Marathon Petroleum
Pre-65 Retiree Vision Plan

Amended and Restated
January 1, 2021

Pre-65 Retiree Vision Plan

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Pre-65 Retiree Vision Plan

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

I. Purpose

The purpose of the Pre-65 Retiree Vision Plan is to provide routine eye exams and vision wear, including eyeglass frames and eyeglass lenses or contact lenses at reduced and discounted costs for eligible retirees and their eligible spouses and dependents. Anthem Blue View Vision is the Claims Administrator of the Plan.

II. Eligibility

Retirees

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

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

Dependents

Any of your eligible Dependents, as defined later in this section under *Definition of Dependent*, can be covered, provided such dependents were not acquired by you (for example, by marriage, birth or adoption) on or after your date of retirement. If Dependents are covered, you will be charged the Retiree+Spouse, Retiree+Child(ren) or Retiree+Family rate, depending on the number and type of Dependents covered. No one may be considered as a Dependent of more than one Retiree.

Coverage for your eligible Dependent(s) begins:

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

Coverage for any Dependent ceases at the earliest of:

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

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

Definition of Dependent

Dependents are:

- Your under age 65 spouse. The term "spouse" means a lawful spouse and will be interpreted to refer to any individuals who are lawfully married, including a same-sex spouse. "Spouse" also includes a common law spouse established under the laws of a state in which common law marriage is legal and for which the Member can provide confirmation of such common law marriage as required in the Marathon Petroleum Certification of Common Law Spouse Relationship form;
- Your under age 65 Domestic Partner if covered as your Domestic Partner under the active Vision Plan immediately prior to your retirement. The term Domestic Partner means a person for whom a Retiree has certified meets the requirements established in the *Marathon Petroleum Certification of Domestic Partnership Relationship* form; and
- Your children, up through the end of the month in which they turn age 26, are eligible dependents under the Plan. Children include your:

  a. Natural children of the first degree;

  b. Legally adopted children, and children placed with you for adoption;

  c. Stepchildren;

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

- Children of Domestic Partner

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

- Dependent Disabled Child

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

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

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

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

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

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

- Children Covered by QMCSOs

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

III. Enrolling in the Plan

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

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

A. Member Enrollment

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

1. Enrollment When First Eligible for Coverage

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

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

2. Late Enrollment

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

a. Your loss of eligibility for coverage under another employer's group health plan providing vision coverage or under other health insurance coverage providing vision 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 vision coverage.

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

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

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

3. Annual Enrollment

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

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

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

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

IV. Premiums

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

- Retiree Only $ 7.00
- Retiree + Spouse $12.00
- Retiree + Child(ren) $13.00
- Retiree + Family $20.00

Premiums are based on claim experience and administrative costs of the Plan. Changes in monthly premiums will be provided to Members prior to the start of each calendar year. You will be billed by the retiree billing administrator, BenefitSolver.

V. Coordination with Active Vision Plan

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

VI. Benefit Coverage

A. Coverage Provided through Anthem Blue View Vision PPO

The Anthem Blue View Vision's national network consists of over 50,000 providers and provider locations, including independent optometrists and ophthalmologists, as well as LensCrafters®, Target Optical® and Pearle Vision® locations.

To locate Anthem Blue View Vision provider locations, visit www.anthem.com, select "Find a Doctor" and select "Search as a Guest by Selecting a Plan," then complete the following steps:

1. Under "What type of care are you searching for?": Select **Vision**.
2. Under "What state do you want to search in?": Select the **state** in which you want to search.
3. Under "What type of plan do you want to search with?": Select **Vision**.
4. Under "Select a plan/network": Select **Blue View Vision**.

Members may also call the Anthem Blue View Vision Interactive Voice Response (IVR) line at 1-866-723-0515.

In-network Provider: Maximum benefits are achieved when Members access their benefits from a participating Anthem Blue View Vision provider. When services are received from an In-network Provider, the Provider will submit the claim and receive its payment directly from Anthem Blue View Vision. The In-network Provider, at the time of service, will only charge you only the applicable copayment(s) and other costs not covered under the Plan.

