Marathon Oil Company
Dental Plan

Amended and Restated Effective as of
January 1, 2017

Marathon Oil Corporation

Dental Plan

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Dental Plan

This document serves both as the Plan instrument and the Summary Plan Description (SPD) for the Marathon Oil Company (the "Company") Dental Plan (the "Plan") that the Company is required to provide to Plan participants. To the extent not preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), the provisions of this instrument shall be construed and governed by the laws of the State of Texas.

I. Purpose

The purpose of the Dental Plan is to improve the dental health of employees and their dependents. The Plan is specifically designed to encourage preventive dental care. Dental problems are cumulative, and early treatment helps avoid later, more serious issues. The Plan also provides financial assistance for a broad range of dental treatment, and offers a PPO network feature which provides for negotiated discounts for dental services when Members use network dentists.

II. Classes of Membership and Eligibility

A. Members — The following individuals are eligible for membership in the Plan at the times indicated:

1. Employees who work on a Regular "full-time" or Regular "part-time" basis (Employee Members) — On the first day of employment with the Company, provided such employee is not a member of an employee group for whom the Company provides or contributes to other dental care.

For purposes of benefit eligibility, Regular "full-time" basis means the employee has a normal work schedule of at least 40 hours per week, or at least 80 hours on a bi-weekly basis. In addition, if a Regular "full-time" employee's normal work schedule is reduced (a) to 20 hours or more per week to accommodate a bona fide and documented health problem or disability or (b) under a furlough program, such employee will continue to be eligible for benefit plan participation as a Regular Full-time employee. Regular Part-time means the employee is 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.

Regular employees who work on a full-time or part-time basis must be specifically designated as such by the Company to be eligible to participate in the Plan. Casual employees and common law employees who have not been designated by the Company as Regular employees who work on a full-time or part-time basis are excluded from eligibility to participate. Specifically excluded from eligibility to participate in the Plan are any individuals who have signed an agreement, or have otherwise agreed, to provide services to the Company as an independent contractor, regardless of the tax or other legal consequences of such an arrangement. Also specifically excluded from eligibility to participate are leased employees compensated through a leasing entity, whether or not the leased employee falls within the definition of "leased employee" as defined in Section 414(n) of the Internal Revenue Code.

2. Surviving Spouse Members and Child Members are referred to collectively as "Survivor Members."

    a. Surviving spouses of deceased Employee Members (Surviving Spouse Members) — On the day following the death of the Employee Member, provided such spouse is under age 65 and was eligible to participate in this Plan as a dependent at the time of the Employee Member's death.

    b. Eligible Dependent Child, or Dependent Disabled Child of a former Employee Member whose parents are both deceased, or whose former Employee Member is deceased and whose other parent is not eligible to join the Plan (Child Members) — Coverage may continue, provided the child (or children) was covered under the Plan as an eligible dependent immediately prior to the death of the child's parent who was a Member of the Plan, provided the child's other parent is either not eligible to join the Plan or is deceased.

    c. If a Surviving Spouse Member remarries, coverage for the Surviving Spouse and dependent children terminates at the end of the month in which the marriage occurs. If a Surviving Spouse Member does not remarry, coverage for such Surviving Spouse Member terminates on such Member's 65th birthday, and coverage for dependent children will also terminate on such Member's 65th birthday, unless terminated sooner because the children ceased to satisfy the definition of eligible dependent.

B. Dependents Coverage — Dependents of an Employee Member or Surviving Spouse Member are eligible for coverage on the same date as the Member, or on the date such dependents are acquired, whichever is the later. In the case of Surviving Spouse Members electing family coverage, the dependents must have been eligible dependents of the former Employee Member. In addition, these dependents must continue to meet the definition of an eligible dependent of the Surviving Spouse Member under the provisions of the Plan. Eligible dependents include:

1. **Spouse:** Wife or husband of an Employee Member;

2. **Domestic Partner:** Qualified domestic partner of an Employee Member;

3. **Dependent Child:**

    a. A child up to 26 years of age regardless of access to other coverage and who meets one of the following:

        (i) A blood descendant of the first degree of the Member, Member's spouse or Member's domestic partner;

