Marathon Petroleum
Health Care
Flexible Spending Account Plan

Amended and Restated
January 1, 2024

Health Care Flexible Spending Account

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Health Care Flexible Spending Account

This document serves both as the plan document and the summary plan description ("SPD") for the Marathon Petroleum Health Care Flexible Spending Account Plan (the "Plan").

I. Purpose

The Plan allows eligible Employees of the Company to reduce their Compensation by an amount elected by the Employee, which amount the Employee may then use to pay certain Qualified Medical Expenses during the Plan Year with pre-tax dollars. By making an election, you authorize and agree to Salary Reduction Contributions in the amount elected by you for the Plan Year.

If you choose to participate in the Plan, you may set aside pre-tax dollars from your pay to reimburse yourself on a tax-free basis for the cost of qualifying health care expenses incurred by you or your dependents that are not otherwise paid by a medical, prescription drug, dental, vision or other health plan. Any health care expenses that would otherwise qualify as a deduction from your personal income tax qualify for reimbursement. (See IRS Publication 502 or Internal Revenue Code ("Code") Section 213, which can be found at your local library or IRS office or online at www.irs.gov/uac/About-Publication-502.)

The Plan is established pursuant to Code Section 125 and the regulations thereunder. The Plan is also intended to qualify as a self-funded medical reimbursement plan under Code Section 105.

A Note About Taxes and About Retirement Plan Benefits:

When you contribute to a Health Care FSA under the Plan, your taxable pay is reduced by the amount of your contributions. As a result, you lower your federal income tax. Medicare tax, and in most cases your Social Security tax, and state and local income taxes, because your taxable pay is less. This means that your contributions are made on a pre-tax basis.

Because Health Care FSA contributions are not subject to Social Security tax, your Social Security benefits may be affected by your Plan participation as follows:

- If your pay after your Health Care FSA contributions is higher than the Social Security wage base, your future benefits are not affected; or
- If you are earning less than the Social Security wage base, your Social Security benefits may be reduced; however, the effect on your future Social Security benefits likely will be minimal.

Your contributions to your Health Care FSA are included with your pay for purposes of contributions under the Marathon Petroleum Thrift Plan and Marathon Petroleum Retirement Plan. This means that your contributions will not reduce the maximum amount you may contribute from your pay to the Thrift Plan or amount of Company matching or other contributions you may receive under the Thrift Plan, and it means that the amount of Company pay credits you may receive under the Retirement Plan will not be reduced.

II. Eligibility

If you are a Regular employee who works on a full-time or part-time basis, you are eligible to participate in the Plan, effective January 1 of each Plan Year, except where a collective bargaining agreement prohibits your participation.

Full-time means you have a normal work schedule with the Company of at least 40 hours per week or at least 80 hours on a bi-weekly basis.

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

You are not eligible for this Plan if you are:

- An intern, co-op, or casual employee who has not been designated by the Company as a Regular Full-time or Regular Part-time Employee; or
- An employee covered by a collective bargaining agreement that prohibits participation; or
- An individual who has signed an agreement, or has otherwise agreed, to provide services to the Company as an independent contractor, regardless of the tax or other legal consequences of such an arrangement; or
- A leased Employee compensated through a leasing entity, whether or not you fall within the definition of "leased Employee" as defined in Code Section 414(n); or
- Ineligible for coverage under (a) the Marathon Petroleum Health Plan or (b) the Michigan Conference of Teamsters Welfare Fund Actives Plan or another group health plan that is not limited to so-called "excepted benefits" and that is contributed to by the Company to provide health care (directly or otherwise) to employees of the Company or their families (as defined in this clause (b), each a "Qualifying Health Plan"); or
- An employee subject to a work stoppage[1] (the work stoppage results in a reduction of hours for the employee, which results in a loss of eligibility to participate).

III. Definitions

Account means the Health Care Flexible Spending Account described in Article VII.C.

Annual Enrollment means the annual period of time designated by the Plan Administrator during which eligible Employees may elect to participate in the Plan for the next Plan Year.

Carryover means the amount up to $640[2] of unused funds from one year to the following year.

Code means the Internal Revenue Code of 1986, as amended.

Compensation includes pay for hours worked, sick pay, vacation pay, pay for allowed hours, military leave allowance, commissions, overseas premiums, temporary hardship allowances, and any other location premium approved by the Plan Administrator, while a Participant in the Plan; however, bonuses paid after a Participant retires or terminates, travel pay, and other similar special payments are excluded.

Company means Marathon Petroleum Company LP and its subsidiaries and affiliates that participate in the Plan.

[1] "Work stoppage" for purposes of this Plan means a concerted failure by employees to report for duty, a concerted absence of employees from work, a concerted stoppage of work, or a concerted slowdown in the full and faithful performance of duties by a group of employees, and includes a strike or lockout. Whether a work stoppage exists shall be determined by the Company in its sole discretion.

[2] This amount is subject to change on an annual basis. Any increase in the maximum carryover limit announced by the IRS will be permitted if administratively feasible.

Employee means any individual who is employed by the Company and who is eligible to participate in the Plan.

Participant means an eligible Employee as defined in Article II who makes an election to participate in the Plan for a Plan Year.

Plan Year means the period from January 1 of any calendar year through December 31 of the same year.

Qualified Medical Expenses means expenses incurred for medical care as defined in Code Section 213(d).

Spouse means an individual who is legally married to a Participant and who is treated as a spouse under the Code. The term "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 Participant can provide confirmation of such common law marriage as required in the Marathon Petroleum Affidavit of Common Law Marriage form.

IV. Enrollment/Effective Date of Participation

A. Initial Participation

If you are a new Employee, you may make an election to participate in the Plan within the first 31 days of your employment, including your date of hire. You can enroll online through Workday Benefits (you must be logged on to the Company network). 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.

If you do not enroll within 31 days of your initial eligibility date, you are not eligible to participate and will have to wait until 1) the next Annual Enrollment, or 2) you experience a qualifying change in family or employment status, to enroll.