Out-of-network Provider Reimbursement: Members may go to an Out-of-network Provider and pay the provider directly for services and materials. Members may then submit a completed Out-of-network Claim form, original itemized invoice and a copy of the prescription along with the Member's identification number to Anthem Blue View Vision for reimbursement. Claims for covered vision services should be submitted to Anthem Blue View Vision, Attn: Vision Claims, P.O. Box 8504, Mason, OH 45040-7111. Reimbursement forms are available at: http://www.myMPCbenefits.com/forms.aspx.

Covered Benefits

The covered benefits under the Plan are divided into three areas: Vision examination, lenses and frames, and contact lenses. See Appendix A for a summary of Blue View Vision In-network and Out-of-network benefits and discounts.

Vision Examination

Each covered Member is entitled to a vision examination once every calendar year at no cost if the examination is performed by an Anthem Blue View Vision In-network Provider. Reimbursement to the Member for an examination provided by an Out-of-network Provider is up to $35.00.

Lenses

A choice of plastic (CR39) lenses in single vision, bifocal or trifocal (FT 25-28); lenses up to 55 mm, and all ranges of prescriptions. Each covered Member is entitled to a lens choice once every calendar year, with an In-network Provider co-pay of $10.00 and an out-of-network reimbursement from up to $25.00 to $55.00. Special treatments to lenses such as edge polishing or tinting will be provided to the Member at a discount from in-network providers.

Frames

The Plan provides coverage for frames purchased once every two calendar years. For any frame over $130.00, the Member will receive a 20% discount off the balance if purchased through an In-network Provider. If frames are obtained from an Out-of-network Provider, the Member will be reimbursed for cost up to $45.00.

Contact Lenses

Members have a $130.00 plan allowance once every calendar year toward elective contact lenses in lieu of the eyeglass lenses benefit. For conventional contact lenses, the Member will receive a 15% discount off the balance. If the Member chooses contact lenses greater than the plan allowance, the Member is responsible for the difference. If the contact lenses are obtained from an Out-of-network Provider, the Member will be reimbursed for cost up to $105.00.

Non-elective contact lenses that are prescribed for extreme visual acuity that cannot be corrected by spectacle lenses are covered in full when purchased from an In-network Provider or up to $210.00 when purchased from an Out-of-network Provider.

SPECIAL NOTE: The Plan will not reimburse for non-elective contact lenses for any Member who has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

B. Recovery of Excess Benefits (Subrogation Rights)

In the event a service or benefit is provided by Anthem which is not required under this Plan or if it has provided a service or benefit which should have been paid by another plan, that service or benefit shall be considered an excess benefit. Anthem shall have the right to recover to the extent of the excess benefit. If the excess benefit is a service, recovery shall be based upon the Reasonable Cash Value for that service. If the excess benefit is a payment, recovery shall be based upon the actual payment made. Recovery may be sought from among one or more of the following, as Anthem shall determine: any person to, or for, or with respect to whom, such services were provided or such payments were made; any insurance company, health care plan or other organization. This right of recovery shall be Anthem's alone and at its sole discretion. If determined necessary by Anthem, the Member (or his or her legal representative if a minor or legally incompetent), upon request, shall execute and deliver to Anthem such instruments and papers required and so whatever else is necessary to secure Anthem's right hereunder.

C. Coordination of Coverage

Since the Plan has no annual or lifetime maximums, there is no coordination of coverage provisions. There are no pre-existing conditions applied for vision coverage.

D. Exclusions

See Appendix B of this document for exclusions that may apply.

VII. Claim Appeal Procedure

The Claims Administrator's customer service representatives are specially trained to answer your questions about vision benefits. Please call during business hours, Monday through Friday, with questions regarding:

- Your coverage and benefit levels, including reimbursement amounts;
- Specific claims or services you have received.

You will be notified, in writing, if a claim or other request for benefits is denied in whole or in part. If such a request is denied, the notice of denial will explain why benefits were denied and describe your rights under the appeals procedure. A complaint procedure also exists to help you understand the Plan's determinations.

