount is satisfied, you will pay your share through a copay. Charges under the Medical/Surgical Program will not be applied toward the Prescription Program deductible. Deductibles incurred during a plan year under the Marathon Petroleum Health Plan will be transferred to the Marathon Petroleum Retiree Health Plan, if enrolled, provided such enrollments occur within the same plan year.

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Classic Option	Member Pays		
	Retail (30-Day Supply)	Mail Order (90-Day Supply)	Smart90 Walgreens (90-Day Supply)
Prescription Deductible	\$100 individual/\$200 family (retail and mail order combined)		
Generics	\$10 after deductible	\$25 after deductible	\$25 after deductible
Brand Name Drugs on the Formulary	\$30 after deductible	\$75 after deductible	\$75 after deductible
Brand Name Drugs Not on the Formulary	\$60 after deductible	\$150 after deductible	\$150 after deductible
Specialty Drugs⁹	Certain specialty drugs must be filled through Express Scripts Specialty Pharmacy (Accredo) after first fill (subject to deductible). Specialty drugs are subject to formulary and non-formulary brand copays.		
Excluded Drugs	Member responsible for full cost; does not count toward deductible or out-of-pocket maximum. More information is available at www.mympcbenefts.com/Your-Health/Prescription-Drug.aspx , or contact Express Scripts at 1-877-207-1357.		

⁹ To participate in manufacturer copay programs that will reduce costs to the Plan, copays for certain specialty medications may be set to maximize any available manufacturer-funded copay assistance. This will not result in increased copay costs to the Member, and any manufacturer assistance provided will not be applied toward the Member's deductible or out-of-pocket maximum.

There is also a specialty pharmacy assistance program called SaveOnSP. With this program, there are certain specialty pharmacy drugs that are considered non-essential health benefits under the plan where the Member will be responsible for a 30% coinsurance based on approved cost of such drugs, and the Member's cost for such drugs will not be applied toward satisfying the Member's deductible or out-of-pocket maximum. See Appendix F for the SaveOnSP Specialty Drug List. If you are currently taking or will be taking a medication on the SaveOnSP Specialty Drug List, you are eligible to participate in the SaveOnSP program where the Member cost of such specialty drug will be as low as \$0. To participate, simply call SaveOnSP at 1-800-683-1074 to avoid delays in obtaining your prescription(s). Enrollment in the program is voluntary. However, if you choose **not** to participate, you will be responsible for a 30% coinsurance for the cost of the specialty drug listed in Appendix F. Keep in mind that the coinsurance amount will **not** count toward your deductible or out-of-pocket maximums. This program is only available to those enrolled in the plan's Classic option.

Under the Saver HSA Option: When you use a participating retail pharmacy or Express Scripts Mail Order, you will first pay the deductible amount, which is combined with the Medical/Surgical Program. After the combined deductible amount is satisfied, you will pay your share through coinsurance. The deductible amounts are listed in Appendix D. Deductibles incurred during a plan year under the Marathon Petroleum Health Plan will be transferred to the Marathon Petroleum Retiree Health Plan, if enrolled, provided such enrollments occur within the same plan year. Under the Saver HSA Option, the deductible does not apply for certain generic preventive medications. Utilizing drug manufacturer coupons or financial assistance prior to meeting your deductible or out-of-pocket maximums under the Saver HSA option could impact your eligibility to make or receive HSA contributions or receive an HSA Company contribution.



Saver HSA Option	Member Pays	
	Retail (30-Day Supply)	Mail Order or Smart90 Walgreens (90-Day Supply)
Type of Medication		
Deductible	Combined with medical	Combined with medical
Generics	20% after deductible (for certain generic preventive drugs, the deductible does not apply ¹⁰)	20% after deductible (for certain generic preventive drugs, the deductible does not apply ¹⁰)
Brand Name Drugs on the Formulary	20% after deductible	20% after deductible
Brand Name Drugs Not on the Formulary	20% after deductible	20% after deductible
Specialty Drugs	Certain specialty drugs must be filled through Express Scripts Specialty Pharmacy (Accredo) after first fill. Member pays 20% after deductible.	
Excluded Drugs	Member responsible for full cost; does not count toward deductible or out-of-pocket maximum. More information is available at www.mympcbbenefits.com/Your-Health/Prescription-Drug.aspx , or contact Express Scripts at 1-877-207-1357.	

¹⁰ There are certain prescription drugs that the IRS calls “preventive” because they prevent or treat catastrophic conditions, such as high blood pressure, high cholesterol and asthma. This list is different from the drugs covered at 100% under the provisions of the Patient Protection and Affordable Care Act (PPACA).

Under both Classic and Saver HSA Options: Deductibles and coinsurance will not be applied to vaccines, supplements and over-the-counter products (prescribed by a physician or other appropriate provider) recommended by the U.S. Preventive Services Task Force, provided that such vaccines, supplements and OTC products are provided by an in-network provider. Such items will be covered at 100%. To access the federal government’s website listing of Recommended Preventive Services (which may be updated from time to time), go to <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations>.

2. There are certain situations where you will pay more:

a. Brand Name Drugs When a Generic Is Available (Generic Election Provision) — At both Retail and Mail Order, if you purchase a brand name drug when a generic equivalent is available, the plan benefit will be based on the cost of the generic equivalent drug. You will pay the coinsurance or copay (based on your Option) of the generic drug cost plus 100% of the difference in price between the generic drug and the brand name drug. The difference in price between the generic drug and the brand name drug will not be applied toward meeting any deductible or out-of-pocket maximum. The Generic Election Provision does not apply to insulin and covered diabetic supply items.



- b. Maintenance Drugs (Incentive Mail Order and Smart90 Walgreens)** — Under the incentive mail order and Smart90 Walgreens provisions, you will pay more for a “maintenance” drug purchased at a participating retail pharmacy instead of at Express Scripts Mail Order or a Smart90 Walgreens pharmacy the third time you purchase the drug at retail and each subsequent time that you purchase the “maintenance” drug at a retail pharmacy.

The first two times you fill a “maintenance” drug at a participating retail pharmacy your benefit coverage will be as indicated above under Article XIII, “Managed Prescription Drug Program,” Section (C)(1) “Prescription Drug Benefit Levels.” To encourage you to purchase “maintenance” drugs through Express Scripts Mail Order or Smart90 Walgreens, the third and later times you purchase a “maintenance” drug at a participating retail pharmacy (that is not through the Smart90 Walgreens program or Express Scripts Mail Order), you will pay 100% of the cost, which will not be applied toward any deductible or out-of-pocket maximum.

A “maintenance” drug is one taken for a long period of time and is designated by Express Scripts as a “maintenance” drug. Call Express Scripts’ Customer Service at 1-800-841-3423 to find out if a prescription drug is designated as a “maintenance” drug by Express Scripts. The cost of prescription drugs is less when purchased through mail order than when purchased through a participating retail pharmacy. You are encouraged to purchase maintenance drugs through mail order.

Obtaining a new prescription for the exact same maintenance drug will not allow you to avoid the maintenance prescription coverage provision. If you obtain a new prescription at retail for the exact same maintenance drug, it will be treated as an extension of the previous retail maintenance prescription. For example, if you have obtained two fills of a maintenance drug at a participating retail pharmacy and obtain a new prescription for the exact same drug, your first fill of the new prescription will be considered the third time you filled the prescription and the Plan coverage will be 0%.

- c. Brand Name Drugs Not on the Formulary (Incentive Formulary Provision)** — You will pay more for brand name drugs that are not on the Express Scripts Preferred Prescription Formulary. The Generic Election Provision (Article XIII, Section C(2)(a)) also applies if you purchase a brand name drug not on the formulary and that brand name drug has a generic equivalent available. You will pay the coinsurance or copay (based on your Option) of the generic drug cost plus 100% of the difference in price between the generic drug and the non-formulary brand name drug. The difference in price between the generic drug and the non-formulary brand drug will not be applied toward meeting any deductible or out-of-pocket maximum.

Call Express Scripts at 1-800-841-3423 to see if a drug is on the formulary or to request a copy of the formulary. You can also obtain information about the formulary online at www.express-scripts.com.

D. Using the Retail Pharmacy Component

Use the Retail Pharmacy Component when a prescription is to be taken on a short term basis or for your first prescription of a medication you will be taking for a long period of time (such as 60 days or more). Prescriptions under the Retail component are generally limited to



a 30-day supply maximum per fill. Present your Express Scripts ID card to the pharmacist at a participating pharmacy. At the pharmacy you will pay the applicable deductible amount and after the deductible amount is satisfied, if enrolled in the Saver HSA option, you will pay the lesser of 1) the 20% coinsurance share, or 2) the retail price; or, if enrolled in the Classic option, you will pay the lesser of 1) the copay as listed in Article XIII, “Managed Prescription Drug Program,” Section C(1), or 2) the retail price. No claim forms are required. To encourage purchase of “maintenance” drugs through Express Scripts Mail Order or Smart90 Walgreens, the third and later times you purchase a “maintenance” drug at a participating retail pharmacy (that is not through the Smart90 Walgreens program or Express Scripts Mail Order), you will pay 100% of the cost, which will not be applied toward any deductible or out-of-pocket maximum.

The names of participating pharmacies in your area or throughout the country (when you travel) are available by calling Express Scripts Customer Service at 1-800-841-3423 or from Express Scripts’ website, www.express-scripts.com.

E. Exceptions

In certain situations, there are exceptions to these provisions. Each of the four following situations requires the submission of a claim form when outpatient prescription drugs (including covered diabetic supplies) are purchased as indicated. The four exception situations are as follows:

1. Outpatient prescription drugs purchased outside the United States by covered individuals who reside in the United States, but who are temporarily out of the country due to business or leisure and where a medical need arises, are covered by the Plan at 80% of the purchase price for generic or brand-name drugs after the deductible (if enrolled in the Saver HSA Option) or will be subject to the Member copay amount after the deductible (if enrolled in the Classic Option). None of the following provisions apply in this situation: Generic Election Provision, Incentive Mail Order Provision and Incentive Formulary Provision.
2. If the covered individual receives outpatient prescription drugs in the situations listed below and is billed by an out-of-network pharmacy, coverage levels will be the same as coverage provided under the in-network Retail Pharmacy Component, however, the Incentive Mail Order Provision for maintenance drugs does not apply in this situation.
 - a. Patient lives in and receives outpatient prescription drugs through a rest home, nursing home, sub-acute care facility (or other extended care facility or skilled nursing facility), convalescent hospital, or similar institution; or
 - b. Patient receives outpatient prescription drugs from a hospice or home health agency.
3. If the covered individual purchases outpatient prescription drugs at a participating retail pharmacy but the claim is not filed electronically by the pharmacist for reasons listed below, coverage will be as indicated in Article XIII, “Managed Prescription Drug Program,” Sections (C)(1) or (C)(2) “Prescription Drug Benefit Levels” after the deductible is paid. In both situations the Generic Election, Incentive Mail Order or Smart90 Walgreens, and Incentive Formulary Provisions apply.



- a. For a new Member (within the first 30 days of coverage) not included in the Express Scripts system, coverage is based on the purchase price of the prescription drug.
 - b. If the individual did not have their Express Scripts ID card, or for any other reason the claim was not filed electronically, coverage is based on the negotiated network price of the prescription drug.
4. If the covered Member resides in the United States and does not have access to (beyond 10 miles) a participating Network pharmacy, coverage will be as indicated in Article XIII, “Managed Prescription Drug Program,” Sections (C)(1) or (C)(2) “Prescription Drug Benefit Levels” after the deductible is paid. In this situation the Generic Election, Incentive Mail Order or Smart90 Walgreens, and Incentive Formulary provisions apply.

F. Using Express Scripts Mail Order Pharmacy or Smart90 Walgreens Program for Maintenance Drugs

If you have an ongoing condition that requires you to take an outpatient prescription drug over a long period of time (such as more than 60 days), you can order up to a 90-day supply of your prescription and have it mailed directly to your home through Express Scripts Mail Order. Or, through the Smart90 Walgreens program, you can have your 90-day prescription filled at Walgreens retail pharmacies and affiliates (including Duane Reade pharmacies). The applicable deductible applies, depending on whether you are enrolled in the Classic Option or Saver HSA Option.

It is more cost effective for you and the Plan to purchase your outpatient maintenance prescription drugs via Express Scripts Mail Order or Smart90 Walgreens. The cost of outpatient prescription drugs is less when purchased through Mail Order or Smart90 Walgreens than when purchased through other participating retail pharmacies because the outpatient prescription drug discounts at Express Scripts Mail Order and Smart90 Walgreens are greater than the discounts at other retail pharmacies. This means your share of the cost of the drug is less when using Express Scripts Mail Order or Smart90 Walgreens.

G. Prescription Drug Out-of-Pocket Maximum

To protect those who have illnesses requiring significant prescription drugs, there is an out-of-pocket maximum, which includes covered services under the Medical/Surgical Program, Preventive Services Program and Managed Prescription Drug Program under both the Classic and HSA Options. The combined medical and prescription drug out-of-pocket maximum limits are contained in Appendix D. Out-of-pocket maximums incurred during a plan year under the Marathon Petroleum Health Plan will be transferred to the Marathon Petroleum Retiree Health Plan, if enrolled, provided such enrollments occur within the same plan year.

When the coinsurances, copays and any cost differentials between generic and preferred/non-preferred brand an individual has paid, for medical and prescription drug combined, total the amount of the individual combined out-of-pocket maximum in a calendar year, covered charges for that individual under the Medical/Surgical Program and Prescription Program of the Plan are paid at 100% for the rest of the calendar year.



