Execution Version

MARATHON OIL COMPANY

CAFETERIA PLAN

Amended and Restated Effective January 1, 2019

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ARTICLE I
PURPOSE

1.01 Purpose of Plan. The Company has established the Plan as hereinafter set forth to provide its Employees with the ability to purchase certain employee benefits on a pre-tax basis through salary reduction. Specifically, the Plan allows an Eligible Employee to pay for his or her share of premiums and contributions under the Premium Payment Arrangement on a pre-tax, salary reduction basis. In addition, the Plan allows an Eligible Employee to contribute on a pre-tax, salary reduction basis to accounts for reimbursement of certain qualifying medical, dental and vision and dependent care expenses under the respective HSA, Limited Purpose Health Care FSA and Dependent Care FSA. Only Employees may participate in the Plan, and the provisions described in the Plan shall apply uniformly to all participants.

1.02 Qualification. This Plan is intended to qualify as a "cafeteria plan" within the meaning of Code section 125 such that salary reductions under the Premium Payment Arrangement, the Limited Purpose Health Care FSA, and the Dependent Care FSA will be eligible for exclusion from Participants' taxable income. It is intended that the Limited Purpose Health Care FSA meet the requirements of ERISA, operate in accordance with the rules under Code section 125, and qualify as an "accident and health plan" within the meaning of Code section 105(e) such that contributions and reimbursements will be eligible for exclusion from Participants' taxable income under Code sections 105(a) and 105(b), respectively. It is intended that the Dependent Care FSA qualify as a dependent care assistance program within the meaning of Code section 129 such that contributions and reimbursements will be eligible for exclusion from Participants' taxable income under Code section 129(a). It is intended that the HSA qualify as an HSA arrangement within the meaning of Code section 223 such that contributions will be excludable from Participants' taxable income under Code section 106(d). To the extent that a provision of this Plan relates to a requirement of the Code or ERISA, it must be interpreted to impose such requirement, but only to the extent required by law, unless the terms of the provision expressly provide otherwise.

1.03 Restatement of the Plan. This Plan is an amendment and restatement of the Prior Plan, which was initially effective April 1, 1990. The Marathon Oil Company Flexible Spending Account Plan (Effective January 1, 2014) (Plan Number 525) is merged into the Plan effective January 1, 2019, and by this restatement, this Plan is expanded to include the Limited Purpose Health Care FSA, the Dependent Care FSA, and the HSA.

1.04 Definitions and Interpretation. The capitalized words and phrases used throughout the Plan have the meanings set forth in Article II. The Plan is to be interpreted in accordance with the principals set forth in Article III.

1.05 Rights of Employees Not Expanded. Neither the Plan, nor the action of an Employer in establishing or continuing the Plan, nor participation in the Plan may be construed as giving any person the right to be employed by or remain employed with an Employer or, except as provided in the Plan, the right to any payment or benefit.

1.06 Application of ERISA. The Limited Purpose Health Care FSA portion of the Plan is an "employee welfare benefit plan" within the meaning of ERISA section 3(1). Certain

requirements of ERISA, including the fiduciary responsibility provisions, apply to the Limited Purpose Health Care FSA, as referenced in Article XII. The Premium Payment Arrangement, the Dependent Care FSA, and the HSA portions of the Plan are not subject to the requirements of ERISA, and the Plan shall not be interpreted as applying the requirements of ERISA to such portions of the Plan.

1.07 Unfunded Plan. The Plan is an unfunded plan without a trust or any other separate funding vehicle. Plan bookkeeping accounts are maintained, including for amounts attributable to Employee pre-tax salary reduction elections. Employer contributions towards coverage are paid from the general assets of the Employer.

ARTICLE II
DEFINITIONS

Whenever used in the Plan, the following terms, when capitalized, shall have the respective meanings indicated, unless otherwise expressly provided herein.

2.01 "Accidental Death & Dismemberment Benefit" means the accidental death and dismemberment benefit provided to Participants by the Employer as described in the Summary Plan Description.

2.02 "Benefit Option" means any of the following benefits which Eligible Employees can elect and pay for with pre-tax salary reduction contributions: the Medical Benefit, the Dental Benefit, the Vision Benefit, the Accidental Death & Dismemberment Benefit, the Level Premium Life Insurance Benefit, the CIGNA International Health Plan, the Limited Purpose Health Care Flexible Spending Account, the Dependent Care Flexible Spending Account, and the Health Savings Account.

2.03 "CIGNA International Health Plan" means the international medical, dental, and drug plan provided to Participants who accept a long-term assignment abroad, as described in the certificate of coverage provided by Cigna.

2.04 "Code" means the Internal Revenue Code of 1986, as amended from time to time.

2.05 "Company" means Marathon Oil Company or any successor entity by merger, consolidation, purchaser or otherwise, unless such successor entity elects not to adopt the Plan."

2.06 "Controlled Group" means the Company and any other entity or organization required to be aggregated with the Company pursuant to Section 414(b), (c), (m), (n) or (o) of the Code.

2.07 "Controlled Group Entity" means an entity or organization that is part of the Controlled Group.

2.08 "Dental Benefit" means the dental benefit provided to Participants by the Employer, as described in the Summary Plan Description.

2.09 "Dependent" means a beneficiary of a Participant as designated or determined under the terms of a Benefit Option, as described in the applicable Summary Plan Description.

2.10 "Dependent Care Account" means the individual account established under the Plan in the name of each Participant for the purpose of accounting for credits and for benefits for Qualifying Dependent Care Expenses paid for or on behalf of the Participant.

2.11 "Dependent Care Flexible Spending Account" or **"Dependent Care FSA"** means the Employer's Dependent Care Flexible Spending Account as described in Article V and in the Summary Plan Description.

2.12 "Effective Date" means January 1, 2019.

2.13 "Election" means the elections a Participant makes for the Plan Year in his or her Election and Pay Reduction Arrangement.

2.14 "Election and Pay Reduction Arrangement" means the arrangement through which the Employer allows each Eligible Employee to elect benefits under the Plan and specify salary reduction amounts. This Election and Pay Reduction Arrangement may be undertaken through electronic means.

2.15 "Eligible Employee" means an Employee who satisfies the requirements of Section 3.01.

2.16 "Employee" means each individual employed by an Employer as reported on the Employer's payroll records, including such an employee who is on a leave of absence. "Employee" does not include:

(a) any individual who performs services for an Employer pursuant to a leasing agreement between an Employer and a third-party, regardless of whether such individual is later determined by a court or any governmental or administrative agency to be, or to have been, a common law employee of an Employer; and

(b) any individual who performs services for an Employer and is working in a classification described as independent contractor, is paid directly or indirectly through an Employer's accounts payable systems, or performs such services pursuant to a contract or agreement which provides that the individual is an independent contractor or consultant, regardless of whether any such individual is later determined by a court or any governmental or administrative agency to be, or to have been, a common law employee of an Employer.

2.17 "Employer" means the Company and any other related corporation, trade or business from time-to-time listed on Appendix A which has adopted the Plan pursuant to Article XIV.

2.18 "ERISA" means the Employee Retirement Income Security Act of 1974, as amended from time to time.

2.19 "Fiduciary" means a person who has discretionary authority over the administration of the Limited Purpose Health Care FSA within the meaning of ERISA section 3(21).

2.20 "FMLA Leave" means leave under the Family and Medical Leave Act of 1993, as amended from time to time.

2.21 "High-Deductible Health Plan" means the high-deductible health plan offered by the Company as a Medical Benefit Option that is intended to qualify as a high-deductible health plan under Code section 223(c)(2), as described in the Summary Plan Description.

2.22 "Highly Compensated Employee" for purposes of Section 2.23, means an Employee who:

(a) performs services for the Employer during the determination year; and

(b) for the look-back year received compensation (as defined in Code section 415(c)(3), including elective deferrals as defined in Code section 402(g) and amounts excludible from salary under Code sections 125, 132(f)(4), or 457) in excess of $120,000 (for 2018), as adjusted to reflect cost-of-living increases; and

(c) was a Participant of the top 20% of Employees during the look-back year when ranked on the basis of compensation received during the year.