B. Annual Enrollment

You must enroll **each** year during Annual Enrollment (usually held during the month of November) in order to participate in the Plan for the following Plan Year, beginning January 1. Elections must be made on or before the specified end of Annual Enrollment. If you fail to make an election on or before the specified Annual Enrollment cutoff date, then you will be deemed to have waived benefit participation under the Plan for the following Plan Year. Your election under the Plan is irrevocable during the Plan Year, unless you or one of your dependents experiences a qualifying change in family or employment status as described below.

If you are on an unpaid leave of absence during Annual Enrollment, you may elect to participate in the Plan within 31 days of your return from your leave of absence, including your return date. Following your election, your participation will become effective on the date you return to active employment. If you are on a leave of absence protected by the Family and Medical Leave Act ("FMLA") during Annual Enrollment, you may enroll to participate in the Plan for the following Plan Year.

C. Change in Family or Employment Status

If you experience a qualifying change in family or employment status during a Plan Year, as set forth in Article VII below, you may be able to cancel or change an election under this Plan. You must make a request to change an election within 31 days of the date of the qualifying status change, including the date of the event, and the change in election must be consistent with the status change. Required documentation supporting the election change also must be submitted within the 31-day election period. Documentation may include, but is not limited to, a marriage certificate, birth certificate, divorce decree or proof of loss of coverage.

Enrollment or a change in election submitted after the 31-day election period will not be accepted.

You may not make a new election mid-year to reduce the amount available in your Account if you have received reimbursements from the Account during the Plan Year that would exceed the total salary reduction amounts for the remainder of the Plan Year under the new election.

Note: If you separate from employment and are subsequently reemployed within the same calendar year by any of the participating companies of this Plan, you may elect to participate effective upon the first day of the next Plan Year. (Participation is not permitted in the same calendar year in which both separation from employment and re-employment occur.)

V. Types of Health Care FSAs

There are two types of Health Care Flexible Spending Accounts ("Health Care FSAs") offered under the Plan, (1) a General Purpose Health Care FSA and (2) a Limited Purpose Health Care FSA. A General Purpose Heath Care FSA can be used for eligible health, dental and vision expenses. A Limited Purpose Health Care FSA can be used only for eligible dental and vision expenses, unless and until you meet your deductible in the Saver HSA option of the Marathon Petroleum Health Plan (the "Health Plan"), at which time you can then also use for eligible health care expenses.

If you are a participant in the Classic or Kaiser options of the Health Plan or waive coverage under that plan, you are eligible to enroll in the General Purpose Health Care FSA.

If you are a participant in the Saver HSA option of the Health Plan, you are eligible to enroll in the Limited Purpose Health Care FSA only; you are not eligible to enroll In the General Purpose Health Care FSA.

You should note that being eligible for reimbursement of your medical expenses under another family member's (for example, your spouse's) general purpose type health care FSA will disqualify you from making contributions to a Health Savings Account ("HSA").

However, if you are a participant in the Saver HSA option under the Health Plan, you may elect to participate in the Limited Purpose Health Care FSA without adversely affecting your eligibility to make contributions to an HSA. Under the Limited Purpose Health Care FSA, only eligible dental and vision expenses are reimbursable from the Account. However, once you meet your Saver HSA deductible(s), based upon your Plan level election, you may use your Limited Purpose Health Care FSA for **all** eligible health care expenses. You will need to submit your Explanation of Benefits ("EOB") to PayFlex showing you have met your plan level deductible(s).

VI. Making a Change in Election

Except as provided below, any election that you make under the Plan may not be changed during the Plan Year unless you have a qualifying status change.

You may only change your election under the Plan during a Plan Year if it is due to and consistent with a "change in family or employment status." For Plan purposes, a "change in family or employment status" includes the following events:

A. You have a change in legal marital status, including marriage, divorce, legal separation, annulment, or death of your spouse;

B. You have a change in the number of your dependents (as defined in Code Section 152), including birth, adoption, placement for adoption, or death of a dependent;

C. You, your spouse, or your dependent has a change in employment status, meaning termination or commencement of employment;

D. You, your spouse, or your dependent has a change in work schedule, including a reduction or increase in hours, a switch between part-time and full-time, or commencement of or return from an unpaid leave of absence, which affects eligibility under the Plan;

E. Your dependent satisfies or ceases to satisfy the requirements for an eligible dependent (as defined by the IRS);

F. You, your spouse, or your dependent has a change in residence or work site which affects eligibility under the Plan;

G. A court order requires accident or health coverage for your child;

H. You, your spouse, or your dependent gains or loses Medicare/Medicaid entitlement; or

I. Such other events as the Plan Administrator shall determine qualify in accordance with Code Section 125 and the regulations or other guidance issued thereunder.

The Plan Administrator will require you to submit satisfactory proof that the change in family or employment status occurred prior to permitting a mid-year change to your election under the Plan.

If you have a change of status you may revoke your election under the Plan for the balance of the Plan Year and make a new election, but only if both the revocation and the new election are consistent with your change in status.

A change in election made due to and consistent with a change in family or employment status must be made within 31 days of the change in family or employment status. If you do not make a change in election within 31 days of a change in family or employment status, including the date of the status change, you may not make a change in election until you again become eligible as a result of a subsequent change in family or employment status, or the next Annual Enrollment, whichever occurs first. Required documentation supporting the election change also must be submitted within the 31-day election period. Documentation may include, but is not limited to, a marriage certificate, birth certificate, divorce decree or proof of loss of coverage.

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

YOU MUST SUBMIT AN ELECTION, INCLUDING SUPPORTING DOCUMENTATION, THROUGH WORKDAY BENEFITS (must be logged on to Company network) WITHIN 31 DAYS OF A QUALIFYING STATUS CHANGE, INCLUDING THE DATE OF THE STATUS CHANGE, TO CHANGE YOUR CURRENT ELECTION.