When the coinsurances, copays and any cost differentials between generic and preferred/non-preferred brand that a family has paid, for medical and prescription drug combined, total the amount of the family combined out-of-pocket maximum in a calendar year, covered charges for the family under the Medical/Surgical Program and Prescription Program of the Plan are paid at 100% for the rest of the calendar year.

You can refer to Article II, “Helpful Terms,” of this document for more information about how the out-of-pocket maximum limit works.

H. Clinical Programs Administered by Express Scripts

The Retiree Health Plan has authorized Express Scripts to implement a number of clinical programs that assure the drugs are clinically appropriate and consistent with the Plan’s intent. These programs are subject to change as Express Scripts continues to develop and enhance existing programs. As the pharmaceutical industry changes rapidly, the Plan will actively pursue administrative opportunities to assure patient safety and optimize health plan effectiveness for Plan Members. At any time, a current list of clinical programs administered by Express Scripts can be requested and will be provided to the Member on a timely basis. The major clinical program areas are as follows:

- **Drug Utilization Review** — Concurrent and Retrospective to assure safety and appropriate use.
- **Specialty Pharmacy** — To provide enhanced pharmacy services for some conditions such as anemia, hepatitis C, multiple sclerosis, asthma, growth hormone deficiency, and rheumatoid arthritis that are treated with specialty medications. The Retiree Health Plan requires certain specialty drugs to be dispensed only through the Specialty Pharmacy after first retail fill. Specialty drugs are subject to the applicable formulary/non-formulary brand copays in the Classic option and subject to 20% Member coinsurance in the Saver HSA option.
- **Coverage Management Programs** — These programs help ensure the appropriateness of coverage for specific drugs and specific amounts of drugs. The following programs are included under Coverage Management – Traditional Prior Authorization, SMART Prior Authorization, Dose Duration, Quantity Duration, Dispensing Quantity, and Dose Optimization.

These Clinical Programs will work with the prescribing physician, dispensing pharmacist and Member to assure that any conflicts that may arise are resolved in a prompt and safe manner.

I. Special Preventive Coverage

Your physician may prescribe a preventive vaccine that is available in oral form. Your physician may also write a prescription for you to purchase an injectable vaccine at the pharmacy, prior to administration in the physician’s office. In such cases, the Managed Prescription Drug Program will cover the vaccine at 100% not subject to a deductible if purchased at Retail or Mail Order. Services to administer the vaccine would still be covered by the Medical/Surgical Program portion of the Retiree Health Plan.



XIV. Expenses Not Covered Under the Plan

The Plan does not cover certain types of services and supplies, as well as services for certain conditions. Your out-of-pocket expenses for such services do not count toward the annual deductible or out-of-pocket maximum limit.

Limitations and Exclusions

No benefits are payable under the Plan for, and the term “Covered Charges” will not include, charges for:

1. Any charge not determined to be Medically Necessary by Anthem.
2. Expenses resulting from experimental or investigational procedures including experimental drugs, other than under the Clinical Program administered by Express Scripts or due to routine care costs incurred during participation in a qualifying clinical trial.
3. Treatment of illness or injury resulting from war in which the United States is an active participant.
4. Expenses in excess of the “Maximum Allowed Amount.”
5. Treatment in a federal hospital, including a Veterans’ Administration hospital, for an insured person with a military service-connected disability.
6. Expenses incurred because of an illness or an injury resulting from employment to the extent that these expenses could have been covered by Workers’ Compensation.
7. Dental work or dental X-rays, except as required by accidental injury to sound natural teeth or to correct Temporomandibular Joint Dysfunction (TMJ).
8. Eyeglasses, contact lenses or eye refractions, including examinations for these purposes.
9. LASIK surgery, radial keratotomies and other related eye surgeries whose sole purpose is to correct refractive problems.
10. Transportation other than emergency ambulance transportation unless authorized through Plan sponsored Case Management.
11. Services for manipulations, regardless of provider type or specialty, are limited to a 20 visits per person per year benefit limit, except during confinement in a hospital.
12. Educational testing or training on account of mental, nervous, or emotional disorders except as approved as a mental health treatment.
13. Expenses related to educational speech therapy, except speech therapy with a diagnosis and for treatment of Autism Spectrum Disorder and Rett Syndrome as approved through Anthem’s Autism Spectrum Disorders Program.
14. Professional services related to marriage counseling.
15. Expenses resulting from reversals of voluntary sterilizations.



16. Medical services generally considered to be cosmetic in nature (unless to correct for a congenital deformity or a deformity resulting from illness or injury), or complications resulting from such services.
17. Coverage for any surgical procedure for weight loss except as approved in advance with treatment rendered by a Plan recognized Center of Excellence.
18. Expenses for over-the-counter drugs, remedies, vitamins, dietary supplements and supplies, except as approved by the Managed Prescription Drug (Prescription) Program.
19. Expenses for weight reductions drugs except as approved by the Prescription Program.
20. Expenses for certain compounded drugs, unless such therapy contains estriol.
21. Services and supplies for smoking cessation programs and treatment of nicotine addiction, including gum and patches, to eliminate or reduce the dependency on, or addiction to, tobacco and tobacco products unless otherwise required by law. This paragraph does not apply to smoking cessation drug therapy coverage that is limited to 180 days of therapy (consisting of one or more prescriptions-including prescribed over the counter medications) per year per individual under the Managed Prescription Drug Program provisions of the Plan.
22. Treatments or consultations provided by the patient's parents, siblings, children, current or former spouse, or domestic partner.

XV. Coordination of Benefits

A. Coordination With Other Group Health Plans

The Marathon Petroleum Retiree Health Plan coordinates benefits with other health plans under which you or your dependents are covered (such as a spouse covered under their employer's plan). In these instances, the plans work together through what is called "coordination of benefits" or "non-duplication of benefits" provisions.

With the exception of benefits under the Managed Prescription Drug Program, when the Plan is secondary to another group plan, benefits paid are determined using the "Benefits Less Benefit" method of coordination of benefits. This method calculates the amount payable under standard Plan provisions, and then reduces that amount by the amount of payment due for the same charges from any other group plan that is primary to the Plan.

The Plan follows standard rules accepted by the insurance industry to determine which plan is primary when an individual is covered by more than one group plan. Some — but not all — of the rules are as follows:

- The plan that covers a Member as active is primary to a plan that covers the Member as inactive (for example, retired).
- The plan that covers an individual as a Member pays primary to a plan that covers the same individual as a dependent of a Member.
- The plan that has covered an individual the longest pays primary if the individual is covered in the same category by two plans (for example, an individual is actively employed by two different companies).

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- If a child is covered as a dependent under two different group plans, coverage is primary under the plan of the parent whose birthday (month and day) occurs earlier in the calendar year. For example, if the father was born on August 16 and the mother on June 11, the mother's plan is primary and would pay benefits first.
- In the case of divorce or separation, the plan of the parent with custody of the dependent child usually pays benefits for the child first. If the person with custody remarries, the stepparent's plan pays second, and the plan of the parent without custody pays third. However, if a court decree places financial responsibility for the dependent child's medical care on one parent, that parent's plan always pays benefits first.

B. Coordination With Other Plans

Coordination with Medicare and other government-sponsored plans follows regulations as issued by the appropriate government agencies.

The following types of plans normally coordinate with the Marathon Petroleum Retiree Health Plan:

- Governmental benefit programs provided or required by law, other than Medicare and Medicaid.
- No-fault automobile insurance plans. The Plan always pays secondary to any medical payment, personal injury protection (PIP) or no-fault insurance coverage provided under any automobile policy available to you or a covered dependent.
- Plans provided by an employer, union, trust, or other similar provider.
- Other group health care plans by which you or your dependents are covered, including student coverage provided through a school above the high school level.

C. When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

To the extent permitted by law, this Plan will pay benefits second to Medicare when a Member becomes eligible for Medicare due to disability, even if the Member does not elect it. There are, however, Medicare-eligible individuals for whom the Plan may pay benefits first and Medicare pays benefits second:

- Members with end-stage renal disease, for a limited period of time.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the Provider accepts Medicare. If the Provider does not accept Medicare, the Medicare limiting charge (the most a Provider can charge Member if they don't accept Medicare) will be the allowable expense. Medicare payments, combined with Plan benefits, will not exceed 100% of the total allowable expense.



If the Member is eligible for, but not enrolled in, Medicare, such as, Parts A and/or B, and this Plan is secondary to Medicare, benefits payable under this Plan will be reduced by the amount that would have been paid if the Member had been enrolled in Medicare.

Additionally, the Plan does not coordinate with Medicare for purposes of prescription drug coverage and will pay for covered prescription drug benefits under this Plan as primary, even when the Member is eligible for Medicare, such as, Parts A and/or B and/or D.

XVI. Claims and Appeals

The Plan has formal procedures in place for you to submit a claim for medical benefits or to appeal a decision denying your claim for medical benefits. Generally, if your claim is denied you may ask the claims administrator to review its decision. If the claims administrator determines that the claim continues to be denied, you may ask the claims administrator to again review the decision. These two steps are referred to as “internal appeals.” If you disagree with the claims administrator’s decision, and the basis for the denial involves medical judgment or relates to a rescission of benefits, you may request that a third party independent organization review the decision. This is called an “external review” by an Independent Review Organization. The decision by the third party Independent Review Organization is final and binding on both you and the Plan, subject to any right to file a lawsuit in court.

The process outlined in this section relates to a claim for a particular benefit under the Plan. If you have an eligibility claim — that is, a claim to participate in the Plan or to change an election to participate in the Plan during the plan year — you should submit your claim to the Plan Administrator, Marathon Petroleum Retiree Health Plan, 539 S. Main Street, Findlay, OH 45840, 1-888-421-2199. Eligibility claims are not subject to the requirements for internal and external review.

Claims for medical benefits are divided into four categories.

1. **Post-service claims** are claims for medical services already received.
2. **Pre-service claims** are claims for which you have not received medical services or for which prior authorization is required by the Plan.
3. **Concurrent care claims** are claims for ongoing treatments over a period of time or number of treatments. For example, if you have been authorized to receive seven treatments from a doctor or therapist and during the course of your treatment your doctor or therapist suggests 10 treatments, this is a concurrent care claim. Some concurrent care claims are also urgent care claims (see below).
4. **Urgent care claims** are claims for medical care or treatment that requires immediate action if a delay in treatment could significantly increase the risk to health or the ability to regain maximum function or cause severe pain or jeopardize the life or health of patient or a patient’s unborn child.



A. Filing an Initial Claim for Benefits

To file an initial claim for benefits, you should contact the appropriate claims administrator for that benefit. For instance, if you have a claim for prescription drug coverage, you should contact Express Scripts; if you have a claim for a medical benefit under the Plan, contact the medical claims administrator, Anthem BC/BS. Contact information for each claims administrator is listed below. A claim for benefits may be filed by you or your authorized representative. All Retiree Health Plan claims not filed for you must be submitted to the appropriate address indicated below within six months after the end of the calendar year in which the claims were incurred. Claims filed after that time will be denied.

1. Medical/Surgical Claims and Preventive Services Claims

Medical/surgical claims must be submitted with the provider's original itemized bill.

Claims for benefits (for both in- and out-of-network claims), must be submitted to the appropriate address for your PPO Provider area as follows. Claims for services obtained from a PPO participating network provider will be submitted by the provider. Providers may require reimbursement for your portion of the bill (coinsurances and deductible) at the time of service.

- **Providers who are participating in the BC/BS Network** are to submit the claim to the local BC/BS claim office for the provider's location. If the provider does not have this address they can contact Anthem BC/BS Customer Service at 1-855-698-5676.
- **Providers who are not participating in the BC/BS Network** and Members submitting a claim directly are to send the claim to:

Anthem BC/BS
P.O. Box 105187
Atlanta, GA 30348-5187

2. Managed Prescription Drug Program Claims

In general, when you purchase a prescription through the Retail Pharmacy component or the Mail Order component of the Managed Prescription Drug Program, no claim forms are needed. There is no coverage for outpatient prescription drugs not filled through a participating retail pharmacy or through the Express Scripts Health Mail Order Pharmacy.

a. However, four situations do require you to file a claim form:

- You or your covered dependent reside in the United States and, while temporarily outside the United States due to business or leisure, a medical need arises which requires an outpatient prescription drug to be purchased outside the United States;
- You or your covered dependent receive outpatient prescription drugs in the following situations and were billed by a pharmacy which is not a participating retail pharmacy for the prescription drugs.
 - Lives in and receives prescription drugs through a rest home, nursing home, sub-acute care facility (or other extended care facility or skilled nursing facility), convalescent hospital, or similar institution; or



- Receives prescription drugs from a hospice or home health agency.
- You or your covered dependent purchased outpatient prescription drugs at a participating retail pharmacy, but the claim was not filed electronically by the pharmacist into Express Scripts' computer;
- You or your covered dependent do not have “access” to a participating retail pharmacy.

Claim forms for use with the above four situations, and mail order forms can be obtained by calling Express Scripts at 1-877-207-1357. Submit claim forms to:

Express Scripts
P.O. Box 14711
Lexington, KY 40512

The claims administrator will provide you with any instructions regarding what information you need to provide with your initial claim for benefits, but generally you should include a description of your claim and any relevant documentation. If you are filing an urgent care claim, you or your authorized representative should call the claims administrator and state that you are filing an urgent care claim.

For urgent care claims, you will be notified whether or not your claim is approved as soon as possible, taking into account medical exigencies (that is, the medical circumstances surrounding your claim), but no later than 72 hours after your claim has been received. If you do not follow the proper procedure or provide sufficient information to determine whether benefits are covered under the Plan, the claims administrator will notify you as soon as possible, but no later than 24 hours after your claim was received. You will have 48 hours to provide the information requested. In this case, you will be notified whether or not your claim is approved as soon as possible, but in no case later than 48 hours after the requested information is received or the end of the 48 hour period after you have received the request to provide additional information.