For purposes of the Dependent Care FSA, "Highly Compensated Employee" means an Employee who is:

(a) a more-than-5 percent owner; or

(b) for the look-back year received compensation (as defined in Code section 415(c)(3), including elective deferrals as defined in Code section 402(g) and amounts excludible from salary under Code sections 125, 132(f)(4), or 457) in excess of $120,000 (for 2018), as adjusted to reflect cost-of-living increases; and was a Participant of the top 20% of Employees during the look-back year when ranked on the basis of compensation received during the year.

For purposes of this definition of Highly Compensated Employee, the "determination year" is the Plan Year, and the "look-back year" is the 12-month period immediately preceding the determination year.

2.23 "Highly Compensated Individual" means, with respect to Code section 125, a 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), Highly Compensated Individual means 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.

2.24 "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

2.25 "HSA or Health Savings Account" means an individual trust or custodial account described in Article VII, which is established under Code section 223 by an Employee with a trustee/custodian that has contracted with the Employer to receive pre-tax salary reduction contributions. Although funded by salary reduction under this Plan, the HSA is not part of or intended to be part of an ERISA-covered benefit plan.

2.26 "HSA Benefit" has the meaning described in Section 7.01.

2.27 "HSA-Eligible Individual" means an individual who is eligible to contribute to an HSA under Code section 223, who has elected the High Deductible Health Plan, and who, in the reasonable belief of the Employer, has not elected any disqualifying non-High Deductible Health Plan coverage.

2.28 "Key Employee" means any person who is a key employee as defined in Section 416(i)(1) of the Code.

2.29 "Limited Purpose Health Care Account" means an account established under the Plan in the name of each Participant for the purpose of accounting for credits and for benefits for Qualifying Limited Purpose Dental and Vision Expenses as described in Article VIII paid for or on behalf of the Participant.

2.30 "Limited Purpose Health Care Flexible Spending Account" or **"Limited Purpose Health Care FSA"** means the Employer's Limited Purpose Health Care Flexible Spending Account as described in Article VIII and in the Summary Plan Description.

2.31 "Level Premium Life Insurance Benefit" means the level premium life insurance benefit provided to Participants by the Employer as described in the Summary Plan Description.

2.32 "Medical Benefit" means the medical benefit provided to Participants by the Employer as described in the Summary Plan Description.

2.33 "Named Fiduciary" means a named fiduciary within the meaning of ERISA section 402(a)(2).

2.34 "Participant" means any Employee who participates in the Plan in accordance with Article III.

2.35 "Plan" means the Marathon Oil Company Cafeteria Plan, as set forth herein, as amended from time to time thereafter.

2.36 "Plan Administrator" as defined in section 3(16)(A) of ERISA means the Benefits Administrative Committee or "BAC."

2.37 "Plan Year" means a twelve (12) consecutive month period beginning January 1 and ending on December 31.

2.38 "Premium Payment Arrangement" means the Employer's Premium Payment Arrangement described in Article IV, which allows each Participant to pay for his or her share of the contribution or premium for the Medical Benefit, the Dental Benefit, the Vision Benefit, the Accidental Death & Dismemberment Benefit, the Level Premium Life Insurance Benefit, and the CIGNA International Health Plan on a pre-tax basis.

2.39 "Prior Plan" means the Marathon Oil Company Contribution Conversion Plan.

2.40 "Protected Health Information" means individually identifiable health information (within the meaning of 45 CFR § 160.103) that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium, subject to the exclusions listed in 45 CFR § 160.103.

2.41 "Qualifying Dependent Care Expenses" means expenses that are eligible to be reimbursed from the Dependent Care FSA, as described in Section 5.06.

2.42 "Qualifying Limited Purpose Dental and Vision Expenses" means expenses that are eligible to be reimbursed from the Limited Purpose Health Care FSA, as described in Section 8.08.

2.43 "Spouse" means an individual who is lawfully married to a Participant. An individual shall be considered lawfully married regardless of where the individual is domiciled, if either of the following apply: (1) the individual is married in a state, possession or territory of the U.S. and the individual is recognized as lawfully married in that state, possession or territory of the U.S. or (2) the individual was married in a foreign jurisdiction and the laws of at least one state, possession or territory recognize him or her as lawfully married. Notwithstanding any language to the contrary, for purposes of the Dependent Care FSA, the term "Spouse" does not include (a) an individual legally separated from the Participant under a divorce or separate maintenance decree; or (b) an individual who, although married to the Participant, files a separate federal income tax return, maintains a principal residence separate from the Participant during the last six months of the taxable year, and does not furnish more than half of the cost of maintaining the principal place of abode of the Participant.

2.44 "Summary Plan Description" means the Summary Plan Description for the Marathon Oil Company Health and Welfare Plan.

2.45 "Vision Benefit" means the vision benefit offered to Participants by the Employer, as described in the Summary Plan Description.

ARTICLE III
ELIGIBILITY AND PARTICIPATION

3.01 Eligibility.

(a) **Eligibility Requirements.** An Eligible Employee is an Employee who satisfies any conditions described in the Summary Plan Description applicable to a particular Benefit Option.

(b) **Effective Date of Participation.** An Employee shall be eligible to participate in the Plan on the first date of employment or, if later, the date that such Employee satisfies all requirements for participation described in the Summary Plan Description applicable to a particular Benefit Option.

3.02 Election to Participate.

(a) Participation in the Premium Payment Arrangement is automatic, and no completion of election forms is required. Eligible Employees participate in the Premium Payment Arrangement upon employment with the Employer at the same time they elect to participate in the Medical Benefit, the Dental Benefit, the Vision Benefit, the Accidental Death & Dismemberment Benefit, the Level Premium Life Insurance Benefit, and/or the CIGNA International Health Plan. This is deemed to constitute the Election and Pay Reduction Arrangement.

(b) For the Limited Purpose Health Care Flexible Spending Account and the Dependent Care Flexible Spending Account, an Eligible Employee may become a Participant in the Plan for that Plan Year by entering into an Election and Pay Reduction Arrangement with the Employer during his or her first 30 days of employment, within 30 days after he or she first becomes eligible (if later), or during any subsequent annual benefits open enrollment period. For the Limited Purpose Health Care Flexible Spending Account, an Eligible Employee must also be enrolled in a High-Deductible Health Plan in order to become a Participant.

(c) For the Health Savings Account, an Eligible Employee may become a Participant at any time during the Plan Year by entering into an Election and Pay Reduction Arrangement with the Employer, provided he or she is enrolled in a High-Deductible Health Plan.

3.03 Cessation of Participation. A Participant shall cease to be a Participant as of the earliest of:

(a) the date on which the Plan terminates;

(b) the end of the Plan Year if the Participant: (i) does not make an election to receive benefits under the Limited Purpose Health Care FSA or Dependent Care FSA, and (ii) waives coverage under all other Benefit Options for the next Plan Year;

(c) the date on which the Participant's Election and Pay Reduction Arrangement expires or is terminated under the Plan;

(d) the date on which the Participant revokes coverage pursuant to the Family

and Medical Leave Act;

(e) the date on which the Participant terminates employment with the Employer;

(f) the date on which the Participant ceases to be an Eligible Employee; or

(g) the date on which the Participant dies.

3.04 Reinstatement During Plan Year. If a Participant terminates employment with the Employer and is rehired within thirty (30) days, his or her Benefit Option elections (and corresponding compensation reduction agreement) in effect at the time of the Participant's termination of employment will automatically resume and, subject to Article VI, remain in effect for the balance of the Plan Year in which re-employment occurs; provided, however, to the extent such Benefit Options or previously elected levels of coverage are no longer available due to a modification of the Benefit Options, a change in the Employee's classification or otherwise, the Participant shall be deemed to have elected those Benefit Options and levels of coverage determined by the Plan Administrator to be the default elections in like circumstances. Any other rehired Employee shall be treated as a new Employee for purposes of this Plan.