        (ii) A legally adopted child of the Member, Member's spouse or Member's domestic partner, provided that a court of competent jurisdiction has entered a final order for adoption or a child who has been "placed for adoption" but for whom the adoption process has not yet been finalized. "Placed for adoption" means the Member has the legal obligation to provide primary support for the child in anticipation of the adoption of the child; Note that if a child who has been "placed for adoption" is not legally adopted, all dental Plan coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

(iii) A child, whose parents are both deceased, for whom the Member has legal custody as determined by a court of competent jurisdiction and whose permanent residence is with the Member.

b. Dependent Disabled Child: An unmarried child who has reached age 26 and is under the age of 65, who is incapable of self-support due to a mental or physical disability, and who meets both of the following requirements:

(i) Is primarily dependent upon the Member for support, and

(ii) Became mentally or physically disabled before they attained the age of 26, provided they were covered under the Plan as a Dependent Child on the day prior to their 26th birthday.

If the Plan Administrator receives a "medical child support order" as that term is defined under section 609(a) of the Employee Retirement Income Security Act of 1974, as amended (ERISA), the Plan Administrator shall determine whether the medical child support order is a "qualified medical child support order" (QMCSO) as that term is defined under section 609(a)(2) of ERISA. If the order is determined to be a QMCSO, the Plan Administrator shall administer the Plan in accordance with the terms of the order, with such terms taking precedence over any provisions in the Plan which would otherwise be in conflict with the provisions of the order, to the extent such precedence is required by applicable law. To the extent permitted by applicable law, the Plan Administrator has the authority for determining the appropriate membership classification and Member contributions for a child the Plan is required to cover pursuant to a QMCSO. The Plan's procedures shall provide for appropriate notification to certain interested parties, to the extent required by ERISA, and shall permit designation by or on behalf of an "alternate recipient," as that term is defined by section 609(a)(2) of ERISA, for receipt of notices that are sent to the alternate recipient with respect to a medical child support order.

"Primarily dependent," when the term is used pertaining to a Dependent Child above, is defined as follows:

(i) The Member provides over 50% of the child's support, and

(ii) The child must qualify as a dependent under the Internal Revenue Code as evidenced by the Member claiming the child as a dependent on the Member's federal income tax return or by the Member providing such other evidence as the Plan Administrator determines to be satisfactory.

Evidence satisfactory to the Plan Administrator of such primary dependency may be requested from time to time by the Plan Administrator.

However, a natural child (blood descendent of the first degree of the Member) or adopted child of a Member will be deemed to have satisfied the above "primarily dependent" definition provided the following conditions are met:

(i) The Member is divorced or legally separated from the child's other parent, and

(ii) The judgment, order or decree (including approval of a settlement agreement), issued by a court of competent jurisdiction and pursuant to a state domestic relations law, is presented to the Plan Administrator and requires health benefit coverage for the child by the Member.

This exception shall not, however, be interpreted to require that the Plan provide any type or form of benefit or option not otherwise provided under the Plan.

C. Continued Members — A former Member or an individual formerly covered as a qualified dependent who, pursuant to applicable federal law, has elected to continue coverage beyond the date coverage would otherwise terminate if not for such federal law (see "Continuation of Coverage Privilege" Article X).

No individual is eligible for benefits as a Member and as a dependent, or as a dependent of more than one Member.

No individual is eligible for coverage under this Plan who is also eligible for dental assistance benefits:

1. Under another plan maintained in the United States toward which the Company makes contributions, except when dependent coverage under the individual's spouse's plan to which the Company also contributes cannot be waived; or
2. Under another plan sponsored by a non-participating member of the controlled group which includes Marathon Oil Company.

III. Joining the Plan and Changing Coverage

Prospective Members must complete online enrollment or sign and submit the proper enrollment form to become covered under the Plan on the applicable participation dates as outlined below. Members must begin and change coverage under the Plan subject to the terms of this Plan and Contribution Conversion Plan (CCP) participation rules (see Section D below).

A. Enrollment for Employee Member, Surviving Spouse Member, Child Member Coverage

1. Enrollment When First Eligible for Coverage

a. Employee Member Coverage

(i) If the Marathon Oil Benefits department receives the properly completed enrollment form within 30 days of the date of hire, coverage will begin on the date of hire.