A complaint procedure is available to provide reasonable, informative responses to complaints that you may have concerning the Plan. A complaint is an expression of dissatisfaction that can often be resolved by an explanation from the Plan of its procedures and contracts. The Plan invites you to share any concerns you may have over benefit determinations or coverage cancellations. If you have a complaint or problem concerning benefits or services, please contact the Claims Administrator. You may submit your complaint by letter or by telephone call. Or, if you wish, you may meet with your local service representative to discuss your complaint.

Members are encouraged to file complaints within 60 days of an initial, adverse action, but must file within 180 days after receipt of notice of the initial, adverse action. The time required to review complaints does not extend the time in which appeals must be filed.

A. Formal Claims Appeals Procedure

An appeal is a formal request from you for the Plan to change a previous determination. If you are notified in writing of a coverage denial or any other adverse decision by the Claims Administrator, you will be advised of your right to an internal appeal.

A coverage denial means the Claims Administrator's determination that a service, treatment, drug or device is specifically limited or excluded under this Plan.

The internal appeals process may be initiated by the Member, the Member's authorized representative, or a provider acting on behalf of the Member within 60 days of receipt of the Plan's written notice of a coverage denial, or any other adverse decision made by the Claims Administrator, but must be filed within 180 days of your receipt of the initial decision. The request should include any medical information pertinent to the appeal. All portions of the medical records that are relevant to the appeal and any other comments, documents, records or other information submitted by the Member relating to the issue being appealed, regardless of whether such information was considered in making the initial decision, will be considered in the review of the appeal. Any new medical information pertinent to the appeal will also be considered. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, documents, records, and other information relevant to the Member's appeal.

If a representative is seeking an appeal on behalf of a Member, the Claims Administrator must receive a signed Appointment of Authorized Representative form from the Member. The appeal process will not begin until the Claims Administrator has received a properly completed authorization. Upon request, the Plan will provide the appropriate authorization form to the Member for completion.

The individuals responsible for reviewing your request for an internal appeal will not be the same individuals who made the initial denial or determination. They will not be the subordinates of the initial decision-maker and no deference will be given to the initial decision.

Within a reasonable period of time but no later than 30 days after receiving a written or an oral request for an appeal, the Claims Administrator will send a written decision to the Member or their authorized representative.

The request for an internal appeal must be submitted to the following address or telephone number or to the appeal address or telephone number provided on your written notice of an adverse decision:

Blue View Vision
ATTN: Appeals
555 Middle Creek Parkway
Colorado Springs, CO 80921
Telephone Number: 1-866-723-0515

The Plan encourages Members to submit requests for appeal in writing. The request for appeal should describe the problem in detail. Attach copies of bills, medical records, or other appropriate documentation that may be in your possession to support the appeal.

You must file appeals on a timely basis. As stated above, you are encouraged to file internal appeals within 60 days of your receipt of the Plan's initial decision. Internal appeals must be filed, however, within 180 days of your receipt of the initial decision.

B. Finality of Decision and Legal Action

A claimant must follow and fully exhaust the applicable claims and appeals procedures described in this Plan before taking action in any other forum regarding a claim for benefits under the Plan. Any suit or legal action initiated by a claimant under the Plan must be brought by the claimant no later than one year following a final decision on the claim for benefits under these claims and appeals procedures. The one-year statute of limitation 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.

C. Appointment of Authorized Representative

An authorized representative may act on behalf of a claimant with respect to a benefit claim or appeal under the Plan's claim and appeal procedures. No person will be recognized as an authorized representative until the Plan receives an Appointment of Authorized Representative form signed by the claimant, except that for urgent care claims the Plan shall, even in the absence of a signed Appointment of Authorized Representative form, recognize a health care professional with knowledge of the claimant's medical condition (e.g., the treating physician) as the claimant's authorized representative unless the claimant provides specific written direction otherwise.

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

A representative who is appointed by a court or who is acting pursuant to a document recognized under applicable state law as granting the representative such authority to act, can act as a claimant's authorized representative without the need to complete the form, provided the Plan is provided with the legal documentation granting such authority.

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

VIII. Non-Assignability

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

IX. Termination of Coverage

Coverage will cease as described below:

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

X. Group Plan Coverage Instead of Medicaid

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

XI. Rescission and Cancellation of Coverage

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

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

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

XII. COBRA Continuation Rights Under Federal Law

What is COBRA Continuation Coverage?