VII. Plan Benefits

A. Salary Reduction Contributions

Under the Plan, you may choose to either receive your full Compensation for the Plan Year in cash (subject to such elections which you may make for any Plan Year with respect to other benefit plans and benefit programs offered by the Company) or have a portion of it applied through Salary Reduction Contributions by the Company toward the cost of benefits elected by you to be received under this Plan.

Salary Reduction Contributions are not subject to federal income taxes, Medicare tax or Social Security tax. (Appendix A presents a tax savings example.) Depending on state and local law, Salary Reduction Contributions may be subject to state and local income taxes. By making an election under the Plan, you authorize and agree to Salary Reduction Contributions in the amount that the Plan Administrator determines appropriate to cover the benefits elected by you for the Plan Year.

The amount you elect to receive in the form of reimbursements for Qualified Medical Expenses during the period of coverage is equal to the amount of Salary Reduction Contributions elected under this Plan.

Salary Reduction Contributions elected by you will be deducted from your Compensation on a pro rata basis over the period covered by your election based on the number of pay periods in the Plan Year to which your election applies.

As explained in the preceding paragraph, once you have specified a Salary Reduction Contribution amount, that amount is divided equally over the number of pay periods that remain following your effective date of participation in the plan. If you do not receive a paycheck, or have insufficient Compensation from which to take your pro rata Salary Reduction Contribution, your Salary Reduction Contribution amount will increase in the following pay periods in order to reach your annual contribution amount.

B. Maximum and Minimum Contribution Amounts

The minimum Salary Reduction Contribution that you may elect is $120 per year, and the maximum amount that you may elect is $3,200[3] per year. If two Employees are married, each Employee may elect a Salary Reduction Contribution up to $3,200[3] per year.

[3] This amount is subject to change on an annual basis. IRS changes to the maximum contribution amount will be implemented as soon as practicable. If the IRS announces a change during or following the conclusion of the Annual Enrollment period and it is not administratively feasible to allow new contribution amounts to be elected, employees will not be permitted to make election changes. Employees who are newly hired or who experience a qualifying status change and who are still within their election period at the time of any IRS announced contribution limit changes will be permitted to make new elections if administratively feasible.

The maximum dollar amount elected for reimbursement of Qualified Medical Expenses incurred during a period of coverage (reduced by prior reimbursements during the period of coverage) will be available at all times during the period of coverage, regardless of the actual amounts credited to the Participant's Account. However, no reimbursements will be made for Qualified Medical Expenses incurred after participation in the Plan has terminated, unless you have elected COBRA continuation coverage as described in Article X.

C. Health Care Flexible Spending Accounts

The Plan Administrator will establish and maintain a Health Care Flexible Spending Account ("Account") for each Participant for each Plan Year, but will not create a separate fund or otherwise segregate assets for this purpose. The Account will be a recordkeeping account for the purpose of tracking contributions, reimbursements, and forfeitures. The amount available for reimbursement of Qualified Medical Expenses is the Participant's annual contribution amount, reduced by prior reimbursements made during the Plan Year; it is not based on the amount credited to the Account through contributions at any particular time. Thus, a Participant's Account may have a negative balance during a Plan Year or other period of coverage, but the aggregate amount of reimbursement shall in no event exceed the maximum dollar amount elected by the Participant for the Plan Year.

Account information can be viewed at www.payflex.com or by contacting PayFlex at 1-844-PAYFLEX (1-844-729-3539).

D. Description of Benefits

If you elect to receive benefits under this Plan, you will be reimbursed for Qualified Medical Expenses incurred by you, your spouse and your dependents (children, and other qualified dependents as defined in Code Sections 152 and/or 213(d)(5)) during a Plan Year, subject to the maximum reimbursement limitations of this Plan and the limits elected by you for the Plan Year. The Plan will not, however, reimburse any payments for services that are paid by an insurer, claims administrator or other third party payer on your behalf.

"Qualified Medical Expenses" means expenses incurred for medical care (as defined in Code Section 213(d)), including but not limited to expenses for diagnosis, cure, mitigation or treatment of disease or injury to the body or mind, or the prevention of such disease. **If you have questions as to whether particular medical expenses qualify for reimbursement under the Plan, contact your tax advisor *prior* to enrolling in the Plan.** You may also refer to Appendix B for a list of eligible and ineligible medical expenses.

General Purpose Health Care FSA

Under the General Purpose Health Care FSA, qualified expenses are those that meet the requirements under Code Section 213(d). Generally, these are out-of-pocket medical, dental, vision, or hearing expenses, for you or an eligible dependent, of the type that would qualify for deduction on your federal income tax return.

Limited Purpose Health Care FSA

Under the Limited Purpose Health Care FSA, qualified expenses are limited to out-of-pocket dental and vision expenses, for you or an eligible dependent, of the type that would qualify for deduction on your federal income tax return. **Once you meet your Saver HSA deductible(s),** based upon your Plan level election, you may use your Limited Purpose Health Care FSA for **all** types of qualified expenses — but in order to do so, you must provide an EOB to PayFlex verifying the Health Plan deductible has been met.

General Qualification Rules

Only expenses for goods bought or services provided (incurred) during the Plan Year while you're a participant in the Health Care FSA are eligible for reimbursement. These expenses include your deductibles, co-payments, and other out-of-pocket expenses under your group health plans — to the extent eligible for reimbursement under your applicable Health Care FSA (see above).

Certain over-the-counter ("OTC") medications, including acne products and dietary/nutritional/herbal supplements, require a physician's prescription before purchase in order to submit the expense under your Health Care FSA. Each calendar year, you must provide written documentation from your physician stating your medical condition and indicating that the OTC medication will treat or alleviate your condition. After you have provided the documentation from your doctor, you may submit claims for the OTC medication for the rest of the calendar year.