(ii) Benefit enrollment elections will not be accepted after 30 days from hire date until the next Benefits Open Enrollment.

(iii) New hires and rehires cannot commence benefits unless they are actively at work.

b. Surviving Spouse Member and Child Member Coverage

(i) If a Member dies, the Spouse, Domestic Partner or Dependent Child of such Member will have their coverage automatically continued under the Plan. The Surviving Spouse, Domestic Partner, or Child Member will not be required to complete and submit an enrollment form to the Company in order to commence Surviving Spouse, Domestic Partner, or Child Member Coverage.

(ii) The Spouse, Domestic Partner or Dependent Child of a Member who dies who is not enrolled in the Plan must complete, sign, and submit the proper enrollment form to the Company in order to be covered as a Member under the Plan. If the enrollment form is received by the Company on or before the first date of eligibility, participation is effective on the eligibility date. If the enrollment form is received by the Company within 31 days after the date of the Member's death, participation is effective on the date the form is received.

B. Changing Coverage

1. A Member may make coverage changes during the year only upon experiencing a change in family status. The change in coverage must be consistent with the change in status (e.g., you cover your Spouse following your marriage, your child following an adoption, etc.). The following are considered family status changes for purposes of the Plan:

a. an Employee Member's marriage, divorce, legal separation or annulment;

b. an Employee Member's registering a Domestic Partner;

c. the birth, adoption, placement for adoption or legal guardianship of a child;

d. a change in a Spouse's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan;

e. loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis;

f. the death of a Dependent;

g. a Dependent Child no longer qualifying as an eligible Dependent;

h. a change in an Employee Member or Spouse's position or work schedule that impacts eligibility for health coverage;

i. contributions were no longer paid by the employer (this is true even if an eligible employee or eligible Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer);

j. a Member or eligible Dependent who was enrolled in an HMO no longer lives or works in that HMO's service area and no other benefit option is available;

k. benefits are no longer offered by the Plan to a class of individuals that include a Member or eligible Dependent;

l. termination of a Member's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (the Member or Dependent must contact the Benefits Department within 60 days of termination);

m. a Member or Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact the Benefits Department within 60 days of determination of subsidy eligibility);

n. a strike or lockout involving a Member or Spouse; or

o. a court or administrative order.

Unless otherwise noted above, a Member wishing to change his or her elections must contact the Marathon Oil Benefits Center within 31 days of the change in family status. Otherwise, the Member must wait until the next annual Open Enrollment.

While some of these changes in status are similar to qualifying events under COBRA, a Member or eligible Dependent does not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed above. These rights will also be available if COBRA is elected.

C. Contribution Conversion Plan (CCP)

For active employee Members, the Member's contribution shall be paid through the CCP and changes in coverage at the annual Benefits Open Enrollment or as the result of a special occurrence will result in changes to the employee's CCP election.

IV. Waiver of Coverage

A Member may waive coverage under the Plan:

A. When the waiver is due to a "change in family or employment status" as outlined above; or

B. During Benefits Open Enrollment, with the election effective January 1 of the year following the election.

In all events, if Member coverage is waived, all dependent coverage must also be waived.

A Member and dependents may rejoin the Plan, subject to the procedures listed under "Joining the Plan and Changing Coverage" in Article III above.

V. Contributions

Cost of coverage is normally shared by the Member and the Company. Member contributions are subject to change. The total cost of the Plan is ultimately determined by claims experience and administrative costs. For Continued Member coverage, the Company will contribute only amounts required by law, if applicable.

A. Member Contributions

Contributions for coverage are made through payroll deductions. Members not receiving pay from the Company must pay their contributions (i) on a monthly basis on or before the applicable due date specified by the Company, if they are an Employee Member; (ii) at the times required by applicable law, if they are a Continued Member; or (iii) in advance, if they are not an Employee Member or a Continued Member.

1. Company contributions for Regular Part-time Member coverage will be equal to approximately 50%, of the Company contribution amount for Regular Full-time employees. However, if at the time an Employee Member becomes a Regular Part-time employee, such employee is eligible for retirement under the Retirement Plan of Marathon Oil Company, the Company contributions will remain at 100% of the Company contribution amount for Regular Full-time employees.