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

When is COBRA Continuation Available?

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

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

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

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

Who is Entitled to COBRA Continuation?

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

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

Termination of COBRA Continuation

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

- The end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
- Failure to pay the required premium within 30 calendar days after the due date;

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

How to Elect COBRA Continuation Coverage

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

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

How Much Does COBRA Continuation Coverage Cost?

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

When and How to Pay COBRA Premiums

First Payment for COBRA Continuation

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

Subsequent Payments

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

Grace Periods for Subsequent Payments

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

You Must Give Notice of Certain Qualifying Events

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

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

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

COBRA Continuation for Retirees Following Employer's Bankruptcy

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

XIII. Use and Disclosure of Protected Health Information

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

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

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

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

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

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

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

XIV. Further Information

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

The Company has appointed David R. Sauber as Plan Administrator of the Marathon Petroleum Pre-65 Retiree Vision Plan. The Company shall appoint assistant administrators as may be deemed necessary. The Plan Administrator shall be the named fiduciary under the Plan.

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

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

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

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

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

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

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

Employer Identification Number (EIN): 31-1537655

Plan Number: 563

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

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

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

The plan is a self-funded welfare benefit plan providing vision assistance coverage and is administered through an administrative services only contract with Anthem Blue View Vision.

XV. Statement of Rights

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

Receive Information About Your Plan and Benefits

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare 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 report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

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

Assistance With Your Questions

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

XVI. Plan Modification, Amendment and Termination

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

XVII. Participation by Associated Companies and Organizations

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

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

Appendix A

Summary of Vision Benefits

Your Blue View Vision Plan Benefits	In-Network	Out-of-Network	Frequency
Routine Eye Exam			
A comprehensive eye examination	$0 copay	Up to $35 allowance	Once every calendar year
Eyeglass Frames			
One pair of eyeglass frames	$130 allowance, then 20% off any remaining balance	Up to $45 allowance	Once every two calendar years
Eyeglass Lenses *(instead of contact lenses)*			
One pair of standard plastic prescription lenses:			
• **Single vision lenses**	$10 copay	Up to $25 allowance	Once every calendar year
• **Bifocal lenses**	$10 copay	Up to $40 allowance	
• **Trifocal lenses**	$10 copay	Up to $55 allowance	
Eyeglass Lens Enhancements *When obtaining covered eyewear from a Blue View Vision provider, you may choose to add any of the following lens enhancements at no extra cost.*			
• Transitions **Lenses (for a child under age 19)**	$0 copay	No allowance when obtained out-of-network	Same as covered eyeglass lenses
• **Standard polycarbonate (for a child under age 19)**	$0 copay		
• **Factory scratch coating**	$0 copay		
Contact Lenses *(instead of eyeglass lenses)* *Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.*			
• **Elective conventional (non-disposable)**	$130 allowance, then 15% off any remaining balance	Up to $105 allowance	Once every calendar year
OR			
• **Elective disposable**	$130 allowance *(no additional discount)*	Up to $105 allowance	
OR			
• **Non-elective (medically necessary)**	Covered in full	Up to $210 allowance	

This is a primary vision care benefit intended to cover only routine eye examinations and corrective eyewear. Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care doctor from your medical network. Benefits are payable only for expenses incurred while the group and insured person's coverage is in force. This summary is intended to be a brief outline of coverage. All terms and conditions of coverage, including benefits and exclusions, are contained in the member's Plan, which shall control in the event of a conflict with this overview. This benefit overview is only one piece of your entire enrollment package.

EXCLUSIONS & LIMITATIONS (not a comprehensive list)

Combined Offers: Not to be combined with any offer, coupon, or in-store advertisement.

Excess Amounts: Amounts in excess of covered vision expense.

Sunglasses: Plano sunglasses and accompanying frames.

Safety Glasses: Safety glasses and accompanying frames.

Not Specifically Listed: Services not specifically listed in this plan as covered services.

Lost or Broken Lenses or Frames: Any lost or broken lenses or frames are not eligible for replacement unless the insured person has reached his or her normal service interval as indicated in the plan design.

Non-Prescription Lenses: Any non-prescription lenses, eyeglasses or contacts. Plano lenses or lenses that have no refractive power.