OTC medications and products that do NOT require a doctor's prescription include allergy prevention and treatment, cough medicines, decongestants, pain relievers, topical antibiotics and wound care products such as bandages and gauze, thermometer, heating pad and contact lenses solution, expenses for personal protective equipment (PPE), such as masks, hand sanitizer and sanitizing wipes for the primary purpose of preventing the spread of the Coronavirus Disease 2019 (COVID-19 PPE), for use by the Participant and Participant's covered family members.

E. Limitations on Benefits

Before the beginning of each Plan Year, the Plan Administrator will determine the maximum amount of reimbursement benefits that will be permitted for Participants under the Plan for the Plan Year. Reimbursements to you under the Plan for Qualified Medical Expenses covered for a Plan Year may not exceed the maximum reimbursement amount. You will be advised of the maximum reimbursement amount prior to the commencement of the Plan Year. In no event may the reimbursements to you under the Plan exceed the maximum amount elected by you for the Plan Year. In addition, your benefits may be further limited if you do not file timely claims for benefits under the Plan.

For the Plan Year beginning January 1, 2024, the maximum reimbursement amount is $3,200.

F. Funding

Benefits shall be paid from the general assets for the Company. There is no trust or other fund from which benefits are paid.

G. Carryover

If your Health Care FSA balance equals $640 or less at the end of a Plan Year, it will be automatically carried over to either a General Purpose Health Care FSA or a Limited Purpose Health Care FSA (as applicable to you) for the next Plan Year. You may use it for Qualified Medical Expenses incurred in that Plan Year as applicable to the account you are enrolled. Any balance in excess of $640 following the claims submission period will be forfeited. The forfeited amounts are not available for future expenses or a refund.

Should you elect to change Health Plan options, any carryover amount in your FSA will be adjusted to correspond with your elected Health Plan option. For example, if you are enrolled in the Health Plan's Classic or Kaiser options, you will have a General Purpose Health Care FSA. If you are enrolled in the Health Plan's Saver HSA option, you will have a Limited Purpose Health Care FSA.

H. Forfeitures

No Participant shall have any right, title or interest in any assets of the Company as the result of any Salary Reduction Contribution election made by such Participant.

This meant that at the end of the Plan Year, amounts contributed by you to this Plan through Salary Reduction Contributions that were not reimbursed to you or carried over for such Plan Year will be forfeited. It is, therefore, important that you plan carefully in electing your annual contribution amount. Refer to Appendix C for assistance in estimating your annual health care expenses.

VIII. Continuation of Participation

You may be able to continue participation in the Plan during a leave of absence, as follows:

A. Participation may continue for the duration of the leave if you are on a Military Leave. If the leave extends into a new calendar year, you must make an election during Annual Enrollment to participate in the new calendar year. Your elected contributions will continue to be deducted from your Compensation, on a pre-tax basis, while you are on a Military Leave and receiving a Company pay offset.

B. Participation may continue for Seasonal employees on layoff for up to three months or until the end of the year, whichever occurs first.

C. Participation may continue for up to six months if you are on any of the following leaves of absence:

   1. Medical Leave;
   2. Family Leave;
   3. Paid Parental Leave; and
   4. "Wounded Warrior" Family Leave of 26 workweeks or less.

   Participation may be continued for no longer than six months from the commencement of your leave of absence, or until the end of the Plan Year, whichever is earlier. (You cannot elect to participate in a new Plan Year if you are on a leave of absence, other than a Military Leave, as described in Article VIII.A. above, or FMLA protected leave.)

While you are on an unpaid leave of absence of more than 30 days, you may make an election change during the Plan Year, as described in Article VI above. Therefore, you may choose to terminate participation upon commencement of an unpaid leave of absence.

If you continue participation, your Salary Reduction Contributions will continue to be deducted on a non-taxable basis from your Compensation, including sick benefits while on Medical Leave, or military pay while on Military Leave. For periods of unpaid leave, you may, to the extent possible, pre-fund your elected contributions from your last paycheck for the payroll period immediately prior to your unpaid status. Upon return to work in a Plan Year, your elected contributions to the Plan will resume and additional contributions to the extent possible will be deducted from your pay on a pre-tax basis to cover elected contributions not made for periods while you were on an unpaid leave during the Plan Year.

D. Participation terminates if you are on a leave of absence or layoff other than described in A., B. and C. above, such as those listed below. You may elect to continue your coverage through COBRA (see Appendix D). Information on COBRA will be mailed to you by PayFlex.

1. Medical Leave while receiving LTD benefits[4];
2. Educational Leave; and
3. Personal Leave.

Employees on an unpaid leave of absence during Annual Enrollment may elect to participate in the Plan within 31 days of their return from a leave of absence, including return date.

[4] Participation ends on the latest of 1) the effective start date of the LTD benefit, 2) the date of the last pay date that includes a sick pay benefit, or 3) the date participant is notified of the LTD determination.

IX. Transfer of Employment

If you are transferred to another employer within the controlled group to which Marathon Petroleum Company LP belongs (see Appendix D), you will remain a Participant for the remainder of the Plan Year. Your annual Salary Reduction contributions must remain at the same level as your initial election amount, unless you incur a qualifying status change during the Plan Year.

X. Termination of Participation

Your participation in the Plan will terminate on:

A. the end of a Plan Year (December 31) for which you have elected to participate; or

B. the date you cease to be eligible to participate (including due to a leave of absence as described in Article VIII.D. above); or

C. the date on which your employment with the Company terminates; or

D. the date on which your employer discontinues participation; or

E. the date on which Marathon Petroleum Company LP terminates the Plan itself.

Note: *You may not terminate participation in the Plan during the Plan Year unless the change is due to and consistent with a change in family or employment status, and your request is made within 31 days of the qualifying status change. See Article VI above.*

Upon your termination of participation in the Plan, any remaining Salary Reduction Contributions that you have elected for the balance of the Plan Year and your period of coverage will cease with the date of termination. You will have the right to submit a claim for reimbursement at any time prior to the expiration of the period for filing claims for any Qualified Medical Expenses incurred during the period of coverage for which contributions have been paid.