Upon the death of a Regular Part-time or a Regular Full-time employee who was a Regular Part-time employee for more than 50% of their total service, the Company contribution for eligible Surviving Spouse, Domestic Partner, or Child Member coverage will be approximately 50% of the Company contribution for eligible Surviving Spouse, Domestic Partner, or Child Member coverage for a Regular Full-time employee.

A Surviving Spouse and dependents can continue coverage at the rates applicable to Regular full-time or Regular part-time (as applicable) Employee Members until a remarriage occurs.

2. Effective January 1, 2017 (and subject to change), except for Continued Members, the monthly Member contributions for the Plan are:

	Monthly Contribution
Regular Full-time Member Only	$ 8.00
Regular Full-time Member & Spouse	$15.00
Regular Full-time Member & Children	$16.00
Regular Full-time Member & Family	$26.00
Regular Part-time Member Only	$23.00
Regular Part-time Member & Spouse	$46.00
Regular Part-time Member & Children	$49.00
Regular Part-time Member & Family	$78.00

B. Company Contributions

The Company pays all costs of the Plan in excess of the Members' contributions.

VI. Benefits Under the Plan

A. General

For the purpose of administering the Plan, the term "dentist" will mean any dentist legally licensed to practice dentistry and any licensed limited practice professional in the dental care field practicing within the field for which he or she is legally licensed.

Treatment, services, and supplies must be prescribed by a dentist and must meet the standards of dental practice accepted by the American Dental Association.

The Claims Administrator reserves the right at any time to request additional information to substantiate the necessity of any dental service, supplies, or treatment for which benefits are claimed, including the right to have the Member's dental treatment plan examined at the Company's expense by a dentist or dental consultant of the Company's choice.

I. PPO In-Network Providers

For Members who reside in areas eligible for the PPO feature — CIGNA has contracted with dentists to provide discounts for dental procedures. Charges by network dentists are covered as follows:

Preventive services:	100% of the negotiated amount
Basic dental services:	80% of the negotiated amount
Major dental services:	50% of the negotiated amount
Orthodontic service:	50% of the negotiated amount

II. Out-of-Network Providers

For Members who do not utilize a network dentist, benefits are paid based on "Reasonable and Customary" charges. Reasonable and Customary amounts are calculated at the 90th percentile of all provider charges in the provider's geographic area. Charges are covered as the follows:

Preventive services:	100% of the reasonable and customary amount
Basic dental services:	80% of the reasonable and customary amount
Major dental services:	50% of the reasonable and customary amount
Orthodontic service:	50% of the reasonable and customary amount

For further information on how dental changes are covered under the PPO feature, or to find providers in the network, Members can visit www.cigna.com or call CIGNA at 1-800-244-6224.

B. Preventive and Diagnostic Expenses

To encourage proper dental maintenance and long-term dental health, the Plan will pay 100% of the reasonable and customary charges (or 100% of the negotiated amount, if incurred at a network dentist) for the following covered expenses:

1. Oral examinations, including scaling and cleaning of teeth, not more than twice in any calendar year.
2. Topical application of sodium or stannous fluoride.
3. Dental X-rays, not more than two sets of bitewing X-rays in any calendar year and not more than one set of full-mouth X-rays within any three consecutive calendar years.
4. Fixed and removable space maintainers.
5. Sealants (for children up to age 19).

C. Basic and Major Restorative Expenses

The following types of expenses are paid according to the Schedule of Dental Procedures, after the deductible has been satisfied. If these services are incurred at a network dentist, they are reimbursed at 80% of the negotiated amount for basic services and 50% of the negotiated amount for major services after the deductible has been satisfied.