For post-service claims, you will be notified whether or not your claim is approved within 30 days from when your claim is received. This period may be extended for 15 days. If you do not provide sufficient information to determine whether benefits for a post-service claim are covered under the Plan, the claims administrator may notify you within 30 days that additional information is needed, and you will then have 45 days to provide the additional information. If you do not provide any additional information requested, the claim will be decided based on the information originally provided.

For pre-service claims, you will be notified whether or not your claim is approved within 15 days from when your claim is received. This period may be extended for an additional 15 days. If you do not provide sufficient information to determine whether benefits for a pre-service claim are covered under the Plan, the claims administrator may notify you within 15 days that additional information is needed, and you will then have 45 days to provide the additional information. If you do not provide any additional information requested, the claim will be decided based on the information originally provided.



For concurrent care claims, you will be notified whether or not your claim is approved within a time period sufficiently in advance of the reduction or termination of coverage to allow you to appeal and obtain a response to that appeal before your coverage is reduced or terminated. For concurrent care that is urgent, you will be notified within 24 hours (provided that you submit your claim at least 24 hours in advance of reduction or termination of coverage).

If your initial claim is denied, you will be provided with a notice explaining why the claim was denied. This notice will include the following information:

- a. Description of the claim at issue, including date of service, healthcare provider, and the amount of the claim, as well as notification of your right to receive, upon request, the diagnosis and treatment codes related to your claim and the corresponding meanings of such codes;
- b. Specific reason or reasons your claim was denied;
- c. Plan provisions on which the decision was based;
- d. Description of any information that may be needed to perfect the claim and an explanation of why such information is necessary;
- e. Description of how you may have this decision reviewed, the time limits for requesting such review, and, for urgent care claims, a description of the expedited review process; and any internal procedures or clinical information on which the decision was based (or a statement that you may request this information free of charge).

B. Appealing a Denied Claim

If your claim for benefits is denied you may appeal the initial decision. The Plan provides for two levels of internal appeals for a claim for benefits — a first level mandatory appeal to the claims administrator who made the initial adverse benefit determination and a second “voluntary” appeal to the claims administrator. You may also seek external review by an Independent Review Organization (“external review”) of an adverse benefit determination by the claims administrator. You must exhaust the first level mandatory appeal process to the claims administrator before seeking external review by an Independent Review Organization, if your claim is otherwise eligible for external appeal, unless the claim is urgent or the Plan does not follow the requirements for internal claims and appeals required by law. In this case, you may immediately seek an external review, unless the action by the Plan was de minimis, non-prejudicial, attributable to good cause beyond the control of the Plan, in the context of an ongoing exchange of information, and not reflective of a pattern or practice of non-compliance. You have the right to request an explanation of the plan’s assertion that it met this standard before deciding whether to seek immediate external review or any remedies under state or federal law. In addition, you must exhaust the first level mandatory appeal process before bringing a lawsuit in court, unless the Plan does not follow the requirements for internal claims and appeals required by law.



1. First Level of Internal Appeal for Denied Claims (Mandatory)

For claims other than urgent care claims, you must file your appeal within 180 days from the date you receive notice of your denied claim, and your appeal should be directed to the claims administrator listed in the denial notice. For an appeal relating to a concurrent care decision, you must file your claim within a reasonable period of time, considering the time period scheduled for reduction or termination of benefits.

For urgent care claims, you must file your appeal within 180 days, however, you may file your appeal to both the claims administrator (first level of internal appeals) and seek expedited external review by the Independent Review Organization at the same time. (See Section XVII.B.3 below for instructions for seeking expedited external review.) You may file your appeal of a claim for urgent care orally, but must indicate that you are appealing an urgent care claim. You will be notified of the final decision relating to your appeal of a claim for urgent care within 72 hours.

When filing your appeal, you should include a copy of your claim denial notice, the reason or reasons for your appeal, and any relevant documentation. For post-service claims, you will be notified of the claims administrator's decision within 60 days. For pre-service claims, you will be notified of the claims administrator's decision within 30 days. For concurrent care claims, you will be notified of the claims administrator's decision before a reduction or termination of benefits would occur, but if the claim relates to an urgent care concurrent claim, you will be notified within 72 hours.

For claim appeal procedures that require the appeal be sent in writing to the claims administrator, the address for sending appeals to the various claim administrators under the Retiree Health Plan are as follows:

Anthem BC/BS (medical/surgical)
Attention: Appeals
P.O. Box 105568
Atlanta, GA 30348-5568
Fax: 1-888-859-3046

Express Scripts (prescription drug program)
Attention: Appeals
P.O. Box 66588
St. Louis, MO 63166-6588
Fax: 1-877-852-4070

For pre-service claims involving urgent/concurrent care, you may obtain an expedited appeal:

Anthem BC/BS (medical/surgical)
Telephone: 1-800-325-3377 (for expedited appeal)
Fax: 1-877-876-4992 (for expedited appeal)

Express Scripts (prescription drug program)
Telephone: 1-800-753-2851 (for expedited appeal)
Fax: 1-877-852-4070 (for expedited appeal)



If your claim is denied, you will receive a letter of denial including the following information.

- a. Description of the appeal at issue, including date of service, healthcare provider, and the amount of the claim, as well as notification of your right to receive, upon request, the diagnosis and treatment codes related to your claim and the corresponding meanings of such codes;
- b. Description of the specific reason or reasons your appeal was denied;
- c. Statement regarding the documents to which you are entitled, upon request and free of charge;
- d. Any internal procedures, standard, or clinical information on which the decision was based, including any new or additional evidence considered by the claims administrator and a reasonable opportunity to respond to this new evidence;
- e. The plan provisions on which the denial was based;
- f. An explanation of how you may file a voluntary second level appeal of the decision to the claims administrator or to an external review organization, if applicable, or your right to bring a lawsuit under federal law (i.e., Section 502(a) of ERISA);
- g. The following statement, "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency."

If your appeal to the claims administrator is denied, you may file a voluntary second level appeal of this decision to the claims administrator or seek external review. The decision by the claims administrator is a final mandatory internal appeal decision. No further appeals are required in order to exhaust internal administrative remedies.

2. Voluntary Second Level of Internal Appeal for Denied Claims

If you disagree with the claims administrator's decision on appeal, you may file a voluntary second level appeal of the decision to the claims administrator. The second level appeal is voluntary and will be reviewed by a person or persons who were not involved in any of the previous determinations; you are not required to complete a voluntary second level appeal prior to submitting a request for an independent external review or prior to bringing a lawsuit in court. The one year limitations period set forth in Section XVII.C. below will be tolled while a second voluntary appeal to the claims administrator is pending. The Plan waives any right to assert that a claimant has failed to exhaust administrative remedies because the claimant did not pursue a second level appeal to the claims administrator.

Contact information for the claims administrators are listed below. You may file your appeal of a claim for urgent care orally, but must indicate that you are appealing an urgent care claim. You will be notified of the final decision relating to your appeal of a claim for urgent care within 72 hours.



You must file your appeal with the claims administrator within 60 days of receipt of the decision of the first level appeal. You should direct your appeal to the claims administrator at the contact information listed below.

Anthem BC/BS (medical/surgical)
Attention: Appeals
P.O. Box 105568
Atlanta, GA 30348-5568
1-800-325-3377

Express Scripts (prescription drug program)
Attention: Appeals
P.O. Box 66588
St. Louis, MO 63166-6588
Fax: 1-877-852-4070

When filing your appeal, you should include a copy of your appeal denial notice, the reason or reasons for your appeal, and any relevant documentation. For post-service claims, you will be notified of the claims administrator's decision within 60 days. For pre-service claims, you will be notified of the claims administrator's decision within 30 days. For concurrent care claims, you will be notified of the claims administrator's decision before a reduction or termination of benefits would occur, but if the claim relates to an urgent care concurrent claim, you will be notified within 72 hours.

3. External Review to an Independent Review Organization

If your first or second level internal appeal of a claim for benefits is denied by the claims administrator and that denial is based on medical judgment or relates to a rescission of benefits, you may seek review of denial by a third party Independent Review Organization. For example, if your claim was denied because it was determined that the claim did not meet a medically necessary standard set forth in the Plan, you may request an external review of the denial. You may also request an external review if your coverage is terminated retroactively ("rescinded") for reasons other than nonpayment of premium or fraud or misrepresentation. A request for an external review must be in writing unless the claims administrator determines it is not reasonable to require a written statement. Except in cases of urgent/concurrent care claims, you must exhaust the first level mandatory internal appeal process before requesting external review.

For pre-service claims involving urgent/concurrent care, you may proceed with an expedited external review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including the claims administrator's decision, can be sent between the claims administrator and you by telephone, facsimile or other similar method. To proceed with an expedited external review, you or your authorized representative must contact the claims administrator at the number shown on your Plan identification card and provide at least the following information:

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- The identity of the claimant;
- The date of the medical service;
- The specific medical condition or symptom;
- The provider's name;
- Any service or supply for which approval of benefits was sought; and
- Any reasons why the appeal should be processed on a more expedited basis.

You must request external review within four months after date of receipt of an adverse benefit determination or final adverse benefit determination. A request for an external review should be sent to the following address:

Anthem BC/BS (medical/surgical program)
Grievances and Appeals
P.O. Box 105568
Atlanta, GA 30348-5568

MCMC LLC (prescription drug program)
Attn: Express Scripts Appeal Program
300 Crown Colony Drive, Suite 203
Quincy, MA 02169-0929
Telephone: 617-375-7700, ext. 28253

Within 5 days of receiving your request, the claims administrator (or designee) will review your request and determine whether the request is eligible for external review based on whether you were covered by the Plan at the time the medical care, item, or service was received, whether you exhausted the internal claims procedures, and whether the final internal review decision was based on medical judgment or rescinded coverage. If your claim is eligible for external review based on these criteria, the claims administrator (or designee) will notify you within one day of completing the review. If eligible for external review, the claim will be referred to an Independent Review Organization. The Independent Review Organization will notify you of your eligibility for review and inform you of your right to submit any additional information within 10 days. The Independent Review Organization will review the claim "de novo," which means it will not take into account any prior decisions at the internal appeal level. You will be provided with the Independent Review Organization's decision within 45 days. If the internal decision denying benefits is reversed, the Plan will immediately provide or pay benefits to you. Urgent care claims that are externally appealed will be decided within 72 hours after the request.

In order to avoid the appearance of any conflicts of interest, the claims administrators contract with various separate Independent Review Organizations and rotate claims for external review among those organizations. None of these organizations receive any financial incentive from the Plan or claims administrator to support a denial of the claim.

The decision of the external Independent Review Organization is binding on both parties, subject to any rights to bring a lawsuit in court.



C. Finality of Decision and Legal Action

A claimant must follow and fully exhaust the applicable claims and appeals procedures described in the 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 the 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. A decision by the claims administrator following the first level mandatory internal appeal is the final decision under these procedures. However, the one year period is tolled during the pendency of a voluntary second level appeal to the claims administrator or external review by an Independent Review Organization.

D. Designating an Authorized Representative

You may designate someone else — an “authorized representative” — to file a claim or appeal on your behalf under the Plan. The purpose of appointing an authorized representative is to relieve you or your beneficiary of the burden of completing claims paperwork by yourself; for example, if you are incapacitated due to a medical condition or for any other reason. For this person to be considered your authorized representative, the following requirements must be satisfied:

- You have given express written consent for the person to represent your interests;
- The person is authorized by law to give consent for you (e.g., parent of a minor, legal guardian, foster parent, and, except as provided otherwise in this section and the Plan's anti-assignment provisions, power of attorney);
- For pre-service and urgent care claims the person may be:
 - Your immediate family member (e.g., spouse, parent, child, sibling);
 - Your primary caregiver; or
 - Your health care professional who knows your medical condition (e.g., your treating physician); or
- For outpatient concurrent care claims the person may be:
 - Your immediate family member (e.g., spouse, parent, child, sibling); or
 - Your primary caregiver; or
- For inpatient concurrent care claims, the person may be a health care professional who knows your medical condition (e.g., your treating physician); or

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- For post-service claims from health care providers, the health care provider (or an employee or representative of the provider), but in this circumstance the health care provider (or an employee or representative of the provider) will only be recognized as your designated representative under the terms of a properly executed *Appointment of Authorized Representative Form* provided by the Plan or its delegate and has satisfied any other Plan rules, or other procedures for recognition as an authorized representative that the Plan Administrator may determine.

No person will be recognized as an authorized representative until the Plan receives an *Appointment of Authorized Representative Form* signed by the claimant, except that for urgent care claims the Plan will, even in the absence of a signed Appointment of Authorized Representative form, recognize a health care professional with knowledge of the claimant's medical condition (e.g., the treating physician) as the claimant's authorized representative unless the claimant provides specific written direction otherwise.

An *Appointment of Authorized Representative Form* may be obtained from, and the completed form must be submitted to, the Marathon Petroleum Benefits Service Center, 539 S. Main Street, Findlay, OH 45840, 1-888-421-2199, or the appropriate claims administrator. The form is also available on <http://www.mympcbenefits.com>. Once an authorized representative is appointed under the Plan's rules, the Plan will direct all information, notification, etc. regarding the claim to the authorized representative. The claimant will be copied on all notification regarding decisions, unless the claimant provides specific written direction otherwise.

You may also need to sign an authorization form for the release of protected health information to the authorized representative.