Under the terms of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), your participation in the Plan may be continued by choosing to continue making monthly after-tax contributions to your Health Care FSA. If you elect COBRA continuation coverage, participation may be continued through the end of the Plan Year, provided claims reimbursement does not exceed your employee contributions as of the date of your qualifying event. Contact PayFlex at 1-844-729-3539 to elect COBRA coverage under this Plan or to request additional information.

XI. Limitation of Benefits to Comply with Tax Laws

The Plan is subject to certain Internal Revenue Code requirements, including nondiscrimination testing requirements, which could make it necessary for the Company to reduce or terminate your contributions during the Plan Year. As a Participant in the Plan, you agree that the Company has the full right to take such action or other actions that the Company may deem necessary for the Plan to comply with Internal Revenue Code requirements. You will be notified if such reductions or other actions are required as applied to you.

For these Code nondiscrimination requirements:

- The Plan shall not discriminate in favor of Highly Compensated Individuals as to eligibility to participate, or as to contributions and benefits, in compliance with the requirements of Code Section 125(b)(1).
- The Plan shall not discriminate in favor of Highly Compensated Individuals as to eligibility to participate, or as to contributions and benefits, in compliance with the requirements of Code Section 105(h).
- "Highly Compensated Individual" means:
  - With respect to Code Section 125, a Plan participant who is (a) an officer, (b) a Highly Compensated Employee, (c) a more-than-5 percent owner, or (d) a spouse or dependent of an individual described in (a), (b) or (c) above.
  - With respect to Code Section 105(h), an individual who is (1) one of the five highest paid officers, (2) a more-than-10% owner of the employer's stock, or (3) among the highest paid 25% of all employees.

- "Highly Compensated Employee" means any employee who was a "5-percent owner" as defined in Code Section 416(i) at any time during either the current year or the preceding ("look-back") year, or who received compensation (within the meaning of Code Section 415(c)(3)) for the look-back year in excess of $150,000 (for a 2024 determination) and was a member of the top-paid group for such look-back year. For this purpose, the determination of who is a Highly Compensated Employee, including the determinations of the number and identity of employees in the "top-paid group", shall be made in accordance with Code Section 414(q) and the Treasury Regulations issued thereunder.

XII. Claim Procedures

There are several ways to obtain reimbursement for Qualified Medical Expenses under the Plan:

A. Debit Card

A debit card will be sent to you to access the balance of your annual Health Care FSA election amount. If you choose to activate the debit card, you can use the debit card to pay for eligible out-of-pocket expenses such as copays, coinsurance, deductibles, eligible over-the-counter items, etc. If you do not or cannot use the debit card to pay for an eligible health care expense, you can pay for it with another form of payment, and then submit a manual claim for reimbursement to PayFlex.

In order to be eligible for the debit card, you must agree to abide by the terms and conditions of the debit card program as set forth in the electronic payment cardholder agreement administered by the debit card provider and/or PayFlex, including limitations as to card usage and the Plan's right to withhold and offset for ineligible claims.

Every debit card transaction must be validated as an eligible expense. You must keep your itemized receipts and/or EOB's for all expenses paid for with your debit card and provide them to PayFlex when requested. PayFlex may require substantiation to verify any expenses as being qualified. If you fail to provide the requested documentation and receipts in a timely manner, or if the Plan or PayFlex determines the payment to have been for a non-qualified expense, the transaction will be deemed ineligible. PayFlex may allow you to either offset the ineligible expense amount with another qualified expense or request that you reimburse PayFlex the amount of the ineligible expense. Your failure to respond promptly to these requests will result in your debit card being suspended or terminated. If you fail to make the required reimbursement either to PayFlex or the Company, the Company will, in accordance with applicable law, withhold the amount from your paycheck. If, despite these efforts, non-qualified expenses are not reimbursed, the amount may be treated as taxable income to you and reported as such on your IRS Form W-2, Wage and Tax Statement.

B. Claim Reimbursement Processes

If you prefer to file your own claims or have expenses that were not previously paid with the PayFlex debit card process, you can file claims for reimbursement of eligible expenses. You are reimbursed from your account on a non-taxable basis.

Submit online claims:	www.payflex.com
Mailed claims:	PayFlex P.O. Box 8396 Omaha, NE 68108-0396
Faxed claims:	1-855-703-5305
Customer Service:	1-844-PAYFLEX (1-844-729-3539)

Claim forms can be obtained online at www.payflex.com after you register or by calling PayFlex Customer Service.

All claims must be submitted online or postmarked by May 31 in the year following the end of the Plan Year for which Qualified Medical Expenses were incurred and for which reimbursement is sought. Any claims submitted after such date will be automatically denied. All claims must be made by you or your authorized representative in writing and delivered to PayFlex.

1. Method of Reimbursement

   Claims are processed within 3 – 5 business days of PayFlex's receipt. There are three forms of reimbursement when you incur qualified expenses, by check, direct deposit or by sending payment to your provider.

   a. Check Reimbursements

      Generally, reimbursement checks are issued within one business day following PayFlex's processing of your claim. Check reimbursement will occur automatically if you have not elected the direct deposit feature described below.

   b. Direct Deposit of Reimbursements

      You can elect to have your reimbursements electronically deposited directly into your bank account instead of receiving reimbursement checks through the mail. Generally, direct deposit reimbursements are issued within 24 – 48 hours following PayFlex's processing of your claim. You can sign up for direct deposit by logging on to your PayFlex account at www.payflex.com and submitting the online election for direct deposit or by calling PayFlex at 1-844-729-3539.

   c. Pay Your Provider

      You can have the funds sent directly to your provider by selecting "Send funds to someone else" and entering the provider information.

If you have questions or want to check the status of your Health Care FSA, you should go to www.payflex.com or contact PayFlex at 1-844-PAYFLEX (1-844-729-3539).

First time users should follow the online registration process.