1. Extractions. (Basic Service)
2. Oral Surgery. (Basic Service)
3. Fillings. (Basic Service)
4. Anesthetics administered in connection with oral surgery or other covered dental services. (Basic Service)
5. Treatment of periodontal and other diseases of the gums and tissues of the mouth. (Basic Service)
6. Endodontic treatment, including root canal therapy. (Basic Service)
7. Injection of antibiotic drugs by the attending dentist. (Basic Service)
8. Initial installation (including adjustments during the six-month period following installation) of partial or full removable dentures to replace one or more natural teeth extracted while the individual is covered under the Plan. (Major Service)
9. Repeat or re-cementing of crowns, inlays, bridgework or dentures or relining of dentures. (Major Service)
10. Replacement of an existing partial or full removable denture, or the addition of teeth to an existing removable denture to replace extracted natural teeth (Major Service), but only if the individual has been a Member of the Plan for two years, and evidence satisfactory to the Claims Administrator is presented that:
    a. The replacement or addition of teeth is required to replace one or more additional natural teeth extracted while the individual is covered under the Plan; or
    b. The existing denture was installed at least five years prior to its replacement, and it cannot be made serviceable.
11. Inlays, gold fillings, crowns (including precision attachments for dentures) and initial installation of fixed bridgework (including inlays and crowns to form abutments) to replace one or more natural teeth extracted while the individual is covered under the Plan. (Major Service)
12. Replacement of fixed bridgework or the addition of teeth to existing fixed bridgework to replace extracted natural teeth (Major Service), but only if evidence satisfactory to the Claims Administrator is presented that:
    a. the replacement or addition of teeth is required to replace one or more additional natural teeth extracted while the individual is covered under the Plan; or
    b. the bridgework was installed at least five years prior to its replacement, and the existing bridgework cannot be made serviceable.

D. Deductible Level

A deductible applies to all basic and major restorative dentistry and for orthodontic treatment. For all three types of treatment, the deductibles are cumulative, so that in any one calendar year, the deductible cannot exceed $50 per individual and $150 per family for Members with family coverage. The deductible is applied against the scheduled amount or the dentist fee, whichever is less. Once the individual deductible of $50 is met, the Plan will begin paying benefits.

E. Predetermination of Benefits

If a dentist has recommended a course of treatment which will exceed $100, the Member is encouraged to have the dentist submit a predetermination claim form prior to having the services performed. By so doing, the Claims Administrator, Connecticut General Life Insurance Company, a CIGNA Company, can provide an advance estimate of how much may be payable under the Plan for the dental treatment. In addition, an equally effective, less costly alternate treatment plan may be suggested.

The claim form can be used for either predetermination or final claims. The dentist should forward the completed form directly to the Claims Administrator. The Claims Administrator will notify the Member and dentist of the approximate amount of benefits for covered services that the Member will receive. If a predetermination is not submitted, no estimate of covered services will be available. Consequently, some services may not qualify for payment under the Plan.

F. Maximum Benefits Payable

The Plan has an unlimited lifetime maximum benefit, excluding orthodontia. The maximum lifetime benefit for orthodontic treatment is $1,750 per individual.

There is a calendar year maximum of $2,000 in benefits for expenses (exclusive of orthodontia) incurred by a covered individual. Benefits payable for orthodontic treatment will not be applied toward this calendar year maximum.

G. Coordination of Benefits

Benefits paid from the Plan are determined using the “Benefit Less Benefit” method, by calculating the amount payable under Plan provisions, then reducing that amount by the amount of payment due for the same charges from any other group plan or any government sponsored plan. Coordination with other group plans follows the National Association of Insurance Commissioners (NAIC) coordination of benefits model utilizing the “Benefit Less Benefit” method. Among other guidelines, this model provides that if a child is covered as a dependent under two different group plans, coverage is primary under the plan of the parent whose birthday (month and day) occurs earlier in the calendar year. Coordination with government sponsored plans follows the relevant federal statute or the regulations issued by the appropriate government agency.

H. Subrogation Rights

1. Subrogation Rights

In the event benefits are paid by the Plan for charges incurred by individuals with coverage under the Plan as a result of injury or illness, and if the Member (including a Continued Member) or dependent makes any recovery, in whole or in part, (whether by settlement, judgment or otherwise) from any person or organization responsible for causing such injury or illness, or under any no-fault automobile insurance statute, then the Plan shall have a lien upon that recovery. A Member or dependent, by submitting a claim for benefits under the Plan, agrees to pay the Plan from any recovery, whether it be a partial or total recovery, the amount the individual received from a third party up to the amount of benefits paid by the Plan; provided, however, that in no event shall the Member or dependent be required to make payment in an amount exceeding the recovery made by the Member or dependent against the person or organization responsible for causing the injury or illness.

