Summary of Material Modification ("SMM")

Marathon Petroleum Retiree Health Plan
Classic and Saver HSA options[1]

To Members Enrolled in the Classic and Saver HSA options of the Marathon Petroleum Retiree Health Plan:

This SMM is to inform Marathon Petroleum Retiree Health Plan (the Plan) members of changes to the coverage of COVID-19 testing, COVID-19 vaccines, and temporarily extended Plan deadlines, as well as the new travel and lodging benefit available when a member is unable to obtain medically necessary in-network care within 75 miles of the member's primary residence.

End of the COVID-19 Public Health Emergency, National Emergency and Outbreak Period

In 2020, a COVID-19 Public Health Emergency and COVID-19 National Emergency was declared. This impacted how the Plan covered COVID-19 vaccines and testing, and temporarily extended the timeframes typically required for making benefit elections and filing appeals under our Plan. The Public Health Emergency is scheduled to end on May 11, 2023.

Due to the end of the COVID-19 Public Health Emergency and National Emergency and Outbreak Period, the following will change:

- **COVID-19 Testing:** During the COVID-19 Public Health Emergency, group health plans were required to cover COVID-19 tests at no cost to members, including limited at-home COVID-19 tests. Beginning **May 12, 2023**, MPC will no longer cover at-home COVID-19 tests. COVID-19 tests performed at a doctor's office or other professional facility will be covered per the plan's standard benefits for diagnostic testing.
- **COVID-19 Vaccines:** During the COVID-19 Public Health Emergency, group health plans were required to cover in-network *and* out-of-network COVID-19 vaccines at no cost to members. Beginning **May 12, 2023**, COVID-19 vaccines administered in-network will continue to be covered at 100%, but COVID-19 vaccines administered by an out-of-network provider or facility will be covered per the plan's standard benefits for out-of-network vaccinations.
- **Outbreak Period Extensions:** Due to the COVID-19 pandemic, regulatory guidance was issued to provide relief to members and qualified beneficiaries in certain situations. This meant that we extended or waived deadlines that were typically required to report COBRA and HIPAA special enrollment events, elect COBRA, pay COBRA premiums, and file benefit claims, appeals, and external review requests during the Outbreak Period related to COVID-19. On **July 11, 2023**, all pre-pandemic deadlines will return. Refer to the MPC Health Plan Summary Plan Description for details around standard deadlines associated with COBRA, special enrollments, and filing claims and appeals. If you have experienced events associated with any of these events on or prior to **July 10, 2023**, you may have additional time to meet the associated deadline for enacting your

[1] Members of the Kaiser Permanente Traditional HMO Plan Northern California Region and Kaiser Permanente Traditional HMO Plan Southern California Region (fully insured Health Plan options available to eligible retirees in California) should have received or will receive information regarding any mid-year changes to its coverage related to COVID-19 testing, vaccine, and services which may differ from the Classic and Saver HSA options. Kaiser Permanente also has travel and lodging benefits that differ from the travel and lodging benefits available under the Classic and Saver HSA options.

rights under the plan. Contact the MPC Benefits Service Center (see the **Questions** section below).

Note: For COBRA elections and HIPAA Special Enrollment elections with retroactive effective dates, you will be responsible for paying applicable healthcare premiums retroactive to the effective date or reinstatement date of your benefits.

Takeaways

- **COVID-19 Testing:** The Plan will no longer cover at-home COVID-19 test expenses incurred after May 11, 2023.
- **COVID-19 Vaccines:** COVID-19 vaccines received out-of-network will be subject to the Plan's standard benefits for out-of-network services incurred after May 11, 2023. COVID-19 vaccines received in-network will continue to be covered at no cost to member.
- **Outbreak Period Extensions:** The Plan will revert to pre-pandemic rules and return to normal deadlines effective July 11, 2023.

Travel and Lodging Benefit

To assist in mitigating travel costs associated with securing appropriate medical care, certain travel and lodging expenses can be treated as eligible claims under the Plan, provided such covered medical care is medically necessary and cannot be obtained at an Anthem in-network facility within 75 miles of the member's primary residence.

- **Effective date**: Eligible expenses incurred on or after **January 1, 2023**. Members can begin submitting claims to Anthem on or after **July 1, 2023**.
- **Annual maximum**: The annual maximum benefit is $5,000 per covered member, per year.