Orthoptics: Orthoptics or vision training and any associated supplemental testing.

(continued)

Pre-65 Retiree Vision Plan

Optional Savings Available From Blue View Vision In-Network Providers Only		In-Network Member Cost (after any applicable copay)
Retinal Imaging — At member's option can be performed at time of eye exam		Not more than $39
Eyeglass Lens Upgrades When obtaining eyewear from a Blue View Vision provider, you may choose to upgrade your new eyeglass lenses at a discounted cost. Eyeglass lens copayment applies.	• Transitions® lenses (Adults)	$75
	• Standard Polycarbonate (Adults)	$40
	• Tint (Solid and Gradient)	$15
	• UV Coating	$15
	• Progressive Lenses[1]	
	– Standard	$65
	– Premium Tier 1	$85
	– Premium Tier 2	$95
	– Premium Tier 3	$110
	• Anti-Reflective Coating[2]	
	– Standard	$45
	– Premium Tier 1	$57
	– Premium Tier 2	$68
	• Other Add-ons	20% off retail price
Additional Pairs of Eyeglasses Anytime from any Blue View Vision network provider.	• Complete pair	40% off retail price
	• Eyeglass materials purchased separately	20% off retail price
Eyewear Accessories	• Items such as non-prescription sunglasses, lens cleaning supplies, contact lens solutions, eyeglass cases, etc.	20% off retail price
Contact Lens Fit and Follow-Up A contact lens fitting and up to two follow-up visits are available to you once a comprehensive eye exam has been completed.	• Standard contact lens fitting[3]	Up to $55
	• Premium contact lens fitting[4]	10% off retail price
Conventional Contact Lenses	• Discount applies to materials only	15% off retail price

[1] Please ask your provider for his/her recommendation as well as the available progressive brands by tier.

[2] Please ask your provider for his/her recommendation as well as the available coating brands by tier.

[3] Standard fitting includes spherical clear lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.

[4] Premium fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal. Discounts are subject to change without notice. Discounts are not "covered benefits" under your vision plan and will not be listed in your plan. Discounts will be offered from in-network providers except where state law prevents discounting of products and services that are not covered benefits under the plan. Discounts on frames will not apply if the manufacturer has imposed a no discount policy on sales at retail and independent provider locations.

Appendix B

Exclusions

The following section indicates items that are excluded from benefit consideration and are not considered Covered Services. This information is provided as an aid to identify certain common items that may be misconstrued as Covered Services, but is in no way a limitation upon, or a complete listing of, such items considered not to be Covered Services. We are the final authority for determining if services or supplies are Covered Services. We do not provide vision benefits for services, supplies or charges:

1. Received from an individual or entity that is not a Provider, as defined in this Certificate.
2. For any condition, disease, defect, aliment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.
3. To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
4. For illness or injury that occurs as a result of any act of war, declared or undeclared.
5. For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.
6. For which you have no legal obligation to pay in the absence of this or like coverage.
7. Received from an optical or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
8. Prescribed, ordered, referred by, or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
9. For completion of claim forms or charges for medical records or reports unless otherwise required by law.
10. For missed or canceled appointments.
11. In excess of Maximum Allowable Amount.
12. Incurred prior to your Effective Date.
13. Incurred after the termination date of this coverage except as specified elsewhere in this document.
14. For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
15. For sunglasses and accompanying frames.
16. For safety glasses and accompanying frames.
17. For inpatient or outpatient hospital vision care.

18. For Orthoptics or vision training and any associated supplemental testing.
19. For non-prescription lenses.
20. For two pairs of glasses in lieu of bifocals.
21. For Plano lenses (lenses that have no refractive power).
22. For medical or surgical treatment of the eyes.
23. For lost or broken Lenses or frames, unless the Member has reached his or her normal interval for service when seeking replacements.
24. For services or supplies not specifically listed in the Certificate.
25. Certain brands on which the manufacturer imposes a no discount policy.
26. For services or supplies combined with any other offer, coupon or in-store advertisement.

Appendix C

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

- Marathon Petroleum Corporation
- Marathon Petroleum Company LP
- Marathon Petroleum Service Company
- Marathon Petroleum Logistics Services LLC

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