The Plan reserves the right to reject the appointment of an individual or entity as an authorized representative at any time. The Plan may reject an authorized representative appointment if the Plan determines the individual or entity has engaged in practices or activities that violate the Plan's terms or that attempt to modify or effectively circumvent, without the Plan Administrator's express approval, the Plan's requirements with respect to cost sharing. The Plan may also reject an authorized representative appointment (including, but not limited to, any document that constitutes a power of attorney) if it would contravene or effectively circumvent any of the Plan's anti-assignment provisions. The Plan's acceptance of an authorized representative appointment (including, but not limited to, any document that constitutes a power of attorney) shall not act as a waiver of a Plan's anti-assignment of benefits provisions and shall not restrict a Plan from asserting such anti-assignment provisions at any time, regardless of whether the Plan has previously communicated with the individual or entity without challenging the individual's or entity's status as authorized representative.



E. Assignment of Benefits

The claims administrator, on behalf of the Plan, may make payments directly to Providers, pharmacies, and other vendors for covered expenses and prescription drugs. In some cases, the claims administrator may make payments directly to a Member (or an alternate recipient, custodial parent, or designated representative). Any payments made by the claims administrator will discharge the Plan's obligation to pay for covered expenses and/or prescription drugs. The right of any Member to receive any benefits or payments under this Plan shall not be alienable by the Member by assignment or any other method and shall not be subject to claims by the Member's creditors or health care providers by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to the extent required by law.

With the exception of a qualified medical child support order (QMSCO) or as the Plan Administrator may otherwise permit by rule or regulation, you cannot directly or indirectly assign, either voluntarily or involuntarily, your benefits under the Plan. Any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge or otherwise dispose of any right to benefits payable under the Plan shall be void; nor will any interest in or benefit payable under the Plan be in any way subject to any legal or equitable process, including garnishment, attachment, levy, seizure or lien. Any attempt to assign a benefit will be treated as a direction to pay benefits to a purported assignee rather than as an assignment of rights, and in no way grants a health care provider (or other third party) assignee status or beneficiary status under the Plan. **For the avoidance of doubt, this anti-assignment rule prohibits any health care provider or other purported assignee from bringing any claim under ERISA or other federal or state law or regulation purporting to have an assignment of benefits or authorization as an attorney-in-fact or agent or similar status with respect to any Plan Member (a participant or beneficiary) under any document that constitutes a power of attorney or similar instrument, and any such attempt to effect such assignment shall be void and untenable at all times.**

In the Plan Administrator's discretion, it is authorized to permit communications between a Plan and a health care provider (or other third party) under the Plan's claims procedures and pursuant to a purported written assignment of benefits or similar document; provided, however, that any such communication shall not act as a waiver of a Plan's anti-assignment provisions, even when this anti-assignment provision is not expressly asserted by the Plan Administrator or the Plan's claims administrator, and shall not restrict the Plan from asserting such anti-assignment provisions at any time. Except as otherwise agreed to in writing by the Plan, in no event shall the Plan, the Company, or its affiliates be liable to any health care provider (or other third party) to whom a Plan Member (a participant or beneficiary) may be liable for medical care, treatment, or other services. Additionally, the Company and its affiliates shall not be liable for, or subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits under the Plan.

F. Outstanding Claim Checks

The Plan has the authority to cancel and stop payment on any claim checks issued by a claim payer under the Plan if the check has been outstanding and not cashed for one year or more. Such action shall not, however, prohibit the Plan from making the claim payment if approached by a Member or designated representative for payment after the claim check has been cancelled.



XVII. Miscellaneous Situations Affecting Your Plan Benefits

A. Expenses for Which a Third Party May Be Responsible

This Plan does not cover:

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

1. Third Parties

The following persons and entities are considered third parties:

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

2. Subrogation/Right of Reimbursement

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

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



- **Right of Reimbursement:** The Plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in immediately preceding paragraph, but only to the extent of the benefits provided by the Plan.

3. Lien of the Plan

By accepting benefits under this Plan, a Participant:

- Grants a lien and assigns to the Plan an amount equal to the benefits paid under the Plan against any recovery made by or on behalf of the Participant which is binding on any attorney or other party who represents the Participant whether or not an agent of the Participant or of any insurance company or other financially responsible party against whom a Participant may have a claim provided said attorney, insurance carrier or other party has been notified by the Plan or its agents;
- Agrees that this lien shall constitute a charge against the proceeds of any recovery and the Plan shall be entitled to assert a security interest thereon; and
- Agrees to hold the proceeds of any recovery in trust for the benefit of the Plan to the extent of any payment made by the Plan.
- Agrees to cooperate with the Plan and its agents in a timely manner to protect its legal and equitable rights to subrogation and reimbursement, including, but not limited to:
 - Complying with the terms of this Plan document;
 - Providing any relevant information requested;
 - Signing and/or delivering documents at its request;
 - Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable;
 - Responding to requests for information about any accident or injuries;
 - Appearing at medical examinations and legal proceedings, such as depositions or hearings; and
 - Obtaining the Plan's consent before releasing any party from liability or payment of medical expenses.

4. Additional Terms

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the Plan. The Plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the Plan without its written approval.

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



B. Limitations on Benefits You May Expect to Receive

The Plan contains numerous provisions regarding such items as eligibility, medical necessity, certification requirements, in-network benefit and out-of-network benefit entitlement, deductibles, excluded expenses, etc. Given these various limitations, it is important to carefully read and review all of the provisions of this document that may relate to whether or not you are entitled to coverage for a particular expense.

C. Rescission and Cancellation of Coverage

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

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

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

A Member who receives a Plan benefit as a result of false or incomplete information or a misleading or fraudulent representation must repay all amounts to the Plan and will be liable for all collection costs including attorneys' fees and court costs. In addition, such Member's coverage under the Plan may be immediately terminated.

D. Missing Person

If, within 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 those delegated authority in attempting to make such payment by providing notice at the Participant's last known address, 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.



E. American Jobs Creation Act of 2004

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

F. Genetic Information Nondiscrimination Act of 2008 (GINA)

Notwithstanding any provision of this Plan to the contrary, this Plan shall be operated and maintained consistent with GINA.

XVIII. Your Legal Right to Continue Coverage Under COBRA

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

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, (COBRA) requires that most employers sponsoring group health plans offer plan Members and their covered dependents the opportunity for a temporary extension of health coverage (continuation of coverage) at group rates in certain instances where plan coverage would otherwise end.

Participants may have other health coverage options available when they lose group health coverage under the Plan. For example, a participant may be eligible to buy an individual health insurance plan through the Health Insurance Marketplace. By enrolling in coverage through the Health Insurance Marketplace, a former participant in the Plan may qualify for lower costs on his or her monthly premiums and lower out-of-pocket costs. Additionally, a participant may qualify for a 30-day special enrollment period for another group health plan for which he or she is eligible (such as a spouse's plan) even if that plan generally does not accept late enrollees.

A. Group Covered

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

B. Qualifying Events and Maximum Length of Continuation Periods

1. Covered Spouse Loses Coverage

If the covered **Spouse or Domestic Partner** of a Retiree, LTD Retiree, or LTD Terminated Member of the Retiree Health Plan loses coverage:

- Because of divorce or legal separation or termination of domestic partner relationship from such Member;



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

2. Eligible Child Loses Coverage

If an eligible **Child** of a Retiree, LTD Retiree, or LTD Terminated Member of the Retiree Health Plan loses coverage:

- Because the child no longer meets the Retiree Health Plan's definition of an eligible Child; or
- Because the parents become divorced or legally separated or due to a termination of domestic partner relationship;

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

3. Bankruptcy

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Marathon Petroleum Company LP, and that bankruptcy results in the loss of coverage of any Retiree covered under the Plan, the Retiree will become a qualified beneficiary. The Retiree's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

C. Maximum Length of Continuation Periods

COBRA continuation coverage is a temporary continuation of group health plan coverage.

When the qualifying event is divorce or legal separation or termination of domestic partner relationship, COBRA continuation coverage for the spouse or domestic partner and/or dependent children lasts for up to a total of 36 months from the date of the qualifying event. Also, the dependent children are entitled to COBRA continuation coverage for up to 36 months after losing eligibility as a dependent child under the terms of the plan.

D. Termination of Continued Coverage

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

1. The date the Continued Member (or continued dependent) first becomes covered after the date of their COBRA election, under another group health plan either as an employee, retiree, dependent, or otherwise;
2. The date the Continued Member (or continued dependent) first becomes entitled, after the date of their COBRA election, to benefits under Medicare;
3. The last day of coverage for which timely premiums have been paid;
4. The date on which the 36-month period ends;
5. The first date on which no employer in the controlled group which includes Marathon Petroleum Company LP provides any group health plan to any of its employees.



E. Notification Procedure

1. In the event of the divorce or legal separation of a Member and spouse, or in the event that a Child no longer meets the Plan's definition of eligible dependent:
 - a. The Member 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
 - b. The Plan Administrator or representative will inform the Member's 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.
2. The Member/dependent must elect to continue coverage within a specified election period. This period ends on the **later** of 60 days from:
 - a. The date of the notice from the Plan Administrator, if applicable; or
 - b. The date of termination of coverage.
3. If no election is made within the election period, coverage ceases at the time of the qualifying event. If you initially waive COBRA continuation coverage, but revoke that waiver within the 60-day election period, coverage will only be effective from the date of the waiver.
4. If you elect COBRA continuation coverage, you must make your initial payment for continuation coverage (including all premiums due but not paid) no later than 45 days after the date of your election. (This is the date the COBRA election notice is post-marked, if mailed.) If you do not make your initial payment for COBRA continuation coverage within 45 days after the date of your election, you will lose all COBRA continuation coverage rights under the plan. **Payment is considered made on the date it is sent to the plan.**

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

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



F. Type of Coverage

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

1. Benefit Coverage

The benefit coverage a Continued Member receives is based on the Non-Employee Group the Member and/or covered eligible dependent(s) were in on the day before the date of their initial qualifying event. Members who make up the “Non-Employee Group” are Retiree Members, LTD Retiree Members, LTD Terminated Members, Spouse Members, Surviving Spouse Members and Child(ren) Members.

2. Change in Coverage Category

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

b. Addition of Eligible Dependents

i. Eligible Dependents at Time of Qualifying Event

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

3. The Continuation Period

During the continuation period, Continued Members are not permitted to move between Options of the Retiree Health Plan except as described in Article VI, “Changing Coverage Options While Enrolled,” of this document.

4. Plan Amendments

Any amendments to the Plan applicable to non-continued Members in the “Non-Employee Group” will also be applicable to similarly situated Continued Members who are in the “Non-Employee Group.”

5. Accumulated Amounts

Any amounts accumulated toward the deductibles or stop-loss limits by an individual before the qualifying event, will be carried over and used toward satisfying the applicable deductible or stop-loss provisions as a Continued Member for the remainder of the calendar year (including, but not limited to, deductibles and stop-loss provisions under the Managed Prescription Drug Program).

6. Coverage Under Another Plan

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



G. Cost

Continued Members will be charged the entire premium applicable to any other Member with the same coverage plus 2% of the total premium amount. The entire premium includes the portions formerly paid by both the Member and MPC.

The rates will be established prior to their effective date and be frozen at that level for a minimum of twelve months. Members or spouses with no dependents, and each former child who, because of losing child status, elects continuing coverage, will be charged the single (Member only) rate.

With the exception of the initial payment, all premium payments must be received in advance of the period of coverage.

H. Surviving Spouse and Surviving Dependents

The Plan provides that an eligible Surviving Spouse and dependents can continue coverage until a remarriage occurs. The Plan also provides that an eligible dependent of certain types of former Members or of a deceased retiree can be covered in their own right

Effective for the qualifying event of the death of a Retiree Member on or after January 1, 2001, the covered spouse and covered children of the deceased Retiree Member will be offered COBRA continuation of coverage which allows them to continue their Retiree Health Plan coverage at the COBRA rate of 102% of the premium if:

- The remarriage or failure to satisfy the eligible dependent requirements of the Plan occurs within 36 months of the date of death; and
- None of the events which would have terminated the 36-month period of COBRA continuation coverage (which otherwise would have been provided if not for the Company-subsidized coverage under the Plan) have occurred.

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

I. Alternatives to COBRA Continuation Coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options available to the Member and his or her family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's employer's group health plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. More information about these options is available at www.healthcare.gov.



XIX. Administrative Information

The Marathon Petroleum Retiree Health Plan is governed by ERISA (the Employee Retirement Income Security Act of 1974, as amended). This section provides important legal and administrative information you may need such as:

- How to contact the Plan Administrator;
- Information about the claims administrator or insurance companies that provide or administer the health plan and how to contact them.

If you have any questions about any of the following, call the Benefits Service Center at 1-888-421-2199, option 1, then option 3.

A. Type of Plan

The Plan is a group health plan providing coverage for various types of health services and supplies.

B. Plan Sponsor and Administrator

The Plan is sponsored by Marathon Petroleum Company LP, 539 South Main Street, Findlay, OH 45840, an employer whose regular full-time and regular part-time employees, and casual employees who meet work hour requirements, are eligible for coverage under the Plan. The Plan Administrator of the Plan is listed below. The Company may appoint assistant administrators as may be deemed necessary.

The Plan Administrator

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

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 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 Plan.

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

C. Plan Funding

The Plan is funded by the contributions of plan Members and the general assets of Marathon Petroleum Company LP. The total cost of the plan is ultimately determined by claims experience and administrative costs. In general, costs are shared on an 80%Company/20% Member basis, but in certain circumstances, Members may pay a higher percentage, and in certain circumstances the Company may pay a higher percentage.



D. Plan Identification Number and Plan Name

When dealing with or referring to the Plan in terms of claim appeals or other correspondence, you will receive a more rapid response if you identify the Plan fully and accurately. To identify a plan, you need to use Marathon Petroleum's employer identification number (EIN): 31-1537655. You also need to know the Plan's official name and number. The Retiree Health Plan's official name is the Marathon Petroleum Retiree Health Plan. It is sometimes referred to, informally, as the Retiree Health Plan, or just the Plan. The plan number is 561.