XIII. Benefit Claims Denial

If a claim for a Plan benefit is wholly or partially denied by the Plan, notice of the decision shall be furnished to the Participant by the Plan or Third Party Administrator within a reasonable period of time, but not later than 30 days after receiving the claim. If more time is needed to review the claim, the Plan may extend the time period up to an additional 15 days, explaining the reason for the extension and will notify the Participant of the extension before the end of the first 30-day period and reasons for the extension and date by which a decision is expected to be made. If a claim is rejected, the Plan will provide a written notification which shall include the following information:

- The specific reason or reasons for the denial;
- Specific reference to the Plan provisions on which the denial is based;
- A description of any additional material or information necessary to complete the claim and an explanation of why this material or information is necessary; and
- An explanation of the steps to be taken to submit the claim for review.

If a claim is incomplete, the extension notice will also specifically describe the required information or will allow a Participant 45 days to submit any requested information, which will suspend the time for a decision until the information is provided.

Appeals of Denied Claims

A Participant or their duly authorized representative may appeal a denial of a claim by requesting a review by written application to the Plan Administrator or designee no later than 180 days after receipt by the Participant of written notification of denial of a claim. The Participant or his or her duly authorized representative:

- May review pertinent documents; and
- May submit issues and comments in writing. Failure to make written request for appeal within the 180-day period after the receipt of the Plan Administrator's notice of denial of the claim shall render the Administrator's decision regarding the claim final, binding and conclusive on all parties.

A decision on review of a denied claim shall be made by the Plan Administrator not later than 60 days after the Plan Administrator's receipt of a request for review.

Written notice will be provided to the Participant, advising if the appeal was granted or denied. If the appeal is denied, the notice will describe the specific reason(s) for the denial; the specific Plan provision(s) upon which the decision is based; a statement of your right to review (upon request and at no charge) relevant documents and other information; a description of an internal rule, guideline, or other similar criteria relied upon in making the decision, if any; and any additional appeal levels, including the right to seek judicial review of the Plan's decision.

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

XIV. Designation 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 (for example, 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 will 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.

XV. Unclaimed Payments

If within five years after any amount becomes payable hereunder to a Participant, the same shall not have been claimed, provided due and proper care have been exercised by the claims administrator and the Company in attempting to make such payments by providing notice at the Participant's last known address, the amount thereof shall be forfeited and shall cease to be a liability of the Plan. In such case, the amount thereof shall be retained by the Company in its general assets. Provided that the claimant initially made a timely claim, the claimant shall have the right and responsibility to re-establish their claim for payment with the Company by providing due proof that such amount is owed to the Participant.

XVI. Statute of Limitations

A claimant must follow and fully exhaust the applicable claims and appeals procedures described in this Plan before taking action in any other forum regarding a claim for benefits under the Plan. Any suit or legal action initiated by a claimant under the Plan must be brought by the claimant no later than one year following a final decision on the claim for benefits under these claims and appeals procedures. The one-year statute of limitations on suits for benefits applies in any forum where a claimant initiated such suit or legal action. If a civil action is not filed within this period, the claimant's benefit claim is deemed permanently waived and abandoned, and the claimant will be precluded from reasserting it.

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

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

In the event that any member of the Company's workforce uses or discloses PHI other than as permitted by the terms of the Plan regarding PHI and 45 Code of Federal Regulations at 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, as required by HIPAA, the Company has agreed to:

- Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law, including the HIPAA Privacy Standards;
- Implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information ("EPHI") (EPHI means PHI that is transmitted by or maintained in electronic media) that the Company creates, maintains or transmits on behalf of the Plan;
- Ensure that any agent or subcontractor, to whom it provides PHI received from the Plan, agrees to the same restrictions and conditions that apply to the Company with respect to such information;
- 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 Administrator any use or disclosure of the PHI of which it becomes aware that is inconsistent with the uses or disclosures permitted by this section, or required by law;
- Report to the Plan Administrator any security incident of which it becomes aware;
- Make available PHI to individual Plan Participants as required by Section 164.524 of the HIPAA Privacy Standards;
- Make available PHI for amendment by individual Plan Participants and incorporate any amendments to PHI requested by individual Plan Participants, as required by Section 164.526 of the HIPAA Privacy Standards;
- Make available the PHI required to provide an accounting of disclosures to individual Plan Participants as required by Section 164.528 of the HIPAA Privacy Standards;
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan and Company with the HIPAA Privacy Standards;
- 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 information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- 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.

XVIII. Administration of the Plan

Important Plan Administration Information	
Plan Name	Marathon Petroleum Health Care Flexible Spending Account Plan
Plan Administrator (Agent for service of legal process)	Marathon Petroleum Employee Benefit Plan Administration Committee P.O. Box 1 539 South Main Street Findlay, OH 45839-0001 Phone: 1-419-422-2121
Employer Identification Number	31-1537655
Type of Plan	Welfare Plan
Plan Sponsor	Marathon Petroleum Company LP 539 South Main Street Findlay, OH 45840
Plan Number	571
Inspection of Plan Documents	Plan documents may be inspected by making a request at any Company Human Resources office or by writing to: Marathon Petroleum Company LP Benefits Administration 539 South Main Street Findlay, OH 45840
Plan Year	The Plan Year is January 1 through December 31. Records are kept on a calendar year basis.
Recordkeeper/ Claims Processing	PayFlex Systems USA, Inc P.O. Box 8396 Omaha, NE 68108-0396 Phone: 1-844-PAYFLEX (1-844-729-3539)

The Plan Administrator shall be responsible for the administration and interpretation of the Plan.

In determining the eligibility of Employees and in construing the Plan's terms, the Plan Administrator has the power to exercise discretion in the construction of doubtful, disputed or ambiguous terms or provisions of the Plan in cases where the Plan instrument is silent, or in the application of Plan terms or provisions to situations not clearly or specifically addressed in the Plan text itself. In situations in which the Plan Administrator deems it to be appropriate, the Plan Administrator may evidence (i) the exercise of such discretion, or (ii) any other type of decision, directive or determination he or she may make with respect to the Plan, in the form of a written administrative ruling which, until revoked, or until superseded by Plan amendment or by a different administrative ruling, shall thereafter be followed in the administration of the Plan.