3.05 Continuation of Coverage. Pursuant to Code section 4980B, any qualified beneficiary (as defined in Code section 4980B(g)(1)), who would lose coverage under the Limited Purpose Health Care FSA as a result of a qualifying event (as defined in Code section 4980B(f)(3)) can elect, within a stated election period, continuation of coverage of benefits previously received under the Limited Purpose Health Care FSA. If a qualified beneficiary timely elects continuation coverage, the benefits elected will be available for the time period prescribed by law (*i.e.*, the end of the Plan Year).

3.06 Absence from Employment Due to Military Service. If an Eligible Employee is absent from employment due to qualifying military service, coverage and benefits will be provided in accordance with the Uniformed Services Employment and Reemployment Rights Act ("USERRA").

ARTICLE IV
PREMIUM PAYMENT ARRANGEMENT

4.01 Generally. Eligible Employees may choose to participate in the Premium Payment Arrangement. The purpose of the Premium Payment Arrangement is to allow Eligible Employees to purchase coverage or make contributions to coverage on a pre-tax basis by paying for Qualifying Expenses through pre-tax salary reduction. This Plan is intended to qualify as a "cafeteria plan" within the meaning of Code section 125 such that salary reductions under the Premium Payment Arrangement will be eligible for exclusion from Participants' taxable income.

4.02 Benefits. The Plan permits Eligible Employees to pay for the cost of the following coverage on a pre-tax salary reduction basis:

(a) the Medical Benefit;

(b) the Dental Benefit;

(c) the Vision Benefit;

(d) the Accidental Death & Dismemberment Benefit;

(e) the Level Premium Life Insurance Benefit; and

(f) the CIGNA International Health Plan

The type and amount of benefits offered under the types of coverage listed above are subject to and governed by the terms and conditions of such coverage. This Plan shall not apply to basic life insurance, occupational accidental death benefits, or long-term disability insurance paid by the Employer or to any premiums paid by the Eligible Employee on an after-tax basis.

4.03 Qualifying Expenses. Qualifying Expenses are all or a portion of the costs for the benefits made available to an Eligible Employee under Section 4.02. The Employer shall notify the Participant prior to the beginning of the Plan Year what portion of the cost of these benefits set forth in Section 4.02 are the sole financial responsibility of the Participant. Qualifying Expenses include all or a portion of the costs for insurance premiums required to be paid by an Eligible Employee, or the contributions for self-funded coverage required to be paid by an Eligible Employee.

ARTICLE V
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

5.01 Generally. Eligible Employees may choose to salary reduce their compensation on a pre-tax basis under the Dependent Care FSA. The purpose of the Dependent Care FSA is to allow Eligible Employees to receive reimbursement for Qualifying Dependent Care Expenses not reimbursed by any other plan or claimed as an income tax credit. It is intended that the Dependent Care FSA qualify as a dependent care assistance program within the meaning of Code section 129, such that contributions and reimbursements will be excludable under Code section 129(a).

5.02 Establishment of Account. An Employer establishes and maintains on its books a Dependent Care Account for each Participant who has elected to participate in the Dependent Care FSA. Each Plan Year is accounted for separately.

5.03 Crediting of Account. A Participant's Dependent Care Account for each Plan Year is credited, as of each date compensation is paid to the Participant in such Plan Year (including the final date on which compensation is paid to a Participant terminating from employment), an amount equal to the reduction made in such compensation in accordance with the Participant's Election and Pay Reduction Arrangement. All amounts credited to a Dependent Care Account are the property of the Employer until paid out.

5.04 Debiting of Account. A Participant's Dependent Care Account for each Plan Year is debited from time to time in the amount of any payment to or for the benefit of the Participant for Qualifying Dependent Care Expenses, as provided in Section 5.06, only if the Participant applies for reimbursement on or before March 31st of the year following the Plan Year in which the Qualifying Dependent Care Expenses are incurred.

5.05 Forfeiture of Accounts. If any balance remains credited to the Participant's Dependent Care Account after all reimbursements are made for that Plan Year, such balance is not carried over to reimburse the Participant for Qualifying Dependent Care Expenses during a subsequent Plan Year, and is not available to the Participant in any other form or manner. Instead, such balance remains the property of his or her Employer, and the Participant forfeits all rights with respect to such balance.

5.06 Reimbursement of Qualifying Dependent Care Expenses. Each Participant is entitled to receive, for each Plan Year, reimbursement of Qualifying Dependent Care Expenses up to the amount elected by the Participant (not to exceed $5,000). Subject to the last sentence of this Section 5.06, Qualifying Dependent Care Expenses are expenses incurred by a Participant which satisfy the following conditions:

(a) are incurred for the care of a Dependent of the Participant or for related household services; expenses are treated as incurred when the services are provided and not when the Participant is billed, charged for, or pays for the services;

(b) are paid or payable to a dependent care service provider;

(c) are incurred during the Plan Year (expenses are treated as incurred when the dependent care services are provided and not when the Participant is billed, charged for, or pays for the services); and

(d) are incurred to enable the Participant to be gainfully employed for any period for which there are one or more Dependents with respect to the Participant.

Qualifying Dependent Care Expenses do not include expenses incurred for services outside the Participant's household for the care of a Dependent unless such Dependent is: (1) a Dependent of the Participant who is under the age of 13 and who lives with the taxpayer for over half the calendar year, (2) a Dependent of the Participant who is mentally or physically unable to care for himself, lives with the taxpayer for over half the calendar year, and regularly spends at least eight hours each day in the Participant's household, or (3) a Spouse of the Participant who is mentally or physically unable to care for himself, lives with the taxpayer for over half the calendar year, and regularly spends at least eight hours each day in the Participant's household.

5.07 Report to Participants on or Before January 31. On or before each January 31, the Employer will furnish to each Participant who participated in the Dependent Care FSA during the prior calendar year a Form W-2 showing the amount of salary reduction contributions made by that Participant during such year with respect to the Dependent Care FSA.

ARTICLE VI
ELECTION AND PAY REDUCTION ARRANGEMENT

6.01 Period of Coverage; Agreement Generally Irrevocable. Subject to Article III, an Election and Pay Reduction Arrangement is effective for the entire Plan Year beginning after the date of such agreement, or, in the case of an individual who becomes an Eligible Employee on or after the first day of the Plan Year, the remainder of the Plan Year in which such agreement is entered. An Election and Pay Reduction Arrangement is irrevocable during the Plan Year, except as provided in Sections 6.03 through 6.10.

6.02 Limits on Salary Reduction Amounts Elected. The limits on salary reduction amounts that a Participant may elect in an Election and Pay Reduction Arrangement shall be determined by the Employer and are set forth in Sections 4.03, 5.06, and 8.06.

6.03 Change in Election Due to Change in Status. A change in Election during the Plan Year is allowed if the following three conditions are satisfied:

(a) One or more of the following "change in status" events occur:

(1) marriage;

(2) divorce;

(3) legal separation;

(4) annulment;

(5) death of Spouse or Dependent;

(6) birth, adoption of child, or placement for adoption of child;

(7) change in the employment status of the Employee, Spouse or Dependent;

(8) a Dependent satisfying or ceasing to satisfy eligibility requirements; or

(9) change in the place of residence of the Employee, Spouse or Dependent.

(b) The proposed change in Election is on account of and corresponds with that change in status (*i.e.*, the proposed change bears a logical relationship to the event that has occurred) (note that this requirement does not apply to the Level Premium Life Insurance Benefit); and

(c) The change in status affects eligibility under the applicable Benefit Option(s) (*i.e.*, an Employee, Spouse or Dependent either gains or loses coverage in response to an event) (note that this requirement does not apply to the Level Premium Life Insurance Benefit).