By submitting a claim for benefits under the Plan, a Member or dependent also agrees to give immediate written notice to the Plan Administrator of any legal proceeding against a third party relating to the injury or illness for which benefits are paid. The Plan reserves the right to assert a subrogation claim in such a legal proceeding or bring an independent action directly against the third party believed to be responsible for the injury or illness.

2. Right of Recovery

If for any reason a benefit is paid which is larger than the amount allowed by the Plan, the Plan has a right to recover the excess amount from the person or agency who received it or to offset future payments that may be due to or on behalf of such person by the amount of the overpayment. The Plan may effectuate this recovery by using the offset procedures or aggregate or bulk payment procedures adopted by its Claims Administrator. To the extent reasonably requested by Plan Administrator or his or her delegate, the person receiving the benefit must assist in enforcing this right of recovery, including by provisions of any instruments or papers necessary to enforce this right of recovery.

I. Coordination of Coverage

If an employee is transferred to employment with the Company from a non-participating member of the controlled group of corporations to which the Company belongs, dental expenses incurred during the calendar year of the transfer and applicable to the deductible provisions of the previous employer's dental plan shall be recognized hereunder solely for purposes of satisfying the deductible provisions of the Plan. Co-payments (unless recognized by the previous employer's dental plan towards satisfying the deductible) will not be recognized by the Plan for purposes of satisfying the deductible.

With the exception of transfers and acquisitions specifically approved by the Plan Administrator, the Plan will not recognize co-payments or dental expenses from any other dental plan for deductible purposes.

J. Orthodontia

Benefits paid under the Plan for orthodontic treatments will vary according to the specifics of the treatment prescribed, and are subject to reasonable and customary determination. The following orthodontic treatments are covered, provided the treatment did not commence prior to the first day of Plan coverage under the Plan:

1. Case Type Removable Treatment (Phase I) includes diagnosis, removable appliances, post treatment stabilization and monthly treatments, including retention and observation, for treatment of permanent or transitional detention.
2. Complete Full Banded Treatment (Phase II) includes preliminary study, cephalometric radiograph, casts, and treatment plan and monthly treatments, including retention and observation, for treatment of permanent or transitional detention.

All orthodontic benefits are subject to a lifetime $1,750 orthodontia maximum per covered individual, and the yearly deductible amount.

Case Type Removable and Complete Full Banded Treatment Plan benefits will be calculated using the following method:

An initial payment amount will be equal to 25% of the total fee, not to exceed reasonable and customary, charged by the dentist. Subsequent monthly payment amounts are determined by dividing the remaining 75% of the total fee by the number of months needed to complete the treatment plan.

K. Limitations

No benefits are payable under this Plan for:

1. Charges for any dental procedure for which an individual is covered under the Health Plan of Marathon Oil Company.
2. Charges for services performed in a Veteran's Administration Hospital or in any charitable institution or government operation.
3. Charges for treatment other than by a dentist or for treatment that does not meet American Dental Association standards, except for scaling or cleaning of teeth performed by a licensed dental hygienist if the treatment is rendered under the supervision and direction of the dentist.
4. Charges for the initial installation of dentures and bridgework (including crowns and inlays forming the abutments), when such charges are incurred for replacement of teeth which were extracted while the individual was not covered under the Plan (except as provided in Article VI, Section C above). The limitation does not apply to dependent children if installation of the prosthetic device is for replacement of teeth which are congenitally missing.
5. Charges for services and supplies that are partially or wholly cosmetic in nature, including charges for personalization or characterization of dentures, athletic mouth guards, educational programs, oral hygiene or dietary instruction.

6. Charges for prosthetic devices if the impression was taken while the individual was not covered under the Plan. The effective date of treatment for prosthetic devices (including bridges, dentures and crowns) is the date on which the impression was taken. The Plan will not pay any charge for installation or follow-up fitting and adjustment of prosthetic devices if such charges are itemized and occur more than thirty (30) days after termination of coverage.
7. Charges for the replacement of a lost or stolen prosthetic device.
8. Certain types of charges such as expenses covered by Workers' Compensation or other laws including "No Fault" automobile insurance.