E. Plan Year

The Plan Year is January 1 through December 31. December 31 is the end of the year for purposes of maintaining the Plan's fiscal records.

F. Type of Administration

The Plan consists of both self-funded and fully insured options which are administered in part by the Plan Sponsor and in part by various third-party claims administrators through administrative-services-only contracts. These various third-party claims administrators assist in the processing of claims and in performing various other Plan functions, but they do not insure any of the benefits provided by the Plan.

Claim Administrators for Classic and Saver HSA Options

- **Medical/Surgical Program — Anthem BC/BS PPO Options**

Anthem Insurance Companies, Inc.
220 Virginia Avenue
Indianapolis, IN 46204
www.Anthem.com

- **Managed Prescription Drug Program — Express Scripts**

Express Scripts
100 Parsons Pond
Franklin Lakes, NJ 07417
www.express-scripts.com

Claim Administrator for Kaiser HMO Northern California Option — Medical/Surgical and Prescription

Kaiser Permanente
Claims Administration – NCAL
P.O. Box 12923
Oakland, CA 94604-2923
www.KP.org



***Claim Administrator for Kaiser HMO Southern California Option —
Medical/Surgical and Prescription***

Kaiser Permanente
Claims Administration – SCAL
P.O. Box 7004
Downey, CA 90242-7004
www.KP.org

G. Agent for Service of Legal Process

The agent for service of legal process on the Plan is the Plan Administrator and process may be served on the Plan Administrator at 539 South Main Street, Findlay, OH 45840.

H. Use and Disclosure of Protected Health Information

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

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

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

Retiree Health Plan



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

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

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



XX. Special Provisions Relating to Medicaid

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

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

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

XXI. Participation by Associated Companies or Organizations

Upon specific authorization and subject to such terms and conditions as it may establish from time to time, Marathon Petroleum Company LP may permit employees of subsidiaries and affiliated organizations to participate in this Plan. Currently, these participating companies include, but are not limited to, Marathon Petroleum Company LP, Marathon Petroleum Service Company, Marathon Petroleum Logistics Services LLC and Marathon Refining Logistics Services LLC. Employee eligibility with respect to current and former participating companies may be limited to certain employee subsets as identified in Appendix A. In addition, eligible subsets of employees must satisfy all eligibility provisions otherwise provided by this Plan.

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

XXII. Modification and Discontinuance of 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. No Member or any other individual who is or may become eligible to participate in the Plan or any of their spouse, domestic partner or children has any vested right to any benefit under the Plan.



XXIII. Further Information

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

The Plan is funded by Member and Company contributions.

In determining the eligibility of Members and other individuals for benefits and in construing the Plan's terms, the Plan Administrator (or a Third Party Administrator in cases where a Third Party Administrator has the authority to make determinations concerning eligibility for benefits) has the power to exercise discretion in the construction or interpretation of doubtful, disputed or ambiguous 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. All decisions of the Plan Administrator (or a Third Party Administrator in cases where a Third Party Administrator has the authority to make determinations concerning eligibility for benefits) made on all matters within the scope of his (or its) authority shall be final and binding upon all persons, including the Company, all participants and beneficiaries, and 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 (or by a Third Party Administrator in cases where a Third Party Administrator has the authority to make determinations concerning eligibility for benefits) shall be the "arbitrary and capricious" standard of review. Any discretionary acts taken under this Plan by the Plan Administrator or the Company, shall be uniform in their nature and shall be applicable to all Members similarly situated, and shall be administered in a nondiscriminatory manner in accordance with the provisions of the Employee Retirement Income Security Act of 1974, as amended, (ERISA) and the Internal Revenue Code (Code).

In situations in which the Plan Administrator deems it to be appropriate, the Plan Administrator may, but is not required to, evidence (i) the exercise of such discretion, or (ii) any other type of decision, directive or determination he may make with respect to the Plan, in the form of 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.

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



XXIV. Your Rights Under Federal Law

As a participant in the Marathon Petroleum Company LP Benefit Plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plans and Benefits

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

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plans, including insurance contracts, collective bargaining agreements 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 plan's annual financial reports. The plan administrator is required by law to furnish each participant with a copy of the summary annual reports.

Prudent Actions by Plan Fiduciaries

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



Enforce Your Rights

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

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

Assistance With Your Questions

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



Appendix A

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

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



Appendix B

Grandfathered Eligible Legacy Andeavor Employees/Retirees Specific to the Andeavor Acquisition of Western Refining

1. El Paso Employees/Retirees

To be eligible for coverage under this Retiree Health Plan, you must have been actively enrolled in the Retiree Medical Plan for El Paso Retirees on December 31, 2018. Continued eligibility for you and your dependents will follow the eligibility requirements of the [Retiree Medical Plan for El Paso Retirees](#), which is incorporated herein for purposes of eligibility only.

If actively employed with Marathon Petroleum on January 1, 2019, you must satisfy the eligibility and participation requirements of the Retiree Medical Plan for El Paso Retirees at the time of your retirement from the Company to be eligible for the Marathon Petroleum Retiree Health Plan. Additionally, you must be at least age 55 with 10 years of accredited service to qualify for coverage under the Marathon Petroleum Retiree Health Plan.

2. NTI

To be eligible for coverage under this Retiree Health Plan, you must have been actively enrolled in the Retiree Medical Plan for Retirees of Northern Tier Energy, Northern Oil Transport, and St. Paul Refining on December 31, 2018. Continued eligibility for you and your dependents will follow the eligibility requirements of the [Retiree Medical Plan for Retirees of Northern Tier Energy, Northern Oil Transport, and St. Paul Refining](#), which is incorporated herein for purposes of eligibility only.

3. Yorktown Retirees

To be eligible for coverage under this Retiree Health Plan, you must have been actively enrolled in the Retiree Medical Plan for Yorktown Retirees on December 31, 2018. Continued eligibility for you and your dependents will follow the eligibility requirements of the [Retiree Medical Plan for Yorktown Retirees](#), which is incorporated herein for purposes of eligibility only.



Appendix C

Non-Employee Group Member Contributions

(Also see contribution chart on following pages.)

A. 4% Accrual Method (Currently in Use)

Members who retire on or after February 1, 2000, along with their covered dependents (including Spouse Members and Surviving Spouse Members), have the percentage of the full company subsidy they receive based on the “4% accrual method.” The percentage of the full company contribution earned at retirement under the “4% accrual method” is equal to 4% multiplied by the number of years of service earned after age 30 as of the retirement date. In addition, employees who had a “change in status” removing them from eligibility for separate health plans established by union contract at a Company facility shall have years of service earned from original date of hire with the Company or age 30 if later. As a point of additional clarification, former casual employees will receive years of service from their “change of status” date only. This means that former casual employees who have a “change of status” date on or after January 1, 2008 but prior to January 1, 2019 (if a legacy MPC employee) or prior to January 1, 2016 if (if a legacy Andeavor employee) and meet all other eligibility provisions, will have Company subsidized Retiree Health Plan eligibility until they are eligible for Medicare due to age; thereafter there is no Company funding available for any post-65 health care.

For purposes of this 4% Accrual Method, service is the years and quarters of a calendar year credited to the Member on their retirement date in accordance with the Employee Service Plan. Commencing with and including the last day of a calendar quarter of an active employee’s 30th birthday, or if hired after age 30 commencing with the last day of the calendar quarter of hire, 1% will be accrued on the last day of each eligible calendar quarter provided the employee is also credited with service under the Employee Service Plan through that date. These accruals will continue for a maximum of 100 calendar quarters as determined by applying the service recognized under the Employee Service Plan to actual service with the Company (including actual service with a company for which service is recognized under the Employee Service Plan) from age 30. For an employee with 25 years of actual service recognized under this provision from age 30 or their date of hire, such employee will be eligible for the maximum company subsidy under the terms of the Plan for eligible retiree health care coverage.

For purposes of determining the number of years of service (as generally determined under the Employee Service Plan) earned after age 30 as of the retirement date under the 4% accrual method, that has been granted to an acquired or merged employee under the Employee Service Plan as a result of an acquisition or merger supported by a definitive agreement signed on or after March 1, 2004, only past service granted to an acquired or merged employee under the Employee Service plan will be used under the 4% accrual method provided the signed definitive agreement governing the merger or acquisition specifically provides for the recognition of service under the Employee Service Plan for these purposes.

Retiree Health Plan



B. Age and Service Point System (Replaced by “4% Accrual Method”)

Members who retired prior to age 62 before February 1, 2000, along with their covered dependents (including Spouse Members and Surviving Spouse Members), had the percentage of the full company subsidy they received based on the “Age and Service Point System” accrual method. The “Age and Service Point System” accrual method used the sum of the employee’s age (years and months) and service at retirement. The sum of the age and service was the point total. The point totals equated to different percentages of the full company subsidy. 80 or more points equated to 100% of the full company subsidy. For more information about the Age and Point System contact the Benefits Service Center at 1-888-421-2199, option 1, then option 3, concerning provisions as they may relate to your benefit situation, or ask to review the Plan Document that was in effect at the time of your separation from service for specific language dealing with Grandfathered Plan Provisions.

C. Members Not Affected by Either Accrual Method

Members who retired after reaching age 62 and before February 1, 2000, along with their covered dependents (including Spouse Members and Surviving Spouse Members) received 100% of the Company subsidy and were not affected by either accrual method.

D. Transitional Provisions

Transitional provisions were used when the Company moved from the Age and Service Point System to the 4% Accrual System. In general, active Members prior to February 1, 2000, with at least 20 years of eligible service had their Age and Service Points frozen under the eliminated point system. As of July 1, 2011, the date of the spinoff of MPC from Marathon Oil Corporation, applicable frozen Age and Service Points will track with eligible active Member as provided in the predecessor Plan sponsored by Marathon Oil Company prior to July 1, 2011.

When the Member retires, the percentage used to determine their Health Plan premium is the greater of the frozen Age and Service percentage or the 4% Accrual percentage accrued at the time of retirement. That percentage will also apply to the retiree’s covered dependents (including Spouse Members and Surviving Spouse Members).

E. Employees Transferred From a Non-participating Member of the Controlled Group Immediately Prior to Retirement

For a transferred employee who immediately prior to retirement is employed by a non-participating Member of the controlled group which include Marathon Petroleum Company LP and who is eligible for participation under the Plan as a Retiree Member, service for purposes of determining the employee’s percentage of company contributions they are eligible to receive at retirement will be calculated by using the controlled group service (years and months) recognized by the non-participating employer on the day immediately prior to retirement from the controlled group. Controlled group service is the service used by the non-participating employer of the controlled group for vacation and sick benefit purposes.

F. Coverage of Spouse/Domestic Partner or Dependent Acquired After Retirement

A spouse/domestic partner or dependent acquired by a Retiree Member on or after Retiree Member’s date of retirement is not eligible for coverage, unless previously enrolled in this Plan as of December 31, 2020.

Retiree Health Plan



The following paragraphs F.1. and F.2. are maintained for purposes of dependents acquired by a Retiree Member after Retiree Member's date of retirement and enrolled in this Plan as of December 31, 2020:

1. **Retiree Members** — Retiree Members of the Retiree Health Plan who acquire a spouse/domestic partner or eligible dependent after their date of retirement and elect to cover the spouse and/or eligible dependent under the Plan will be required to pay the Member only full premium (both Company and Member contributions) for each individual spouse and individual dependent acquired after the date of retirement.
2. **Death of Retiree Who Has Voluntarily Waived Coverage Under the Retiree Health Plan** — Effective January 1, 2003, a spouse/domestic partner and/or eligible dependents acquired by a retiree after their date of retirement who subsequently elects coverage upon the death of the retiree will be required to pay the full premium (both Company and Member contributions).

For purposes of this paragraph (F), a spouse/domestic partner or dependent acquired after the retirement date of the Retiree Member means a spouse/domestic partner or dependent who first becomes eligible for coverage under the Plan after the Retiree Member's retirement date, or in the case of a retiree who voluntarily waived coverage, would have first become eligible for coverage under the Plan had the retiree elected to enroll in the Plan. The Retiree Member, or in the case of a deceased retiree, the Surviving Spouse or eligible dependents, will not receive any Company subsidy for the new spouse or dependent coverage. The full premiums (both Company and Member contributions) are contained in this appendix.

G. Company Contributions

1. Classic and Saver HSA Options
 - a. The Company pays all costs of the Plan in excess of the Member's contributions, however;
 - b. When a Retiree Member retired prior to January 1, 2016 and worked more than 50% of their total service as a regular part-time employee, the Retiree Member (and their dependents if applicable) will receive 50% of the company contribution the Retiree Member is otherwise entitled to. This means that if under the provisions of the above the Retiree Member receives less than 100% of the full company subsidy for the Non-Employee Group, the Member will receive 50% of the percentage of Company contribution the Retiree Member would otherwise be eligible for after the above provisions are applied. A Retiree Member who retired January 1, 2016 or later who worked more than 50% of their total service as Regular Part-time employee will receive 100% of the Company contribution to which Retiree Members are entitled.
2. Kaiser Permanente Northern and Southern California Options

The Company pays no more than 80% of the total Classic option premium for the Kaiser options. (Employees pay excess amounts, if any.)

IMPORTANT NOTE: The Company reserves the right to modify the Company subsidies described in this Appendix C, and to make corresponding changes to the manner in which the Retiree Health Plan Member contributions are to be paid by Retiree Members or members of the Non-Employee Groups, as the Company may, in its sole discretion, determine to be necessary or desirable. Any such changes may be applied to both current Retiree Members as well as Employee Members who may become Retiree Members at a future date.