6.04 Dependent Care FSA Election Changes. With respect to the Dependent Care FSA only, an Employee may change his or her election if there occurs any event that causes a dependent to no longer meet the definition of Dependent or the Employee provides documentation that demonstrates that he or she has experienced an increase or decrease in dependent care provider fees (except for increases by a provider who is related to the Employee), he or she chooses a different dependent care provider who charges a different amount, or he or she makes a change to his or her or his or her Spouse's regular work schedule that increases or decreases his or her need for dependent care.

6.05 Change in Election Due to Certain Other Events. A Participant may change his or her Election during the Plan Year with respect to the Medical Benefit, Dental Benefit, Vision Benefit, the CIGNA International Health Plan, or the Limited Purpose Health Care FSA if one of the following events occurs:

(a) A special enrollment right under HIPAA (only for Medical Benefit). A Participant may also enroll other eligible individuals when a Spouse or Dependent gains eligibility as a result of a HIPAA special enrollment right;

(b) A judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody requiring that an Employee's child receive accident or health coverage under a plan (including a Qualified Medical Child Support Order) (only for benefits identified in the judgment, decree or order); or

(c) A Participant's enrollment in Medicare or Medicaid (for Medical Benefit, Dental Benefit, Vision Benefit, Accidental Death & Dismemberment Benefit, CIGNA International Health Plan, or Limited Purpose Health Care FSA) or, if enrolled in Medicare or Medicaid, loss of eligibility for Medicare or Medicaid.

6.06 Change in Cost or Coverage of a Benefit Option. Generally, a Participant may not change his or her election in response to a change in cost or coverage of a Benefit Option. However, the Plan Administrator, in its sole discretion, shall have the ability to allow Participants to make mid-year changes in election with respect to the Benefit Options other than the Limited Purpose Health Care FSA, as described in this Section.

(a) **Automatic Cost Changes.** If the cost of a Benefit Option increases (or decreases) during a period of coverage, the Plan Administrator may, on a reasonable and consistent basis, automatically make a prospective increase (or decrease) in the Participant's pre-tax contributions.

(b) **Significant Cost Changes.** If the cost charged to Employees for a Benefit Option significantly changes, the Plan Administrator may, on a reasonable and consistent basis, allow Participants to make a corresponding change in pre-tax contributions.

(c) **Significant Curtailment.** If Employees have a significant curtailment of coverage under a Benefit Option (for example, there is a significant increase in the deductible, the copay, or the out-of-pocket cost sharing limit under the Medical Benefits), the Plan Administrator

may, on a reasonable and consistent basis, allow Participants to revoke their elections and receive any similar coverage available under the Plan.

(d) **Significant Curtailment that is a Loss of Coverage.** If coverage is curtailed so significantly that it amounts to a loss of coverage, the Plan Administrator may, on a reasonable and consistent basis, allow Participants to revoke their elections and, in lieu thereof, elect either to receive on a prospective basis similar coverage available under the Plan or drop coverage if no similar coverage is available.

(e) A loss of coverage for purposes of subparagraph (d) means a complete loss of coverage under the option. This includes the elimination of an option, an HMO ceasing to be available, or a substantial decrease in the medical care providers available under the option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the physicians participating in a preferred provider network or an HMO).

(f) **Addition or Improvement of an Option.** If a Benefit Option adds an option or if coverage under an existing Benefit Option is significantly improved during a period of coverage, the Plan Administrator may, on a reasonable and consistent basis, allow Employees (whether or not they have previously made an election) to revoke their election and, in lieu thereof, make an election on a prospective basis for the improved option.

(g) **Change in Coverage under Another Employer Plan.** An Employee may make a prospective election change that is on account of and corresponds with a change made under another employer plan (including a plan of the same employer or of another employer) if: (i) the other cafeteria plan is administered in a manner that is consistent with the cafeteria plan regulations setting forth permitted election changes, or (ii) the other cafeteria plan permits participants to make an election for a period of coverage that is different from the period of coverage under the Plan.

6.07 Timing of Election Changes and Other Limitations. To the extent that an Eligible Employee may change his or her election during the Plan Year with respect to a Benefit Option as set forth under Sections 6.02, 6.03, 6.04, 6.05 and/or 6.06, such election change must be made within 31 days from the date of the relevant event, except for purposes of certain HIPAA special enrollment rights for which an election to enroll is permitted to be made within 60 days of the relevant event under applicable guidance or to the extent that a longer period to change such an election is legally required. Further, notwithstanding anything herein to the contrary, to the extent that an Eligible Employee may change his or her election during the Plan Year with respect to the Limited Purpose FSA and/or the Dependent Care FSA as set forth under Sections 6.02, 6.03, 6.04 and/or 6.06, such Eligible Employee cannot reduce his or her contributions to such flexible spending account to an amount less than what has already been deducted or reimbursed.

6.08 Health Savings Account. Nothwithstanding anything herein to the contrary, with respect solely to the HSA, a Participant who makes an election to contribute an amount on a pre-tax salary reduction basis to his or her HSA may change such election on a prospective basis at any time during the Plan Year. Such election change request will be promptly processed by the Plan Administrator and will be effective on the earliest date that is administratively feasible.

6.09 Required Change in Election. A Participant's election will be changed as necessary pursuant to Section 10.05 to comply with the applicable nondiscrimination rules.

6.10 Change in Election Due to FMLA Leave. Notwithstanding Section 3.04, a Participant on FMLA Leave may change or revoke his or her Election under the Premium Payment Arrangement with respect to the Medical Benefit, the Dental Benefit, the Vision Benefit, the Accidental Death & Dismemberment Benefit, or the Limited Purpose Health Care FSA, subject to the following limitations:

(a) **Revoking Coverage.** A Participant absent on FMLA Leave may elect to cease participation in the Premium Payment Arrangement or the Limited Purpose Health Care FSA at the time the leave begins.

(b) **Resuming Coverage.** Upon return to employment as an Eligible Employee from FMLA Leave, a Participant who has revoked coverage under the Premium Payment Arrangement may elect to reinstate his or her coverage on a prospective basis, but only at the level of coverage in effect under the Premium Payment Arrangement before his FMLA Leave began (adjusted to conform to any amendments to the Plan or a Benefit Option made during the period of FMLA Leave). With respect to the Limited Purpose Health Care FSA, the preceding sentence applies, except that a Participant may either (1) make up the contributions that were due during the period of FMLA Leave, in which case the Participant will resume coverage at the same annual amount elected before FMLA Leave began, or (2) not make up such contributions, with the annual amount of coverage reduced accordingly.

(c) **Continuing Coverage.** A Participant on FMLA Leave who wishes to continue participation in the Plan during FMLA Leave may make up all the contributions that were due during the period of FMLA Leave on an after-tax basis upon return to employment. Failure to pay such premiums will result in the discontinuance of coverage under the Plan during the leave period.

(d) **FMLA Generally.** It is the responsibility of the Employer to determine if it is bound by FMLA and, if so, to ensure the requirements are met in accordance with the rights and provisions described by law.

ARTICLE VII
HEALTH SAVINGS ACCOUNT

7.01 HSA Benefit. An Eligible Employee can elect to participate in the HSA by electing to salary reduce on a pre-tax basis to the Employee's HSA established and maintained outside the Plan by a trustee/custodian with which the Employer has entered into an agreement to forward contributions to be deposited (this funding feature constitutes the HSA Benefit offered under this Plan). It is intended that the HSA qualify as an HSA arrangement within the meaning of Code section 223 such that contributions will be excludable from Participants' taxable income under Code section 106(d). As described in Article VI, such election can be increased, decreased or revoked prospectively at any time during the Plan Year, effective on the earliest date that is administratively feasiable.