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

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

Any discretionary acts taken under the Plan by PayFlex, the Plan Administrator, or the Company shall be uniform in nature and shall be applicable to all Participants similarly situated and shall be administered in a nondiscriminatory manner in accordance with the provisions of the Code. It is intended that the standard of judicial review applied to any determination made by PayFlex or the Plan Administrator shall be the "arbitrary and capricious" standard of review.

The Plan shall be construed, whenever possible, to be in conformity with the requirements of the Code. To the extent not in conflict with the preceding sentence or preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), the construction of the Plan shall be governed by the laws of the State of Ohio. Decisions of the Plan Administrator made on all matters within the scope of that authority shall be final and binding upon all persons, including the Company, all Participants and beneficiaries, their heirs and personal representatives, and all labor unions or other similar organizations representing Participants.

In the event that a benefit provided under the Plan does not satisfy the requirements of Code Sections 105 and/or 106, and therefore becomes taxable to the Participant, 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.

XIX. Further Information

A. Limitation Regarding Employment

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

B. No Interest or Earnings

No interest or earnings of any type will accrue, be credited to, or be payable on any amounts that are credited on behalf of a Participant under the Plan or any supplement thereto.

C. Severability

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

D. Forfeitures

Except as permitted under the Plan's carryover rule, any unused amounts from the end of a Plan Year will be forfeited and restored to the Employer. Amounts so forfeited shall be applied by the Employer to reduce future costs.

E. Internal Revenue Service ("IRS") Regulations

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

F. Non-Assignability

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

XX. Participation by Associated Companies and Organizations

Upon specific authorization and subject to any terms and conditions it may wish to establish, Marathon Petroleum Company LP may permit eligible 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.

XXI. Modification and Termination of the Plan

Marathon Petroleum Company LP 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 Marathon Petroleum Company LP for any reason.

XXII. Your Rights Under Federal Law

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, all Plan documents governing the Plan, including insurance contracts (as applicable) and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts (as applicable) and a copy of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The Plan Administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants ERISA imposes duties upon the people who are responsible for the operation of the 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, 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 Plan 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.

Appendix A

Tax Savings Example

When you elect to contribute to the Health Care FSA, your taxable income is reduced. Here's an example of how a spending account could help you save. Assume all of the following:

- You are single.
- You have an annual income of $50,000.
- You contribute $3,200 to your Health Care FSA, and you will incur at least that amount in Qualified Medical Expenses for the year.

	With Health Care FSA	Without Health Care FSA
Your salary	$50,000	$50,000
Minus your contribution to the Health Care FSA	– 3,200	$ 0
Taxable pay	$46,800	$50,000
Estimated taxes (25%)	–11,700	–12,500
After-tax health care expenses	$ 0	– 3,200
Net pay	$35,100	$34,300
Savings	**$ 800**	**$ 0**

In this example, you save $800 by paying for health care expenses using a Health Care FSA. Keep in mind that this is only an example. Your own tax savings will depend on your personal situation. Tax laws are complex and change frequently. Please see a tax advisor for the tax savings that apply to you.

Appendix B

Qualified and Non-Qualified Medical Expenses

The following is not intended to be a complete list of Qualified Medical Expenses and expenses that are not Qualified Medical Expenses. It is the Company's intention to allow as Qualified Medical Expenses such expenses as permitted under the Code and related IRS guidelines and as interpreted by PayFlex. If you have questions concerning eligibility of medical expenses, contact your tax advisor and/or PayFlex prior to enrolling in the Health Care Flexible Spending Account.

Also, if you have a Limited Purpose Health Care FSA, only dental and vision type Qualified Medical Expenses may be reimbursed unless and until you have met your deductible(s) for the year under the Saver HSA coverage option under the Health Plan.

Qualified Medical Expenses

- Acupuncture
- Alcoholism or drug addiction treatment center, including meals and lodging
- Allergy shots
- Ambulance
- Artificial limbs
- Birth control/family planning (male and female)
- Breast pumps and supplies
- Chiropractic expenses
- Christian Science practitioner expenses
- Contact lenses and contact lens solutions
- Cost of medically necessary operations and related treatments
- Crutches
- Deductibles, coinsurance, copayments and amounts exceeding medical, dental and vision plan limits
- Dental expenses, including preventive, diagnostic, restorative, orthodontic and therapeutic care
- Dentures
- Diagnostic fees
- Eyeglasses, eye exams, prescription sunglasses, artificial eye and polish
- Facility fees (hospital, nursing home, rehabilitation facility, home for mentally or physically disabled)
- Fertility treatments
- Health screenings (cholesterol, diabetes glucose, blood pressure, etc.)
- Hearing expenses (including examinations, hearing aids and batteries, TV or phone adapter)
- Home improvements (capital modification of personal residence ramps/doorways/railings/lifts)

- Hospital services/fees
- Insulin
- Insurance plan co-pays and deductibles
- Laboratory fees
- Lodging while receiving medical care away from home (stipulations apply)
- Medical information plan fees
- Medical supplies
- Menstrual care products
- Nursing services (including wages and fees, extra rent or utility expenses)
- Obstetrical expenses
- Orthopedic shoes
- Over-the-counter products that **do not** require a doctor's statement or prescription may include wound care products such as bandages and gauze, thermometer, heating pad and contact lenses solution
- Over-the-counter medications and products that **do not** require a doctor's prescription for treatment of a medical condition may include allergy prevention and treatment, antacids, antifungals, antihistamines, cough medicines, decongestants, eye drops, pain relievers, smoking cessation aids, topical antibiotics and topical steroids
- Over-the-counter products that **do** require a doctor's prescription **and** a doctor's statement stating the diagnosis or medical condition **and** must be filled at a pharmacy may include acne products, dietary/nutritional/herbal supplements, hair loss treatments and lactose intolerance supplements
- Oxygen
- Personal protective equipment (PPE), such as masks, hand sanitizer and sanitizing wipes for the primary purpose of preventing the spread of the Coronavirus Disease 2019 (COVID-19 PPE)
- Physician fees
- Prescription drugs/medicines
- Psychiatric fees and psychiatric care, including the cost of supporting a mentally ill dependent at a specially equipped medical center
- Psychologist fees
- Service animals for disabled persons (cost and care of the animal)
- Special modification devices of a telephone or television for the hearing-impaired
- Special education for the blind
- Special plumbing for the handicapped
- Speech therapy to treat a medical condition (or is restorative or rehabilitative in nature)
- Sterilization/sterilization reversal fees
- Surgical fees
- Therapy received as medical treatments
- Transplants, organ or tissue
- Transportation essential to obtain medical care (ambulance, mileage, tolls, parking, taxi, bus, etc.)
- Tuition at special school for disabled person