Retiree Health Plan



Marathon Petroleum 2023 Retiree Health Plan Contributions (Refer to Appendix D for Retiree Health Plan Summary of Provisions and Option Comparison)

% of Company Subsidy Earned	Member Only Per Month		Member+Spouse/DP Per Month		Member+Child(ren) Per Month		Member+Family Per Month	
	Classic	Saver HSA	Classic	Saver HSA	Classic	Saver HSA	Classic	Saver HSA
Total Cost->	\$988.00	\$867.00	\$1,975.00	\$1,735.00	\$1,975.00	\$1,735.00	\$2,963.00	\$2,601.00
Comp. Cost->	\$790.40	\$759.00	\$1,580.00	\$1,525.00	\$1,580.00	\$1,525.00	\$2,370.40	\$2,259.00
100	\$197.60	\$108.00	\$395.00	\$210.00	\$395.00	\$210.00	\$592.60	\$342.00
99	\$205.50	\$115.59	\$410.80	\$225.25	\$410.80	\$225.25	\$616.30	\$364.59
98	\$213.41	\$123.18	\$426.60	\$240.50	\$426.60	\$240.50	\$640.01	\$387.18
97	\$221.31	\$130.77	\$442.40	\$255.75	\$442.40	\$255.75	\$663.71	\$409.77
96	\$229.22	\$138.36	\$458.20	\$271.00	\$458.20	\$271.00	\$687.42	\$432.36
95	\$237.12	\$145.95	\$474.00	\$286.25	\$474.00	\$286.25	\$711.12	\$454.95
94	\$245.02	\$153.54	\$489.80	\$301.50	\$489.80	\$301.50	\$734.82	\$477.54
93	\$252.93	\$161.13	\$505.60	\$316.75	\$505.60	\$316.75	\$758.53	\$500.13
92	\$260.83	\$168.72	\$521.40	\$332.00	\$521.40	\$332.00	\$782.23	\$522.72
91	\$268.74	\$176.31	\$537.20	\$347.25	\$537.20	\$347.25	\$805.94	\$545.31
90	\$276.64	\$183.90	\$553.00	\$362.50	\$553.00	\$362.50	\$829.64	\$567.90
89	\$284.54	\$191.49	\$568.80	\$377.75	\$568.80	\$377.75	\$853.34	\$590.49
88	\$292.45	\$199.08	\$584.60	\$393.00	\$584.60	\$393.00	\$877.05	\$613.08
87	\$300.35	\$206.67	\$600.40	\$408.25	\$600.40	\$408.25	\$900.75	\$635.67
86	\$308.26	\$214.26	\$616.20	\$423.50	\$616.20	\$423.50	\$924.46	\$658.26
85	\$316.16	\$221.85	\$632.00	\$438.75	\$632.00	\$438.75	\$948.16	\$680.85
84	\$324.06	\$229.44	\$647.80	\$454.00	\$647.80	\$454.00	\$971.86	\$703.44
83	\$331.97	\$237.03	\$663.60	\$469.25	\$663.60	\$469.25	\$995.57	\$726.03
82	\$339.87	\$244.62	\$679.40	\$484.50	\$679.40	\$484.50	\$1,019.27	\$748.62
81	\$347.78	\$252.21	\$695.20	\$499.75	\$695.20	\$499.75	\$1,042.98	\$771.21
80	\$355.68	\$259.80	\$711.00	\$515.00	\$711.00	\$515.00	\$1,066.68	\$793.80
79	\$363.58	\$267.39	\$726.80	\$530.25	\$726.80	\$530.25	\$1,090.38	\$816.39
78	\$371.49	\$274.98	\$742.60	\$545.50	\$742.60	\$545.50	\$1,114.09	\$838.98
77	\$379.39	\$282.57	\$758.40	\$560.75	\$758.40	\$560.75	\$1,137.79	\$861.57
76	\$387.30	\$290.16	\$774.20	\$576.00	\$774.20	\$576.00	\$1,161.50	\$884.16
75	\$395.20	\$297.75	\$790.00	\$591.25	\$790.00	\$591.25	\$1,185.20	\$906.75
74	\$403.10	\$305.34	\$805.80	\$606.50	\$805.80	\$606.50	\$1,208.90	\$929.34
73	\$411.01	\$312.93	\$821.60	\$621.75	\$821.60	\$621.75	\$1,232.61	\$951.93
72	\$418.91	\$320.52	\$837.40	\$637.00	\$837.40	\$637.00	\$1,256.31	\$974.52

(continued)



Retiree Health Plan

% of Company Subsidy Earned	Member Only Per Month		Member+Spouse/DP Per Month		Member+Child(ren) Per Month		Member+Family Per Month	
	Classic	Saver HSA	Classic	Saver HSA	Classic	Saver HSA	Classic	Saver HSA
71	\$426.82	\$328.11	\$853.20	\$652.25	\$853.20	\$652.25	\$1,280.02	\$997.11
70	\$434.72	\$335.70	\$869.00	\$667.50	\$869.00	\$667.50	\$1,303.72	\$1,019.70
69	\$442.62	\$343.29	\$884.80	\$682.75	\$884.80	\$682.75	\$1,327.42	\$1,042.29
68	\$450.53	\$350.88	\$900.60	\$698.00	\$900.60	\$698.00	\$1,351.13	\$1,064.88
67	\$458.43	\$358.47	\$916.40	\$713.25	\$916.40	\$713.25	\$1,374.83	\$1,087.47
66	\$466.34	\$366.06	\$932.20	\$728.50	\$932.20	\$728.50	\$1,398.54	\$1,110.06
65	\$474.24	\$373.65	\$948.00	\$743.75	\$948.00	\$743.75	\$1,422.24	\$1,132.65
64	\$482.14	\$381.24	\$963.80	\$759.00	\$963.80	\$759.00	\$1,445.94	\$1,155.24
63	\$490.05	\$388.83	\$979.60	\$774.25	\$979.60	\$774.25	\$1,469.65	\$1,177.83
62	\$497.95	\$396.42	\$995.40	\$789.50	\$995.40	\$789.50	\$1,493.35	\$1,200.42
61	\$505.86	\$404.01	\$1,011.20	\$804.75	\$1,011.20	\$804.75	\$1,517.06	\$1,223.01
60	\$513.76	\$411.60	\$1,027.00	\$820.00	\$1,027.00	\$820.00	\$1,540.76	\$1,245.60
59	\$521.66	\$419.19	\$1,042.80	\$835.25	\$1,042.80	\$835.25	\$1,564.46	\$1,268.19
58	\$529.57	\$426.78	\$1,058.60	\$850.50	\$1,058.60	\$850.50	\$1,588.17	\$1,290.78
57	\$537.47	\$434.37	\$1,074.40	\$865.75	\$1,074.40	\$865.75	\$1,611.87	\$1,313.37
56	\$545.38	\$441.96	\$1,090.20	\$881.00	\$1,090.20	\$881.00	\$1,635.58	\$1,335.96
55	\$553.28	\$449.55	\$1,106.00	\$896.25	\$1,106.00	\$896.25	\$1,659.28	\$1,358.55
54	\$561.18	\$457.14	\$1,121.80	\$911.50	\$1,121.80	\$911.50	\$1,682.98	\$1,381.14
53	\$569.09	\$464.73	\$1,137.60	\$926.75	\$1,137.60	\$926.75	\$1,706.69	\$1,403.73
52	\$576.99	\$472.32	\$1,153.40	\$942.00	\$1,153.40	\$942.00	\$1,730.39	\$1,426.32
51	\$584.90	\$479.91	\$1,169.20	\$957.25	\$1,169.20	\$957.25	\$1,754.10	\$1,448.91
50	\$592.80	\$487.50	\$1,185.00	\$972.50	\$1,185.00	\$972.50	\$1,777.80	\$1,471.50
49	\$600.70	\$495.09	\$1,200.80	\$987.75	\$1,200.80	\$987.75	\$1,801.50	\$1,494.09
48	\$608.61	\$502.68	\$1,216.60	\$1,003.00	\$1,216.60	\$1,003.00	\$1,825.21	\$1,516.68
47	\$616.51	\$510.27	\$1,232.40	\$1,018.25	\$1,232.40	\$1,018.25	\$1,848.91	\$1,539.27
46	\$624.42	\$517.86	\$1,248.20	\$1,033.50	\$1,248.20	\$1,033.50	\$1,872.62	\$1,561.86
45	\$632.32	\$525.45	\$1,264.00	\$1,048.75	\$1,264.00	\$1,048.75	\$1,896.32	\$1,584.45
44	\$640.22	\$533.04	\$1,279.80	\$1,064.00	\$1,279.80	\$1,064.00	\$1,920.02	\$1,607.04
43	\$648.13	\$540.63	\$1,295.60	\$1,079.25	\$1,295.60	\$1,079.25	\$1,943.73	\$1,629.63
42	\$656.03	\$548.22	\$1,311.40	\$1,094.50	\$1,311.40	\$1,094.50	\$1,967.43	\$1,652.22
41	\$663.94	\$555.81	\$1,327.20	\$1,109.75	\$1,327.20	\$1,109.75	\$1,991.14	\$1,674.81
40	\$671.84	\$563.40	\$1,343.00	\$1,125.00	\$1,343.00	\$1,125.00	\$2,014.84	\$1,697.40



Retiree Health Plan

% of Company Subsidy Earned	Member Only Per Month		Member+Spouse/DP Per Month		Member+Child(ren) Per Month		Member+Family Per Month	
	Kaiser SoCal	Kaiser NoCal	Kaiser SoCal	Kaiser NoCal	Kaiser SoCal	Kaiser NoCal	Kaiser SoCal	Kaiser NoCal
Total Cost->	\$1,011.21	\$1,175.13	\$2,325.77	\$2,702.81	\$2,022.41	\$2,350.27	\$3,134.74	\$3,642.91
Comp. Cost->	\$790.40	\$790.40	\$1,580.00	\$1,580.00	\$1,580.00	\$1,580.00	\$2,370.40	\$2,370.40
100	\$220.81	\$384.73	\$745.77	\$1,122.81	\$442.41	\$770.27	\$764.34	\$1,272.51
99	\$228.71	\$392.63	\$761.57	\$1,138.61	\$458.21	\$786.07	\$788.04	\$1,296.21
98	\$236.62	\$400.54	\$777.37	\$1,154.41	\$474.01	\$801.87	\$811.75	\$1,319.92
97	\$244.52	\$408.44	\$793.17	\$1,170.21	\$489.81	\$817.67	\$835.45	\$1,343.62
96	\$252.43	\$416.35	\$808.97	\$1,186.01	\$505.61	\$833.47	\$859.16	\$1,367.33
95	\$260.33	\$424.25	\$824.77	\$1,201.81	\$521.41	\$849.27	\$882.86	\$1,391.03
94	\$268.23	\$432.15	\$840.57	\$1,217.61	\$537.21	\$865.07	\$906.56	\$1,414.73
93	\$276.14	\$440.06	\$856.37	\$1,233.41	\$553.01	\$880.87	\$930.27	\$1,438.44
92	\$284.04	\$447.96	\$872.17	\$1,249.21	\$568.81	\$896.67	\$953.97	\$1,462.14
91	\$291.95	\$455.87	\$887.97	\$1,265.01	\$584.61	\$912.47	\$977.68	\$1,485.85
90	\$299.85	\$463.77	\$903.77	\$1,280.81	\$600.41	\$928.27	\$1,001.38	\$1,509.55
89	\$307.75	\$471.67	\$919.57	\$1,296.61	\$616.21	\$944.07	\$1,025.08	\$1,533.25
88	\$315.66	\$479.58	\$935.37	\$1,312.41	\$632.01	\$959.87	\$1,048.79	\$1,556.96
87	\$323.56	\$487.48	\$951.17	\$1,328.21	\$647.81	\$975.67	\$1,072.49	\$1,580.66
86	\$331.47	\$495.39	\$966.97	\$1,344.01	\$663.61	\$991.47	\$1,096.20	\$1,604.37
85	\$339.37	\$503.29	\$982.77	\$1,359.81	\$679.41	\$1,007.27	\$1,119.90	\$1,628.07
84	\$347.27	\$511.19	\$998.57	\$1,375.61	\$695.21	\$1,023.07	\$1,143.60	\$1,651.77
83	\$355.18	\$519.10	\$1,014.37	\$1,391.41	\$711.01	\$1,038.87	\$1,167.31	\$1,675.48
82	\$363.08	\$527.00	\$1,030.17	\$1,407.21	\$726.81	\$1,054.67	\$1,191.01	\$1,699.18
81	\$370.99	\$534.91	\$1,045.97	\$1,423.01	\$742.61	\$1,070.47	\$1,214.72	\$1,722.89
80	\$378.89	\$542.81	\$1,061.77	\$1,438.81	\$758.41	\$1,086.27	\$1,238.42	\$1,746.59
79	\$386.79	\$550.71	\$1,077.57	\$1,454.61	\$774.21	\$1,102.07	\$1,262.12	\$1,770.29
78	\$394.70	\$558.62	\$1,093.37	\$1,470.41	\$790.01	\$1,117.87	\$1,285.83	\$1,794.00
77	\$402.60	\$566.52	\$1,109.17	\$1,486.21	\$805.81	\$1,133.67	\$1,309.53	\$1,817.70
76	\$410.51	\$574.43	\$1,124.97	\$1,502.01	\$821.61	\$1,149.47	\$1,333.24	\$1,841.41
75	\$418.41	\$582.33	\$1,140.77	\$1,517.81	\$837.41	\$1,165.27	\$1,356.94	\$1,865.11
74	\$426.31	\$590.23	\$1,156.57	\$1,533.61	\$853.21	\$1,181.07	\$1,380.64	\$1,888.81
73	\$434.22	\$598.14	\$1,172.37	\$1,549.41	\$869.01	\$1,196.87	\$1,404.35	\$1,912.52
72	\$442.12	\$606.04	\$1,188.17	\$1,565.21	\$884.81	\$1,212.67	\$1,428.05	\$1,936.22
71	\$450.03	\$613.95	\$1,203.97	\$1,581.01	\$900.61	\$1,228.47	\$1,451.76	\$1,959.93
70	\$457.93	\$621.85	\$1,219.77	\$1,596.81	\$916.41	\$1,244.27	\$1,475.46	\$1,983.63