7.02 Contributions for Cost of Coverage for HSA; Maximum Limits. The annual contribution for a Participant's HSA Benefit is equal to the annual benefit amount elected by the Participant, but in no event shall the amount elected exceed the statutory maximum amount for HSA contributions applicable to the Participant's High-Deductible Health Plan coverage option (i.e., single or family) for the calendar year in which the Contribution is made ($3,500 for single and $7,000 for family are the statutory maximum amounts for 2019). An additional catch-up contribution of $1,000 (or such other amount as may be provided by applicable law) may be made for Participants who are age 55 or older.

In addition, the maximum annual contribution shall be:

(a) reduced by any matching (or other) Employer contribution made on the Participant's behalf;

(b) prorated for the number of months in which the Participant is an HSA-Eligible Individual to the extent required under Code section 223 and applicable guidance; and

(c) subject to any other required limitation under Code section 223 or other applicable guidance.

7.03 Recording Contributions for HSA. As described in Section 7.05, the HSA is not an employer-sponsored employee benefit plan subject to ERISA—it is an individual trust or custodial account separately established and maintained by a trustee/custodian outside the Plan. Consequently, the HSA trustee/custodian, not the Employer, will establish and maintain the HSA. The Employer will identify an HSA provider or providers to whom it will forward contributions that the Participant makes via an Election and Pay Reduction Arrangement —such choice is not an endorsement of any particular HSA provider. The Plan Administrator will maintain records to track HSA contributions a Participant makes pursuant to the Election and Pay Reduction Arrangement, but it will not create a separate fund or otherwise segregate assets for this purpose. The Employer has no authority or control over the funds deposited in an HSA.

7.04 Tax Treatment of HSA Contributions and Distributions. The federal income tax treatment of the HSA (including contributions and distributions) is governed by Code section 223.

7.05 Trust/Custodial Agreement; HSA Not Intended to Be an ERISA Plan. HSA Benefits under this Plan consist solely of the ability to make contributions to the HSA pursuant to the Election and Pay Reduction Arrangement. The terms and conditions of each Participant's HSA trust or custodial account are described in the HSA trust or custodial agreement provided by the applicable trustee/custodian to each electing Participant and are not a part of this Plan or subject to ERISA.

ARTICLE VIII
LIMITED PURPOSE HEALTH CARE FLEXIBLE SPENDING ACCOUNT

8.01 Generally. Eligible Employees may choose to reduce their compensation on a pre-tax basis under the Limited Purpose Health Care FSA. The purpose of the Limited Purpose Health Care FSA is to allow Eligible Employees to receive reimbursement for Qualifying Limited Purpose Dental and Vision Expenses that are not reimbursed by any other plan or claimed as an income tax deduction. It is intended that the Limited Purpose Health Care FSA operate in accordance with the rules under Code section 125 and qualify as an "accident and health plan" within the meaning of Code section 105(e) such that contributions and reimbursements will be eligible for exclusion from Participants' taxable income under Code sections 105(a) and 105(b), respectively.

8.02 Establishment of Account. An Employer establishes and maintains on its books a Limited Purpose Health Care Account for each Participant who elects to participate in the Limited Purpose Health Care FSA. Each Plan Year is accounted for separately.

8.03 Crediting of Account. A Participant's Limited Purpose Health Care Account is credited on the first day of the Plan Year with the annual elected amount as reflected on the Participant's Election and Pay Reduction Arrangement. All amounts credited to the Limited Purpose Health Care Account are the property of the Plan until paid out.

8.04 Debiting of Account. A Participant's Limited Purpose Health Care Account for each Plan Year is debited from time to time in the amount of any payment to or for the benefit of the Participant for Qualifying Limited Purpose Dental and Vision Expenses, as provided in Section 8.06, only if the Participant applies for reimbursement on or before March 31 of the year following the Plan Year in which the Qualifying Medical Expenses were incurred.

8.05 Forfeiture of Account. If any balance remains credited to the Participant's Limited Purpose Health Care Account after all reimbursements are made for that Plan Year, such balance is not carried over to reimburse the Participant for Qualifying Limited Purpose Dental and Vision Expenses during a subsequent Plan Year, and is not available to the Participant in any other form or manner. Instead, such balance remains the property of the Employer, and the Participant forfeits all rights with regard to such balance.

8.06 Reimbursement of Qualifying Limited Purpose Dental and Vision Expenses. Each Participant is entitled to receive, for each Plan Year, reimbursement of Qualifying Limited Purpose Dental and Vision Expenses up to the amount elected by the Participant (not to exceed $2,650, or such other amount as determined by the Plan Administrator in its discretion and permitted by law), provided:

(a) such expenses are incurred during the Plan Year (expenses are treated as incurred when the health care services are provided and not when the Participant is billed, charged for, or pays for the services);

(b) such expenses are not reimbursable by the Medical Plan or any other medical benefit plan or coverage; and

(c) such expenses are submitted on or before March 31 of the year following the Plan Year in which the expenses are incurred.

8.07 Debit Card/Credit Card. A Participant may pay for Qualifying Limited Purpose Dental and Vision Expenses with a debit/credit card provided by or on behalf of the Employer, subject to the rules of this Subsection.

(a) **Conditional Charges.** Any debit card/credit card charges that do not fit within one of the categories of automatic substantiation described in Paragraph (b) below are treated as conditional, pending confirmation of the charge. For all conditional charges, a Participant must file a claim for reimbursement with the Employer or a delegate thereof and submit additional third-party information, such as merchant or service provider receipts, for review and substantiation. If, upon review, the Employer or a delegate thereof (including, but not limited to, a designated third party administrator) determines that these charges do not satisfy the definition of vision or dental care within the meaning of Code section 213(d), or preventive care within the meaning of Code section 213(d) as described in IRS Notice 2004-23 and IRS Notice 2013-57, the Employer or a delegate thereof will so notify the Participant. The Employer or a delegate thereof will then recoup the improper payment by requiring the Participant to reimburse the Employer by check, or alternatively, by reducing the Participant's salary on an after-tax basis in an amount equal to the improper payment.

(b) **Automatic Substantiation.** The following categories of debit card/credit card transactions are automatically substantiated without a receipt or further review by the Employer or a delegate thereof :

(1) transactions that take place at a dental or vision provider's office, if the amount of the transaction equals the amount of the Participant's co-payment under the medical plan;

(2) transactions involving a co-payment amount that equals an exact multiple (or combination of co-payments) of not more than five times the dollar amount of the co-payment for the specific service;

(3) transactions where a third-party uses inventory control information to determine whether an expense qualifies as a Qualifying Limited Purpose Medical Expense; and

(4) transactions that are recurring and match previously approved claim.

8.08 Qualifying Limited Purpose Dental and Vision Expenses. Qualifying Limited Purpose Dental and Vision Expenses are any expenses for vision or dental care within the meaning of Code section 213(d), or preventive care within the meaning of Code section 213(d) as described in IRS Notice 2004-23 and IRS Notice 2013-57, incurred by a Participant, Spouse or Dependent. Such expenses do not include premium payments for other coverage, including premiums paid for coverage under a plan maintained by the employer of a Spouse or Dependent. Examples of Qualifying Limited Purpose Dental and Vision Expenses are:

(a) deductibles and co-payments under any Vision or Dental Benefit sponsored by the Employer or under any other vision or dental benefit plan of the Participant, Spouse or Dependents;

(b) dental care, including routine dental checkups, orthodontic work, and dentures;

(c) prescription medicine and drugs and over-the-counter medicine and drugs (if a prescription is obtained) purchased to remedy current vision or dental conditions or for preventive care for the Participant, Spouse, or Dependents; and

(d) eye care, including vision checkups, eyeglasses and contact lenses.

8.09 Refund of Duplicate Reimbursement. If a Participant receives reimbursement under the Limited Purpose Health Care FSA, and reimbursement for the same expense is made under another plan, he or she is required to refund the reimbursement under the Limited Purpose Health Care FSA to his or her Employer. The amount of the Participant's elected coverage under the Plan, to the extent of any such refund, is reinstated for the Plan Year in which the reimbursement was originally made.