  Note: The annual maximum travel and lodging benefit for transplants will remain $10,000 per covered member.
- **Ground travel:** Expenses to and from the medical care facility with a personal automobile are determined using the standard IRS mileage rate in effect at the time of the travel. The current mileage reimbursement rate is $.22 per mile.
  - Other ground travel can include rental car to and from medical care facility, gas for rental car (if not using personal vehicle), buses/shuttle services, taxis/ride share services, parking fees and tolls.
- **Air travel**: Only coach airfare is eligible; first-class or the cost of upgraded seating is <u>not</u> covered.
- **Lodging:** Lodging is an eligible expense if incurred directly enroute from the member's residence to the medical care facility and back. One companion is eligible for expenses for patients over the age of 18, and up to two companions for minors. The amounts eligible for lodging are as follows:
  - $50 per day for patient only
  - $100 per day for patient + companion

        - $150 per day for minor patient + 2 companions
    - The lodging expense is covered at the lesser of the actual lodging charges, or $50 for the member and $50 for companion, for a maximum of $100 per night ($150 if patient is a minor with 2 companions).
    - Lodging expense is for a hotel or motel only.
- **Eligible Expenses:** Expenses may be eligible only if associated covered medical service is obtained at the closest in-network provider to the member's residence or temporary work location.
    - Deductibles and coinsurance will apply.
    - Expenses must be incurred within two days before/after the qualifying claim date of service.
    - Travel and lodging expenses incurred for care from an out-of-network provider are not eligible expenses and will not be covered.
- **Submitting Claims**
    - The member is responsible for the payment of services rendered and should validate covered expenses prior to submitting claims.
    - Travel and lodging claim forms should not be submitted until Anthem has a qualified medical claim on file.
    - Valid receipts must be submitted for the eligible expenses. All receipts must be legible and itemized to include, but is not limited to, name, date, time, amounts and purpose. Credit card and bank statements are not acceptable documentation.
    - Photocopies of itemized receipts, the completed claim form and any supporting documentation should be remitted to TravelandLodgingOHINKYWIMO@anthem.com.

Takeaways

- If covered medically necessary care cannot be obtained at an in-network provider within 75 miles of member's primary residence or temporary work location, then eligible travel and lodging expenses can be treated as eligible claims under the Plan, provided such care is obtained at the closest in-network provider to the member's residence or temporary work location.
- Effective for eligible expenses incurred on or after January 1, 2023. Deductible and co-insurance apply.
- IRS limits apply to mileage and lodging.
- Annual maximum travel and lodging benefit per covered member is $5,000.

Questions

For questions about these changes, please contact Marathon Petroleum Benefits Service Center by creating a Case in Workday, or calling 1-888-421-2199, option 1, then option 3.

This Summary of Material Modifications ("Summary") is a supplement to the Summary Plan Description ("SPD") and official Plan document for the Marathon Petroleum Retiree Health Plan (the "Plan"). Please review this Summary carefully and keep it with your copy of the SPD and official Plan document for future reference. The SPD and official Plan document is available online at www.myMPCbenefits.com at the following link: http://www.mympcbenefits.com/Documents/MPC-Health-Plan.pdf or on request by contacting the Marathon Petroleum Benefits Service Center at 1-888-421-2199 or via email to Benefits@MarathonPetroleum.com. Coverage under the Plan is determined under the terms of the Plan as reflected in the Plan document and this Summary. Nothing in this Summary creates a right to be covered under the Plan. Receipt of this Summary does not guarantee that the recipient is a participant under the Plan and/or otherwise eligible for benefits under the Plan. Marathon Petroleum Company LP reserves the right to make changes or to terminate the Plan for any reason at any time, without prior notice to or consent from any employee, former employee, participant or former participant (or their beneficiaries). If there is any inconsistency between this Summary and the official Plan document, the official Plan document will control to the extent not amended by this Summary. If you have any questions regarding these changes to the Plan, please contact the Marathon Petroleum Benefits Service Center at the telephone number or email provided above, or at the following address: Marathon Petroleum Benefits Service Center, Room M-09-088, 539 S. Main Street, Findlay, Ohio 45840.

ERISA PLAN INFORMATION

Plan Name:	Marathon Petroleum Retiree Health Plan
Plan Sponsor:	Marathon Petroleum Company LP
Plan Sponsor's EIN:	31-1537655
Plan Number:	561
Plan Type:	The Plan is a group health plan providing medical and prescription drug benefits and consists of self-funded and fully insured coverage options which are administered in part by the Plan Sponsor and in part by various third-party claims administrators through administrative-services-only contracts.