- Tuition fees (part), if college or private school furnishes breakdown of medical charges
- Vaccines
- Vision correction surgery (doctor's statement may be required)
- Vision expenses — examinations, eyeglasses, contact lenses, and seeing-eye dogs (and their upkeep)
- Weight-loss or stop-smoking program prescribed by a doctor
- Wheelchair and maintenance
- X-rays

Expenses that are not Qualified Medical Expenses

- Adoption fees
- Church of Scientology practitioners
- Cosmetic surgery-related expenses including doctor, surgical, hospital, supplies, etc.
- Diaper service
- Expenses claimed as a deduction or credit for federal or state income tax purposes
- Expenses reimbursed under another flexible spending account program
- Expenses reimbursed through another benefit program or another employer
- Expenses reimbursed through Medicare or another government program
- Funerals and burials
- General counseling (e.g., family, marital or couple)
- Hair transplants and hair removal
- Health club dues/memberships
- Household and domestic help expenses (even though recommended by a physician due to an employee's or dependent's inability to perform physical housework)
- Insurance premiums, including health, dental, vision, COBRA, life insurance, long-term care insurance, disability insurance, Medicare)
- Lessons (swimming, dancing, gymnastics, aerobics, etc.)
- Liposuction
- Maternity clothes
- Personal hygiene products, including toothpaste, toothbrush, floss, deodorant, shampoo, soap and shaving cream
- Physical therapy treatments for general well-being
- Teeth whitening
- Vitamins (without doctor's statement)

Contact PayFlex at 1-844-PAYFLEX (1-844-729-3539) if you have any questions.

Appendix C

Annual Health Care Expenses Worksheet

(For determining annual contributions to your Health Care FSA*. **Expenses allowed by the IRS are based upon your Health Care FSA election as referenced in Article VII.**)

Expenses that will be paid by you with no reimbursement from other plans.**

	Expenses for Self	Expenses for Dependents
Health expenses:		
Health deductibles/coinsurance	$	$
Immunizations	$	$
Routine physical exams	$	$
Well baby care	$	$
Prescription drug deductibles/coinsurance	$	$
Other expenses	$	$
Dental expenses:		
Dental deductibles/coinsurance	$	$
Dental expenses not covered in full	$	$
Orthodontia expenses not covered in full	$	$
Other expenses	$	$
Vision expenses:		
Exams	$	$
Eyeglasses or contact lenses	$	$
Other expenses	$	$
Hearing expenses:		
Exams	$	$
Hearing aids, batteries	$	$
Other expenses	$	$
Other expenses:	$	$
TOTALS	**$**	**$**

Important Information

* This worksheet is not intended to be applicable in whole or in part to every employee situation. If you have questions about whether an anticipated expense will be eligible, contact your tax advisor prior to enrolling in the Plan.

** All eligible expenses must have been incurred (have a date of service) during the Plan Year for which they are reimbursed. Eligibility for reimbursement is based on date of service, not date of payment.

If you currently itemize deductions on your federal income tax return and you deduct health-related expenses, you should consult your tax advisor to determine if you should participate in the Plan.

Appendix D

Continuation of Coverage Rights Under COBRA

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

COBRA continuation coverage under the Plan will be offered only to Participants and other qualified beneficiaries losing coverage due to a qualifying event who have underspent accounts. A Participant has an underspent account if the annual limit elected by the Participant, reduced by the reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the premiums for Health Care FSA coverage that will be charged for the remainder of the Plan Year.

COBRA coverage will consist of the Health Care FSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by the reimbursable claims submitted up to the time of the qualifying event). The carryover amount, as permitted under the Plan's carryover rule, will be available through the period of COBRA continuation coverage.

Qualifying Events

COBRA continuation coverage is available to employee Participants who lose coverage due to:

- termination for any reason other than gross misconduct; or
- a reduction in hours.

Spouses of Participants may elect COBRA continuation coverage if the spouse loses coverage due to:

- The employee Participant's death; or
- The employee Participant's reduction of hours; or
- The employee Participant's termination for any reason other than gross misconduct; or
- Divorce or legal separation from the employee Participant.

A dependent child of a Participant may elect COBRA continuation coverage if the dependent child loses coverage under the Plan due to:

- The employee Participant's death; or
- The employee Participant's reduction in hours; or
- The employee Participant's termination for any reason other than gross misconduct; or
- The dependent's ineligibility for coverage as a "dependent child."

When the qualifying event is termination, reduction in hours, or death of the Participant, the Plan will offer coverage to qualified beneficiaries. For the other qualifying events (divorce, legal separation, losing eligibility for coverage as a dependent) you must notify the Company in writing within 31 days of the event. Please keep the Company apprised of any changes of address for the Participant and any spouse or dependent children.

If you elect COBRA continuation coverage, you will be required to pay a monthly premium, equal to 102% of your Salary Reduction Contributions, for the remainder of the Plan Year. COBRA coverage will terminate if you fail to pay the required monthly premium, and your Account will be forfeited.

For additional information concerning your COBRA rights, contact PayFlex at 844-PAYFLEX (844-729-3539).