ARTICLE IX
CONTRIBUTIONS

9.01 Funding Arrangement. The Employer may, in its discretion, credit an amount under the Plan each Plan Year to be allocated toward the cost of a Participant's elected benefits under his or her Election and Pay Reduction Arrangement. This credited amount, referred to in the Plan for ease of expression as an "employer contribution," will be paid from the Employer's general assets. Before the beginning of each Plan Year, the Employer will determine the annual employer contribution, if any, and the costs for benefit coverage under the Benefit Options and communicate this information to Eligible Employees.

9.02 Participant Contribution. If, after allocation of any employer contribution for the Plan Year, a Participant's elected benefits under his Election and Pay Reduction Arrangement would not fully be paid, the Participant's pay shall be reduced for each applicable payroll period on a pre-tax basis in accordance with his Election and Pay Reduction Arrangement by the amount of the applicable Participant cost.

ARTICLE X
NONDISCRIMINATION

10.01 Highly Compensated Individuals. This 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).

10.02 Key Employees. Payments made under the Plan for or on behalf of Key Employees of the Employer shall not exceed 25-percent of the aggregate of the payments made for or on behalf of all Employees under the Plan, in compliance with the requirements of Code section 125(b)(2).

10.03 Dependent Care FSA. With respect to the Dependent Care FSA, the average benefits provided to employees who are not Highly Compensated Employees shall be at least 55 percent of the average benefits provided to Highly Compensated Employees in compliance with the requirements of Code section 129(d)(8), and the Dependent Care FSA shall not discriminate in favor of Highly Compensated Employees as to eligibility in compliance with Code section 129(d)(3) or as to contributions or benefits in compliance with Code section 129(d)(2).

10.04 Limited Purpose Health Care FSA. With respect to the Limited Purpose Health Care FSA, 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).

10.05 Modification of Election. The Employer shall send a notice to any Participants whose benefits under the Plan would cause the Plan to violate the requirements of this Article X and indicate the salary reduction amount that, if elected by the Participant, would allow the Plan to qualify under the Code by the end of the Plan Year. The Participant so notified under this Article X will then have 30 days to enter into a modified Election and Pay Reduction Arrangement, valid for the remainder of the Plan Year, electing no more than that salary reduction amount. In the absence of a modification, the Participant's participation in the Plan for the Plan Year will be entirely terminated.

ARTICLE XI
BENEFIT CLAIMS AND OTHER PAYMENT PROVISIONS

11.01 Claims

(a) **Reimbursement or Payment of Claims.** The Employer will cause the Participant to be reimbursed for Qualifying Limited Purpose Dental and Vision Expenses and/or Qualifying Dependent Care Expenses for which the Participant submits documentation in accordance with the claims procedures of the Limited Purpose Health Care FSA and the Dependent Care FSA and that are reimbursable under Articles VIII or V, respectively.

(1) **Limited Purpose Health Care FSA.** With respect to the Limited Purpose Health Care FSA, the total amount elected by the Participant for the Plan Year is, at all times, available for reimbursement without regard to whether the claims exceed the balance of the Participant's Limited Purpose Health Care FSA for the Plan Year at the time of the reimbursement.

(2) **Dependent Care FSA.** With respect to the Dependent Care FSA, no reimbursement or payment may at any time exceed the balance of the Participant's Dependent Care FSA for the Plan Year at the time of the reimbursement or payment. Any Qualifying Dependent Care Expenses not reimbursed or paid as a result of the preceding sentence will be reimbursed or paid if and when the balance in such Dependent Care FSA for the Plan Year equals the amount of such expenses.

(3) **Authority of the Plan Administrator.** To the extent of its responsibility to review the denial of benefit claims, the Plan Administrator or its delegate has full authority to interpret and apply in its discretion the provisions of the Plan, and the decision of the Plan Administrator or its delegate is final and binding upon any and all claimants and any person making a claim through or under them. Benefits will be paid only if the Plan Administrator or its delegate decides in its discretion that the claimant is entitled to them.

(b) **Dependent Care FSA Claims Procedures.** The claims procedures for the Dependent Care FSA shall be set forth in a summary plan description or other claims procedure document for the Dependent Care FSA, and the terms of such claims procedures are herein incorporated by reference. A claimant must follow such claims procedures for purposes of making a claim for benefits or appealing a denial of such a claim under the Dependent Care FSA.

(c) **Limits on Right to Judicial Review.** A claimant must follow the claims procedures for the applicable Benefit Option before taking action in any other forum regarding a claim for benefits under the Plan. Except as otherwise provided in an applicable insurance policy for a Benefit Option, any suit or legal action initiated by a claimant under the Plan must be brought by the claimant no later than three years following a final decision on the claim for benefits under these claims procedures. The three year statute of limitations on suits for benefits applies in any forum where a claimant initiates 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. Any such

legal action must be brought in the U.S. District Court for the Southern District of Texas, where the Plan is administered.

ARTICLE XII
ADMINISTRATION AND FIDUCIARY PROVISIONS

12.01 Plan Administrator. The general administration of the Plan shall be vested in a committee, referred to as the Benefits Administrative Committee. For purposes of the Limited Purpose Health Care FSA only, for purposes of ERISA, the Benefits Administrative Committee or "BAC" will serve as the Plan Administrator and named fiduciary for the Plan.

12.02 Appointment of the Committee.

(a) **BAC Membership.** The BAC will consist of the Company's (1) Senior Vice President ("SVP"), HR, Communications and Administrative Services, (2) Director of Compensation and Benefits, and (3) Benefits and Payroll Manager.

(b) **Quorum.** A quorum of the BAC shall consist of two members.

(c) **Committee Action.** Action of the BAC shall be by vote of a majority of the members present at a meeting, or in writing without a meeting and evidenced by the signature of the SVP, HR, Communications and Administrative Services or of any member who is so authorized by such committee.

The Company's SVP, HR, Communications and Administrative Services will serve as the "Appointing Fiduciary" for purposes of the membership of the BAC and will have the authority to remove a member with or without cause and to fill any vacancy that may result therefrom or for any other reason. If there is no SVP, HR, Communications and Administrative Services of the Company then the senior most human resources officer of the Company (or, if such role is vacant, the equivalent position at Marathon Oil Corporation) will serve as the Appointing Fiduciary. Each member of the BAC will serve until he resigns, dies, or is removed by the Appointing Fiduciary. Any member of the BAC who is an Employee will automatically cease to be a member of such committee as of the date he or she ceases to be employed by Company and all Controlled Group Entities.

12.03 Duties and Powers of the BAC. The BAC will supervise the general administration and enforcement of the Plan according to the terms and provisions hereof and shall have the powers necessary to accomplish these purposes. The BAC's authority shall include (not by way of limitation) the authority to construe, in its discretion, all terms, provisions, conditions, and limitations of the Plan.

The Plan Administrator shall be deemed to have delegated its responsibilities for determining benefits and eligibility for benefits to a third party administrator, insurer or other fiduciary where such person has been appointed to make such determinations. In such case, such other person shall have the duties and powers as the Plan Administrator as set forth above, including the complete discretion to interpret and construe the provisions of the Plan.

12.04 Allocation and Delegation of Duties. The BAC may appoint subcommittees, individuals, assistant plan administrators or other agents or third party service providers as it deems advisable and may delegate, with such delegation conferring fiduciary status upon the delegate, to

such appointees any or all of the powers and duties of such committee. Such appointment and delegation must specify in writing the powers or duties being delegated (such as in a written agreement) and must be accepted in writing by the delegate. Upon such appointment, delegation and acceptance, the BAC shall have no liability for the acts or omissions of any such delegate as long as the BAC does not itself violate any fiduciary responsibility in making or continuing such delegation. To the extent that the BAC has so delegated any of its duties, powers or responsibilities pursuant to this Section, references in the Plan to the BAC or the "Plan Administrator" shall be deemed reference to such delegate with respect to such delegated duties, powers or responsibilities.