Retiree Health Plan

% of Company Subsidy Earned	Member Only Per Month		Member+Spouse/DP Per Month		Member+Child(ren) Per Month		Member+Family Per Month	
	Kaiser SoCal	Kaiser NoCal	Kaiser SoCal	Kaiser NoCal	Kaiser SoCal	Kaiser NoCal	Kaiser SoCal	Kaiser NoCal
69	\$465.83	\$629.75	\$1,235.57	\$1,612.61	\$932.21	\$1,260.07	\$1,499.16	\$2,007.33
68	\$473.74	\$637.66	\$1,251.37	\$1,628.41	\$948.01	\$1,275.87	\$1,522.87	\$2,031.04
67	\$481.64	\$645.56	\$1,267.17	\$1,644.21	\$963.81	\$1,291.67	\$1,546.57	\$2,054.74
66	\$489.55	\$653.47	\$1,282.97	\$1,660.01	\$979.61	\$1,307.47	\$1,570.28	\$2,078.45
65	\$497.45	\$661.37	\$1,298.77	\$1,675.81	\$995.41	\$1,323.27	\$1,593.98	\$2,102.15
64	\$505.35	\$669.27	\$1,314.57	\$1,691.61	\$1,011.21	\$1,339.07	\$1,617.68	\$2,125.85
63	\$513.26	\$677.18	\$1,330.37	\$1,707.41	\$1,027.01	\$1,354.87	\$1,641.39	\$2,149.56
62	\$521.16	\$685.08	\$1,346.17	\$1,723.21	\$1,042.81	\$1,370.67	\$1,665.09	\$2,173.26
61	\$529.07	\$692.99	\$1,361.97	\$1,739.01	\$1,058.61	\$1,386.47	\$1,688.80	\$2,196.97
60	\$536.97	\$700.89	\$1,377.77	\$1,754.81	\$1,074.41	\$1,402.27	\$1,712.50	\$2,220.67
59	\$544.87	\$708.79	\$1,393.57	\$1,770.61	\$1,090.21	\$1,418.07	\$1,736.20	\$2,244.37
58	\$552.78	\$716.70	\$1,409.37	\$1,786.41	\$1,106.01	\$1,433.87	\$1,759.91	\$2,268.08
57	\$560.68	\$724.60	\$1,425.17	\$1,802.21	\$1,121.81	\$1,449.67	\$1,783.61	\$2,291.78
56	\$568.59	\$732.51	\$1,440.97	\$1,818.01	\$1,137.61	\$1,465.47	\$1,807.32	\$2,315.49
55	\$576.49	\$740.41	\$1,456.77	\$1,833.81	\$1,153.41	\$1,481.27	\$1,831.02	\$2,339.19
54	\$584.39	\$748.31	\$1,472.57	\$1,849.61	\$1,169.21	\$1,497.07	\$1,854.72	\$2,362.89
53	\$592.30	\$756.22	\$1,488.37	\$1,865.41	\$1,185.01	\$1,512.87	\$1,878.43	\$2,386.60
52	\$600.20	\$764.12	\$1,504.17	\$1,881.21	\$1,200.81	\$1,528.67	\$1,902.13	\$2,410.30
51	\$608.11	\$772.03	\$1,519.97	\$1,897.01	\$1,216.61	\$1,544.47	\$1,925.84	\$2,434.01
50	\$616.01	\$779.93	\$1,535.77	\$1,912.81	\$1,232.41	\$1,560.27	\$1,949.54	\$2,457.71
49	\$623.91	\$787.83	\$1,551.57	\$1,928.61	\$1,248.21	\$1,576.07	\$1,973.24	\$2,481.41
48	\$631.82	\$795.74	\$1,567.37	\$1,944.41	\$1,264.01	\$1,591.87	\$1,996.95	\$2,505.12
47	\$639.72	\$803.64	\$1,583.17	\$1,960.21	\$1,279.81	\$1,607.67	\$2,020.65	\$2,528.82
46	\$647.63	\$811.55	\$1,598.97	\$1,976.01	\$1,295.61	\$1,623.47	\$2,044.36	\$2,552.53
45	\$655.53	\$819.45	\$1,614.77	\$1,991.81	\$1,311.41	\$1,639.27	\$2,068.06	\$2,576.23
44	\$663.43	\$827.35	\$1,630.57	\$2,007.61	\$1,327.21	\$1,655.07	\$2,091.76	\$2,599.93
43	\$671.34	\$835.26	\$1,646.37	\$2,023.41	\$1,343.01	\$1,670.87	\$2,115.47	\$2,623.64
42	\$679.24	\$843.16	\$1,662.17	\$2,039.21	\$1,358.81	\$1,686.67	\$2,139.17	\$2,647.34
41	\$687.15	\$851.07	\$1,677.97	\$2,055.01	\$1,374.61	\$1,702.47	\$2,162.88	\$2,671.05
40	\$695.05	\$858.97	\$1,693.77	\$2,070.81	\$1,390.41	\$1,718.27	\$2,186.58	\$2,694.75



Appendix D

Classic and Saver HSA Option Comparison

(Refer to Appendices G and H for Kaiser HMO Provisions.)

	Classic		Saver HSA	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Retiree Health Plan <i>(includes Medical, Surgical, Managed Mental Health and Substance Abuse)</i>				
Individual Deductible	\$600	\$1,200	\$1,500 ¹¹	\$3,000 ¹¹
Family Deductible	\$1,200	\$2,400	\$3,000 ¹²	\$6,000 ¹²
Coinsurance	You pay 20% after deductible is met	You pay 40% after deductible is met	You pay 20% after deductible is met	You pay 40% after deductible is met
Individual Out-of-Pocket Maximum Cost	\$3,500	\$7,000	\$5,000	\$10,000
Family Out-of-Pocket Maximum Cost	\$7,000	\$14,000	\$10,000 ¹³	\$20,000
Preventive Services	Plan covers at 100% (no deductible)	You pay 40% after deductible is met, plus any amount over Maximum Allowed Amount	Plan covers at 100% (no deductible)	You pay 40% after deductible is met, plus any amount over Maximum Allowed Amount
Emergency Room (ER) Copay (if <u>not</u> admitted to hospital)	You are responsible for the first \$200 of ER charge for each ER visit, then deductible, then 20% coinsurance (the \$200 copay does not count toward other deductibles)	You are responsible for the first \$200 of ER charge for each ER visit, then deductible, then 20% coinsurance (the \$200 copay does not count toward other deductibles)	You are responsible for the deductible; after deductible is met, you are responsible for 20% coinsurance <i>after</i> a \$200 copay for each ER visit (the \$200 copay does not count toward the deductible)	You are responsible for the deductible; after deductible is met, you are responsible for 20% coinsurance <i>after</i> a \$200 copay for each ER visit (the \$200 copay does not count toward the deductible)

¹¹ Applies only to the Retiree Only coverage tier.

¹² Applies to Retiree+Spouse, Retiree+Children and Family coverage tiers.

¹³ Once one covered family member has reached the individual out-of-pocket maximum, the plan will pay 100% of covered services for that individual. This is known as an embedded out-of-pocket maximum. See Article II, "Helpful Terms," of this document for more information on the out-of-pocket maximum and how it works under both Options.

Retiree Health Plan



Prescription Drugs (Rx)				
	Classic		Saver HSA	
	Retail (30-day supply) ¹⁴	Mail Order or Smart90 Walgreens (90-day supply)	Retail (30-day supply) ¹⁴	Mail Order or Smart90 Walgreens (90-day supply)
Annual Out-of-Pocket Rx Maximum	Combined with medical			
Annual Rx Deductible	\$100 individual/\$200 family (retail and mail order combined)		Combined with medical	
Benefit Level				
– Generic	You pay \$10 after deductible	You pay \$25 after deductible	You pay 20% after deductible (for certain generic preventive drugs, the deductible does not apply ¹⁵)	You pay 20% after deductible (for certain generic preventive drugs, the deductible does not apply ¹⁵)
– Formulary Brand	You pay \$30 after deductible	You pay \$75 after deductible	You pay 20% after deductible	You pay 20% after deductible
– Non-Formulary Brand	You pay \$60 after deductible	You pay \$150 after deductible	You pay 20% after deductible	You pay 20% after deductible

¹⁴ You pay 100% of cost at third and later fills of maintenance drugs.

¹⁵ There are certain prescription drugs that the IRS calls “preventive” because they prevent or treat catastrophic conditions, such as high blood pressure, high cholesterol and asthma. This list is different from the drugs covered at 100% under the provisions of the Patient Protection and Affordable Care Act (PPACA).

Note: If actual cost at retail or actual gross cost at mail order is less than minimum copay, you pay the lesser cost.



Appendix E

Pre-Certification List (2023 Standard Pre-Certification List)

The pre-certification list is subject to change and may be modified from time to time. To ensure coverage, the following services and procedures must be pre-certified by Anthem's review unit for medical necessity. To ensure compliance with the most up-to-date listing, it is best to contact the Anthem pre-certification review unit at 1-866-776-4793 prior to inpatient admissions, outpatient surgeries and other similar services as those listed below.

Inpatient Admission:

- Acute Inpatient
- Acute Rehabilitation
- LTACH (Long Term Acute Care Hospital)
- Skilled Nursing Facility
- OB delivery stays beyond the Federal Mandate minimum LOS (including newborn stays beyond the mother's stay)
- Emergency Admissions (Requires Plan notification no later than 2 business days after admission)

Diagnostic Testing:

- BRCA Genetic Testing
- Chromosomal Microarray Analysis (CMA) for Developmental Delay, Autism Spectrum Disorder, Intellectual Disability and Congenital Anomalies
- Gene Expression Profiling for Managing Breast Cancer Treatment
- Gene Mutation Testing for Cancer Susceptibility and Management
- Genetic Testing for Heritable Cardiac Conditions
- Genetic Testing for Inherited Diseases
- Genetic Testing for Lynch Syndrome, Familial Adenomatous Polyposis (FAP) Attenuated FAP and MYH-Associated Polyposis
- Preimplantation Genetic Diagnosis Testing
- Prostate Saturation Biopsy
- RET Proto-oncogene Testing for Endocrine Gland Cancer Susceptibility
- Wireless Capsule for the Evaluation of Suspected Gastric and Intestinal Motility Disorders



Durable Medical Equipment (DME)/Prosthetics:

- Augmentative and Alternative Communication (AAC) Devices with Digitized or Synthesized Speech Output
- Compression Devices for Lymphedema
- Functional Electrical Stimulation (FES); Threshold Electrical Stimulation (TES)
- Implantable Infusion Pumps
- Intrapulmonary Percussive Ventilation Device
- Microprocessor Controlled Lower Limb Prosthesis
- Myoelectric Upper Extremity Prosthetic Devices
- Noninvasive Electrical Bone Growth Stimulation of the Appendicular Skeleton
- Standing Frames
- Ultrasound Bone Growth Stimulation
- Wheeled Mobility Devices: Wheelchairs-Powered, Motorized, With or Without Power Seating Systems and Power Operated Vehicles (POVs)

Gender Affirming Surgery

Human Organ and Bone Marrow/Stem Cell Transplants:

- Inpatient admits for ALL solid organ and bone marrow/stem cell transplants (Including Kidney only transplants)
- Outpatient: All procedures considered to be transplant or transplant related *including but not limited to:*
 - Donor Leukocyte Infusion
 - Intrathecal treatment of Spinal Muscular Atrophy (SMA)
 - Stem Cell/Bone Marrow transplant (with or without myeloablative therapy)
 - (CAR) T-cell immunotherapy treatment *including but not limited to:*
 - Axicabtagene ciloleucel (Yescarta™)
 - Tisagenlecleucel (Kymriah™)
 - Brexucabtagene Autoleucel (Tecartus)
 - lisocabtagene maraleucel (Breyanzi)
 - Idecabtagene vicleucel (Abecma)
 - Gene Replacement Therapy. *Including but not limited to:*
 - Gene Therapy for Ocular Conditions/Voretigene neparvovec-rzyl (Luxturna™)
 - Gene Therapy for Spinal Muscular Atrophy/onasemnogene abeparvovec-xioi (Zolgensma®)

Retiree Health Plan



Mental Health/Substance Abuse (MHSA):

- Acute Inpatient Admissions
- Transcranial Magnetic Stimulation (TMS)
- Residential Care
- Behavioral Health in-home Programs
- Applied Behavioral Analysis (ABA)¹⁶
- Intensive Outpatient Therapy (IOP)¹⁶
- Partial Hospitalization (PHP)¹⁶

¹⁶ ***Check benefits for any exclusions, or specific precertification requirements.***

Other Outpatient and Surgical Services:

- Aduhelm (aducanumab)
- Air Ambulance (excludes 911 initiated emergency transport)
- Ablative Techniques as a Treatment for Barrett's Esophagus
- Allogeneic, Xenographic, Synthetic, Bioengineered, and Composite Products for Wound Healing and Soft Tissue Grafting
 - Insertion/injection of prosthetic material collagen implants
- Axial Lumbar Interbody Fusion
- Balloon Sinus Ostial Dilation
- Bariatric Surgery and Other Treatments for Clinically Severe Obesity
- Blepharoplasty, Blepharoptosis Repair, and Brow Lift
- Bone-Anchored and Bone Conduction Hearing Aids
- Breast Procedures; including Reconstructive Surgery, Implants and other Breast Procedures
- Bronchial Thermoplasty
- Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure
- Carotid, Vertebral and Intracranial Artery Stent Placement with or without Angioplasty
- Cardioverter Defibrillators
- Cervical and Thoracic Discography
- Cochlear Implants and Auditory Brainstem Implants
- Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedures of the Appendicular System
- Corneal Collagen Cross-Linking