12.05 Indemnification.

(a) The Company shall indemnify and hold harmless to the fullest extent permitted by law any person who was or is (a) made or is threatened to be made a party or is involved in any proceeding whether civil, criminal, administrative or investigative or who incurs any other liability by reason of any act, or failure to act in relation to the Plan or the funds of the Plan, including without limitation, expenses reasonably incurred in the defense of any claim relating to the Plan or funds of the Plan, and amounts paid in compromise or settlement relating to the Plan or the funds of the Plan, (b) by reason of the fact that he or she, or a person for whom he or she is the legal representative, is or was a director, officer, employee or agent of the Company or another participating Employer serving or acting with respect to the Plan. Any such person shall be indemnified against all expenses, liability, and loss reasonably incurred or suffered by such person; provided, however, that the Company shall indemnify any person seeking indemnity in connection with a proceeding initiated by such person only if the proceeding was authorized by the Board of Directors of the Company.

(b) To the fullest extent authorized by law, and to the extent not first covered by insurance or the Company's indemnity set forth in Section 12.05(a), the Plan Administrator, officers and employees of the Company or another participating Employer or Employers who provide services to the Plan shall be fully indemnified by the Plan against any and all liabilities reasonably incurred or suffered by such person and arising by reason of any act, or failure to act, in relation to the Plan or the funds of the Plan, including without limitation, expenses reasonably incurred in the defense of any claim relating to the Plan or funds of the Plan, and amounts paid in compromise or settlement relating to the Plan or the funds of the Plan; provided, however, that the Plan shall indemnify any person seeking indemnity in connection with a proceeding initiated by such person only if the proceeding was authorized by the Board of Directors of the Company.

12.06 Bonding. The Plan Administrator shall serve without bond and without additional compensation for his or her services.

12.07 Plan Expenses. All fees and expenses incurred in connection with the operation and administration of the Plan, including, but not limited to, Plan Administrator, legal, accounting, actuarial, investment, management, and administrative fees and expenses may be paid out of Plan assets to the extent that it is legally permissible for these fees and expenses to be so paid. The Company may, but is not required, to pay such fees and expenses directly. The Company may also advance amounts properly payable by the Plan and then obtain reimbursement from the Plan for these advances.

12.08 Information to be Supplied by Employer. Each Employer shall provide the Plan Administrator and any delegates thereof with such information as they shall from time-to-time need or reasonably request in the discharge of their duties. The Plan Administrator and any delegates thereof may rely conclusively on the information provided by an Employer.

12.09 HIPAA Compliance.

(a) **Disclosures to Company.** The Plan may disclose participant information to the Company, as permitted under the Standards for Privacy of Individuality Identifiable Health Information, 45 CFR Parts 160 and 164 ("HIPAA Privacy Regulations"). In addition, the Plan may disclose Protected Health Information to the Company as necessary to allow the Company to perform plan administration functions, within the meaning of the HIPAA Privacy Regulations.

(b) **Use of PHI.** The Plan will not use or disclose Protected Health Information, that is genetic information for underwriting purposes.

(c) **Access to Health Information.** The following employees or individuals under the control of the Company shall have access to the Plan's Protected Health Information to be used solely for plan administration functions, within the meaning of the HIPAA Privacy Regulations:

(1) The Plan Administrator;

(2) Members of the benefits, legal, information system, and human resources departments of the Company to the extent they perform functions with respect to the Plan; and

(3) Such other individuals or classes of individuals identified by the Plan's Privacy Officer as necessary for the Plan's administration.

(d) **Company Agreement to Restrictions.** The Plan will not disclose Protected Health Information to the Company until the Company has certified to the Plan that it agrees to:

(1) Not use or disclose Protected Health Information other than as permitted or required by law or as specified above;

(2) Not use or disclose the Protected Health Information in any employment-related decisions or in connection with any other benefit or employee benefit plan of the Company;

(3) Report to the Plan any use or disclosure of Protected Health Information that is inconsistent with the uses and disclosures permitted by law or specified above of which Company becomes aware;

(4) Make Protected Health Information accessible to the subject individual in accordance with the HIPAA Privacy Regulations;

(5) Allow the subject individuals to amend or correct their Protected Health Information and incorporate any amendments to Protected Health Information in accordance with the HIPAA Privacy Regulations;

(6) Make available the information to provide an accounting of its disclosures of Protected Health Information in accordance with the HIPAA Privacy Regulations;

(7) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services for determining compliance;

(8) Return or destroy the Protected Health Information received, if feasible, after it is no longer needed for the original purpose and retain no copies of such information or if not feasible, restrict access and uses to those that make the return or destruction of the information infeasible as required by the HIPAA Privacy Regulations;

(9) Ensure that any agents, including a subcontractor, of the Company to whom the Company provides Protected Health Information shall also agree to these same restrictions;

(10) Ensure that adequate separation between the Company and Plan is established as required under the HIPAA Privacy Regulations and restrict access to Protected Health Information to those classes of Employees or individuals identified in Section 12.09(c); and

(11) Restrict the use of Protected Health Information by those Employees identified in Section 12.09(c) for plan administration functions within the meaning of the HIPAA Privacy Regulations.

(e) **Permitted Disclosure to Company.** Notwithstanding the foregoing, the Plan (or a health insurance issuer with respect to the Plan) may disclose to the Company the following types of information:

(1) Summary health information may be disclosed to the Company if the Company requests the summary health information for the purpose of (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan, or (2) modifying, amending, or terminating the Plan.

(2) Information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer offered by the Plan.

(3) Information provided pursuant to an authorization within the meaning of Section 164.508 of the HIPAA Privacy Regulations.

(4) De-identified information, as defined under the HIPAA Privacy Regulations.

(f) **Noncompliance.** In the event of noncompliance with the restrictions of Section 12.09(a) through (d) by a designated Employee or other individual receiving Protected Health Information on behalf of the Company, the Employee or other individual shall be subject to discipline in accordance with the Company's disciplinary procedures. Complaints or issues of noncompliance by such persons shall be filed with the Plan's Privacy Officer.

(g) **HIPAA Security Standards.**

(1) **Safeguards.** The Company shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Plan, as required under 45 CFR Part 160 and Subparts A and C of Part 164 (the "HIPAA Security Standards").

(2) **Agents.** The Company shall ensure that any agent, including a subcontractor, to whom it provides electronic Protected Health Information agrees to implement reasonable and appropriate safeguards to protect such information.

(3) **Security Incidents.** The Company shall report to the Plan any security incident under the HIPAA Security Standards of which it becomes aware.

(4) **Adequate Separation.** The Company shall establish reasonable and appropriate security measures to ensure adequate separation between the Plan and Company, in support of the requirements described in this Section 12.09.

(h) **Application.** The provisions of this Section 12.09 shall only apply with respect to any Plan health benefits subject to the HIPAA Privacy Regulations or HIPAA Security Standards.

ARTICLE XIII
AMENDMENT AND TERMINATION OF THE PLAN

13.01 Right to Modify and/or Discontinue Plan. The Company reserves the right to amend, modify or terminate this Plan, in whole or in part, in such manner as it shall determine. Such modification or termination can be applied, at the sole discretion of the Company, to any or all types of Participants and their Dependents. If the Plan should be terminated, this will not affect any claim for covered expenses incurred prior to the termination of the Plan.

The Company may exercise its reserved rights of amendment, modification and termination (i) by written resolution by the Board of Directors of the Company, (ii) by written resolution by the Compensation Committee of the Marathon Oil Corporation Board of Directors (the "Corporation Compensation Committee"), (iii) by written resolution or written actions exercised by the Executive Committee of Marathon Oil Corporation that is composed of the Chief Executive Officer of Marathon Oil Corporation ("CEO"), the direct reports of the CEO who are officers of Marathon Oil Corporation and such other employees of the Company or a Controlled Group Entity as the CEO may determine ("ExCom"), or (iv) by written actions exercised by any other entity or person to which or to whom the Board of Directors of the Company, the Corporation Compensation Committee, or the ExCom has specifically delegated rights of amendment, modification and/or termination.