Retiree Health Plan



- Cosmetic and Reconstructive Services: Skin Related, *including but not limited to:*
 - Brachioplasty
 - Chin Implant, Mentoplasty, Osteoplasty Mandible
 - Procedures Performed on the Face, Jaw or Neck (including facial dermabrasion, scar revision)
- Cosmetic and Reconstructive Services of the Head and Neck, *including but not limited to:*
 - Facial Plastic Surgery Otoplasty - Rhinophyma
 - Rhinoplasty or Rhinoseptoplasty (procedure which combines both rhinoplasty and septoplasty)
 - Rhytidectomy (Face lift)
 - Cranial Nerve Procedures
 - Ear or Body Piercing
 - Frown Lines
 - Neck Tuck (Submental Lipectomy)
- Cosmetic and Reconstructive Services of the Trunk and Groin, *including but not limited to:*
 - Brachioplasty
 - Buttock/Thigh Lift
 - Congenital Abnormalities
 - Lipectomy/Liposuction
 - Repair of Pectus Excavatum/Carinatum
 - Procedures on the Genitalia
- Cryosurgical Ablation of Solid Tumors Outside the Liver
- Deep Brain, Cortical, and Cerebellar Stimulation
- Diaphragmatic/Phrenic Nerve Stimulation and Diaphragm Pacing Systems
- Doppler-Guided Transanal Hemorrhoidal Dearterialization
- Electric Tumor Treatment Field (TTF)
- Endovascular Techniques (Percutaneous or Open Exposure) for Arterial Revascularization of the Lower Extremities)
- Extraosseous Subtalar Joint Implantation and Subtalar Arthroereisis
- Functional Endoscopic Sinus Surgery (FESS)
- Home Parenteral Nutrition
- Hyperbaric Oxygen Therapy (Systemic/Topical)
- Immunoprophylaxis for respiratory syncytial virus (RSV)/ Synagis (palivizumab)
- Implantable Ambulatory Event Monitors and Mobile Cardiac Telemetry
- Implanted Devices for Spinal Stenosis
- Implanted (Epidural and Subcutaneous) Spinal Cord Stimulators (SCS)
- Implantable Infusion Pumps

Retiree Health Plan



- Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)
- Keratoprosthesis
- Leadless Pacemaker
- Locoregional and Surgical Techniques for Treating Primary and Metastatic Liver Malignancies
- Lower Esophageal Sphincter Augmentation Devices for the Treatment of Gastroesophageal Reflux Disease (GERD)
- Lysis of Epidural Adhesions
- Mandibular/Maxillary (Orthognathic) Surgery
- Manipulation Under Anesthesia of the Spine and Joints other than the Knee and shoulder
- Mastectomy for Gynecomastia
- Mechanical Circulatory Assist Devices (Ventricular Assist Devices, Percutaneous Ventricular Assist Devices and Artificial Hearts)
- Mechanical Embolectomy for Treatment of Acute Stroke
- Meniscal Allograft Transplantation of the Knee
- Nasal Surgery for the Treatment of Obstructive Sleep Apnea and Snoring
- Oral, Pharyngeal and Maxillofacial Surgical Treatment for Obstructive Sleep Apnea or Snoring
- Outpatient Cardiac Hemodynamic Monitoring Using a Wireless Sensor for Heart Failure Management
- Panniculectomy and Abdominoplasty
- Partial Left Ventriculectomy
- Patent Foramen Ovale and Left Atrial Appendage Closure Devices for Stroke Prevention
- Penile Prosthesis Implantation
- Percutaneous and Endoscopic Spinal Surgery
- Percutaneous Neurolysis for Chronic Neck and Back Pain
- Percutaneous Vertebral Disc and Vertebral Endplate Procedures
- Percutaneous Vertebroplasty, Kyphoplasty and Sacroplasty
- Perirectal Spacers for Use During Prostate Radiotherapy (Space Oar)
- Photocoagulation of Macular Drusen
- Presbyopia and Astigmatism-Correcting Intraocular Lenses
- Private Duty Nursing in the Home Setting
- Reduction Mammoplasty
- Sacral Nerve Stimulation (SNS) and Percutaneous Tibial Nerve Stimulation (PTNS) for Urinary and Fecal Incontinence and Urinary Retention
- Sacral Nerve Stimulation as a Treatment of Neurogenic Bladder Secondary to Spinal Cord Injury

Retiree Health Plan



- Sacroiliac Joint Fusion, Open
- Sipuleucel-T (Provenge®) Autologous Cellular Immunotherapy for the Treatment of Prostate Cancer
- Surgical and Ablative Treatments for Chronic Headaches
- Therapeutic Apheresis
- Total Ankle Replacement
- Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins
- Transcatheter Heart Valve Procedures
- Transendoscopic Therapy for Gastroesophageal Reflux Disease, Dysphagia and Gastroparesis
- Transmyocardial/Periventricular Device Closure of Ventricular Septal Defects
- Treatment of Osteochondral Defects
- Treatment of Temporomandibular Disorders
- Treatments for Urinary Incontinence
- Treatment of Varicose Veins (Lower Extremities)
- Vagus Nerve Stimulation
- Vein Embolization as a Treatment for Pelvic Congestion Syndrome and Varicocele
- Venous Angioplasty with or without Stent Placement/ Venous Stenting
- Viscocanalostomy and Canaloplasty
- Wearable Cardioverter-Defibrillator

Out-of-Network Referrals:

- Out of Network Services for consideration of payment at in-network benefit level (may be authorized, based on network availability and/or medical necessity).

Radiation Therapy/Radiology Services:

- Catheter-based Embolization Procedures for Malignant Lesions Outside the Liver
- Cryosurgical or Radiofrequency Ablation to Treat Solid Tumors Outside the Liver
- Intensity Modulated Radiation Therapy (IMRT)
- MRI Guided High Intensity Focused Ultrasound Ablation for Non-Oncologic Indications
- Proton Beam Therapy
- Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiotherapy (SBRT)
- Wireless Capsule Endoscopy for Gastrointestinal Imaging and the Patency Capsule



Appendix F

2023 SaveOnSP Specialty Drug List

This program is applicable to members in the Classic option of the Plan. If member is enrolled in the SaveOnSP Program, member cost for a specialty drug listed below will be as low as \$0. If a member is NOT enrolled in the SaveOnSP program, member will pay a 30% coinsurance based on approved cost, and such coinsurance does not apply to the deductible or out-of-pocket maximum. Refer to Section XIII.C.1 of the Plan.

The drug list is subject to change. The inclusion of eligible drugs within the program is subject to applicable laws or regulations. Once enrolled in the SaveOnSP program, your responsibility will be as low as \$0. Call 1-800-683-1074 to enroll.

A
Abraxane
Actemra
Adakveo
Adbry
Adcetris
Adcirca
Advate
Adynovate
Afinitor
Afstyla
Aldurazyme
Alecensa
AlphaNine
Alprolix
Alunbrig
Amjevita*
Ampyra
Arcalyst
Asceniv
Aubagio
Austedo
Avastin
Avonex
Avsola

B
Bavencio
Benefix
Benlysta
Beovu
Berinert
Blenrep
Bosulif
Braftovi
Brukinsa
C
Cablivi
Cabometyx
Calquence
Camzyos
Carbaglu
Cayston
Cerdelga
Cholbam
Cibinqo
Cimzia
Cinryze
Copaxone
Cosentyx
Crysvita

Cuvitru
Cyramza
Cystadrops
D
Dojolvi
Doptelet
Dupixent
E
Elaprase
Elelyso
Eloctate
Empliciti
Enbrel
Enhertu
Enjaymo
Entyvio
Erbitux
Erivedge
Erleada
Esperoct
Evenity
Evkeeza
Exjade
Exondys 51
Extavia
Eylea

* Drug available upon launch to market.

Retiree Health Plan



F
Fabrazyme
Fasenra
Feiba NF
Ferriprox
Fintepla
Firazyr
Firdapse
Folotyng
Forteo
Fotivda
Fulphila
G
Galafold
Gamifant
Gammagard
Gattex
Gazyva
Gilenya
Gilotrif
Givlaari
Glatiramer Acetate
Glatopa
Gleevec
Gocovri
Granix
H
Haegarda
Hemlibra
Herceptin
Herceptin Hylecta
Herzuma
Humate-P
Humira
Hyqvia

I
Ibrance
Iclusig
Idelvion
Ilumya
Imcivree
Imfinzi
Increlex
Inflectra
Ingrezza
Inlyta
Inqovi
Inrebic
Istodax
Ixempra
J
Jadenu
Jakafi
Jemperli
Jevtana
Jivi
Juxtapid
Jynarque
K
Kadcyla
Kalbitor
Kalydeco
Kanjinti
Kanuma
Kesimpta
Keveyis
Kevzara
Kisqali
Kisqali Femara Co-Pack
Kogenate FS
Koselugo
Kovaltry
Krystexxa
Kuvan
Kyprolis

L
Lenvima
Letairis
Leukine
Libtayo
Livmarli
Lonsurf
Lorbrena
Lucentis
Lumakras
Lumizyme
Lupkynis
Luxturna
Lynparza
M
Makena
Margenza
Mayzent
Mekinist
Mektovi
Mvasi
N
Nerlynx
Neulasta
Neupogen
Nexavar
Nexviazyme
Ninlaro
Nityr
Nivestym
Northera
Novoeight
Novoseven RT
Nplate
Nubeqa
Nucala
Nulibry
Nuplazid
Nuwiq
Nyvepria

Retiree Health Plan



O
Ocaliva
Ocrevus
Ogivri
Olumiant
Ontruzant
Onureg
Opdivo
Opdualag
Orencia
Orenitram
Orfadin
Orgovyx
Orladeyo
Otezla
Oxbryta
Oxervate
Oxlumo
P
Padcev
Palynziq
Pemazyre
Perjeta
Phesgo
Piqray
Plegridy
Polivy
Poteligeo
Procysbi
Promacta
Pulmozyme
Q
Qinlock
R
Radicava
Ravicti
Rebif
Rebinyn

Recombinate
Remicade
Renflexis
Retevmo
Revatio
Revcovi
Riabni
Rinvoq
Rituxan
Rituxan Hycela
Rixubis
Rubraca
Ruxience
Rybrevant
Rydapt
S
Sandostatin Lar Depot
Saphnelo
Sarclisa
Scemblix
Serostim
Signifor
Signifor LAR
Siliq
Skyrizi
Skytrofa
sodium oxybate*
Soliris
Somatuline Depot
Somavert
Spinraza
Sprycel
Stelara
Stivarga
Strensiq
Sublocade
Susvimo
Sutent

T
Tafinlar
Tagrisso
Takhzyro
Taltz
Talzenna
Tasigna
Tavalisse
Tavneos
Tazverik
Tecentriq
Tecfidera
Tegsedi
Tepmetko
Thiola
Tivdak
Tobi
Tracleer
Trazimera
Tremfya
Treprostinil
Tretten
Trikafta
Triptodur
Trodelvy
Truseltiq
Truxima
Tukysa
Tykerb
Tysabri
Tyvaso
U
Udenyca
Ultomiris

* Drug available upon launch to market.

Retiree Health Plan



V
Vabysmo
Valchlor
Vectibix
Venclexta
Verzenio
Viltepso
Vistogard
Vonvendi
Votrient
Voxzogo
Vumerity
Vyleesi
Vyndamax
Vyndaqel
Vyondys 53
Vyxeos
W
Wakix
Welireg
Wilate
X
Xalkori
Xeljanz
Xembify
Xenazine
Xermelo
Xgeva
Xolair
Xospata
Xpovio
Xtandi
Xyntha
Xyrem

Y
Yervoy
Z
Zarxio
Zejula
Zelboraf
Zeposia
Ziextenzo
Zirabev
Zokinvy
Zolgensma
Zynlonta
Zytiga



Appendix G

Kaiser Permanente Northern California HMO Option

Further information regarding Kaiser Permanente Northern California HMO coverage can be found at: <http://mympcbenefits.com/Documents/MPC-2022-Traditional-HMO-EOC-NO-CA-Retiree.pdf>.

A copy of the document located at the above link can be requested free of charge by contacting the Marathon Petroleum Benefits Service Center at 1-888-421-2199, option 1, then option 3, or by email at Benefits@MarathonPetroleum.com.

Questions regarding health care coverage under this option should be directed to Kaiser Customer Service at 1-800-278-3296.



Appendix H

Kaiser Permanente Southern California HMO Option

Further information regarding Kaiser Permanente Southern California HMO coverage can be found at: <http://mympcbenefits.com/Documents/MPC-2022-Traditional-HMO-EOC-SO-CA-Retiree.pdf>.

A copy of the document located at the above link can be requested free of charge by contacting the Marathon Petroleum Benefits Service Center at 1-888-421-2199, option 1, then option 3, or by email at Benefits@MarathonPetroleum.com.

Questions regarding health care coverage under this option should be directed to Kaiser Customer Service at 1-800-278-3296.



Appendix I

Extended Timeframes Due to National Emergency

Due to the COVID-19 pandemic, regulatory guidance was issued to provide relief to employees, members 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, appeal a denied claim, and to file a request for an external review or to submit information to substantiate such request. The third-party administrator of the Plan or the Company's Benefits Service Center will administer extended deadlines as required.

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.