The Company's SVP, HR, Communications and Administrative Services (or, if there is no SVP, HR, Communications and Administrative Services of the Company, then the senior most human resources officer of the Company or, if such role is vacant, the equivalent position at Marathon Oil Corporation) also has the authority to amend and/or modify (but not to terminate) this Plan. This authority shall be exercised in writing.

13.02 Effect of Amendment or Termination. In the event of an amendment to or termination of the Plan as provided under this Article, each Participant shall have no further rights hereunder, and neither the Company, nor any other Employer, shall have further obligations hereunder except as otherwise specifically provided under the terms of the Plan; provided, however, that no amendment or termination shall be made that would diminish any benefits arising from incurred but unpaid claims of Participants prior to the effective date of such modification, alteration, amendment, suspension, or termination.

ARTICLE XIV
MISCELLANOUS PROVISIONS

14.01 Action by the Company or an Employer. Any action to be taken by the Company or an Employer hereunder, to the extent not otherwise provided, may be taken by any authorized officer of the Company or Employer.

14.02 Adoption by Related Employers. Any employer, with the consent of the Company and under such terms and conditions as the Company may prescribe, may become an Employer hereunder, provided that such employer is a corporation, trade or business that, together with the Company, is a member of a controlled group of corporations as defined in Code section 414(b), under common control as defined in Code section 414(c), or a member of an affiliated service group as defined in Code sections 414(m) or (o) (collectively "controlled entities"). An Employer that ceases to be a controlled entity may remain an Employer hereunder for a limited transition time after ceasing to be a controlled entity, solely at the discretion of the Company and solely on such terms and conditions as the Company may prescribe. By its adoption of the Plan and participation therein, each Employer agrees to be bound by the terms of the Plan, as amended from time-to-time. Any Employer shall have the right at any time and under such terms and conditions as the Company may prescribe to withdraw from the Plan on sixty (60) days' written notice to the Company.

14.03 Exclusive Benefit. This Plan has been established for the exclusive benefit of Participants and Dependents and, except as otherwise provided herein, all contributions under the Plan may be used only for such purpose.

14.04 Nonalienation of Benefits. No benefit, right or interest of any Participant or Dependent may be assigned without the Plan Administrator's written consent on behalf of the Plan. When the Plan Administrator's written consent is not obtained, no benefit, right or interest of any Participant or Dependent shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, including any liability for, or subject to, the debts, liabilities or other obligations of such person; and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge, garnish, execute or levy upon, or otherwise dispose of any right to benefits payable hereunder or legal causes of action, shall be void. Notwithstanding the foregoing, even when the Plan Administrator's written consent has not been obtained, the Plan may choose to remit payments directly to health care providers with respect to covered services, if authorized by Participants, but only as a convenience to Participants. Such direct payment shall not operate as a waiver of the Plan Administrator's right on behalf of the Plan to withhold consent to an assignment. Health care providers are not, and shall not be construed as, either "participants" or "beneficiaries" under this Plan and have no rights to receive benefits from the Plan or to pursue legal causes of action on behalf of (or in place of) Participants and Dependents under any circumstances.

14.05 Limitation of Rights. Nothing contained herein shall operate or be construed to give any person any legal or equitable right against the Company or any Employer, except as expressly provided herein or required by law, or to create a contract of employment between an Employer and any Employee, obligate any Employer to continue the service of any Employee or affect or modify the terms of any Employee's employment in any way.

14.06 Gender and Number. Except when the context indicates to the contrary, when used herein, masculine terms shall be deemed to include the feminine and neuter, and terms in the singular shall be deemed to include the plural, and the plural the singular.

14.07 Headings. The headings of Articles and Sections are included solely for convenience of reference and, if there is any conflict between such headings and the text of this Plan, the text shall control.

14.08 Severability. If any provision of this Plan shall be held invalid or, unenforceable, such invalidity or unenforceability shall not affect any other provisions hereof and the Plan shall be construed and enforced as if such provisions had not been included herein.

14.09 Governing Law. The Plan shall be construed and enforced according to the laws of the State of Texas other than its laws respecting choice of law, to the extent not preempted by federal law.

14.10 Participant's Responsibilities.

(a) **Missing Participants.** Each Participant shall be responsible for providing the Plan Administrator and/or the Employer with the Participant's and each Dependent's current address. In the event that a Participant or Dependent becomes entitled to a payment under this Plan and such payment is delayed or cannot be made:

(1) because the current address according to the Employer's records is incorrect;

(2) because the Participant or Dependent fails to respond;

to the notice sent to the current address according to the Employer's records;

(3) because of conflicting claims to such payments; or

(4) because of any other reason;

the amount of such payment, if and when made, shall be that determined under the provisions of this Plan without payment of any interest or earnings. If, after reasonable efforts, the Plan Administrator is unable to locate any Participant or Dependent whose benefits under the Plan have become distributable, such benefits may be forfeited. If the Participant subsequently applies for benefits, the amount so forfeited will be paid to the Participant. Notwithstanding the forgoing, with respect to any benefit or arrangement that is underwritten by insurance, the terms of the insurance policy shall control to the extent such terms are inconsistent with this Section 14.10.

(b) **Uncashed Checks.** If a check to a Participant or Dependent for benefits under the Plan remains uncashed beyond the "void" date, if any, listed on the check, or if no void date, 180 days after issue, amounts attributable to such check shall be forfeited to the Plan. In such event, the Plan shall reissue such check upon request of the Participant or Dependent if made within three years after date of issue.

14.11 Payments to Minors and Incompetents. Upon proof satisfactory to the Plan Administrator, or the appropriate insurer or third party administrator (if applicable), that an individual entitled to receive a payment under the Plan is legally incompetent, including by reason of being a minor, the Plan Administrator may direct that benefit payments be made in any one or more of the following ways:

(a) to the individual's spouse, child, parent, or dependent whom such individual has the duty to support;

(b) to the individual's legal guardian or conservator; or

(c) to any other person, including a recognized charity or governmental institution, to be held and used for the individual's benefit.

The decision of the Plan Administrator is final and binding upon all parties. The Plan Administrator is not obliged to see to the proper application or expenditure of any payments so made.

14.12 Withholding Taxes. The Plan Administrator, or the appropriate insurer or third party administrator (if applicable), may make any appropriate arrangements to deduct from all amounts paid under the Plan any taxes required to be withheld under applicable law. The Participants are responsible for all taxes due on amounts paid under the Plan to the extent that such taxes are not withheld, irrespective of whether withholding is required.

14.13 Clerical Errors or Omissions. Clerical errors or omissions in information provided to a Participant or Dependent do not deprive a Participant or Dependent of his or her right to receive a benefit, and do not affect the amount of his or her benefit. Conversely, clerical errors or omissions do not cause a Participant or Dependent to have the right to receive a benefit to which he or she is not entitled, and a Participant or Dependent receiving an overpayment by mistake must repay the overpayment, if requested to do so. The Plan Administrator reserves the right to correct any mistake in any reasonable manner, including but not limited to, adjusting the amount of future benefit payments, repaying to the Plan any overpayment, or making catch-up payments to a Participant or Dependent for an underpayment. The failure to enforce any provision of the Plan does not affect the Plan's right thereafter to enforce this provision, nor does such failure affect its right to enforce any other Plan provision.

14.14 No Vested Right to Benefits. No Participant or person claiming through such Participant shall have any right to, or interest in, any benefits provided under the Plan upon termination of his or her employment, retirement, termination of Plan participation, or otherwise, except as specifically provided under the Plan.

IN WITNESS WHEREOF, this instrument has been executed by an authorized officer of Marathon Oil Company on the ___th day of December 2018.

PLAN SPONSOR

_____

Deanna L. Jones
Senior Vice President, HR, Communications &
Administrative Services

APPENDIX A

The following entities have adopted the Plan:

Marathon Oil Corporation

Marathon Service Company