VII. Provisions for Termination or Continuation of Participation

Participation in the Plan ceases when an individual is no longer eligible, as described in Article II. Participation for certain Members may be continued, as provided in Article X.

If contributions are not paid for a Member who is not an active employee or the dependent of an active employee, participation will terminate at the end of the month for which contributions were last paid.

Participation will continue for the duration of a Family leave of 12 workweeks or less, at the level and under the conditions coverage would have been provided if the employee had remained on the job.

If the Company discontinues participation in the Plan as a result of non-payment of premiums while an employee is on a Family Leave of 12 workweeks or less, benefits will be restored upon the employee's return to work in accordance with the terms of the Plan.

Participation of the Employee Member and dependents will be continued while an employee is on military leave subject to payment of the required monthly contribution by the Employee Member.

If an Employee Member dies, the employee's surviving spouse and other dependents are eligible to continue participation as Survivor Members.

VIII. Payment of Benefits

Expenses should be submitted as they occur. Payment from the Plan will begin as soon as the submitted expenses exceed the appropriate deductibles.

Claims must be submitted within six months after the end of the calendar year in which the claims were incurred.

Most in-network providers will submit claims directly to CIGNA, in which case benefit payment is generally issued directly to the provider by CIGNA. If a provider (whether network or non-network) does not submit claims, then the Member must submit a completed claim form to:

CIGNA HealthCare Service Center
P.O. Box 188037
Chattanooga, TN 37422-8037

When a claim form is submitted to CIGNA by the Member, all benefits will be paid directly to the Member unless the Member requests that certain benefits be paid directly to the dentist.

Members are not entitled to assign benefits under the Plan to a non-network provider without the Plan's consent. When consent for an assignment is not obtained, the Plan may send the reimbursement directly to the Member. However, the Plan reserves the right, in its discretion, to pay a non-network provider directly for services rendered to a Member, and such direct payment shall not operate as a waiver of the Plan's right to withhold consent to an assignment. If benefits are assigned or payment to a non-network provider is made, the Plan reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes the Plan and further reserves the right to effectuate such offset by means of the Claims Administrator's offset procedures.

For questions concerning dental claims or benefit entitlement, Members can visit www.cigna.com or call CIGNA at 1-800-244-6224.

IX. Claim Appeal Procedure

If a claim for benefits has been denied in full or in part, or if the covered individual does not agree with how the claim was paid, the Member or duly authorized representative are entitled to appeal the decision and the appeal must be made by following the appeal procedures below.

The Plan Administrator, or others who have been delegated authority to hear final appeals by the Plan Administrator, has the authority to render decisions on all appeals submitted under the Plan, and the determination made by the Plan Administrator, or others delegated authority to hear final appeals by the Plan Administrator, to an appeal concerning benefits shall be final.

Appeals should contain all of the required information in order to be identified as an appeal under the Plan. If required information is missing, the request may not be regarded by the Plan as an appeal and may be returned to the covered individual, or designated representative, with no determination made. The covered individual or duly authorized representative should contact CIGNA prior to filing the appeal to ask questions about the denial. Appeals to the Plan Administrator should contain the following information:

- A statement that a formal appeal under the Plan is being made and the type of appeal (Urgent Pre-Service Claim Appeal, Non-Urgent Pre-Service Claim Appeal or Post-Service Claim Appeal).
- The name of the individual for whom the claim was denied.
- The Social Security number of the covered Member and, if the individual for whom the claim was denied is not the covered Member, the name of the covered Member.
- Name of Plan: Marathon Oil Company Dental Plan.
- Identifying information about claim, including the date of service, name of the provider, and/or facility.
- Any and all information that the claimant wishes the Plan Administrator to consider or believes to be necessary for a complete and thorough review of the claim appeal, including the complete name and phone number of any medical professionals who have additional information supporting the approval of the appeal.
- Address and telephone number of the individual or duly authorized representative making the appeal.
- Authorization for release of personal health information if appropriate and necessary.

The following explains the three types of appeals for the three types of claims and the procedures for making an appeal for each of the three types of appeals: Urgent Pre-Service Claim Appeal, Non-Urgent Pre-Service Claim Appeal, and Post-Service Claim Appeal.

For those claim appeal procedures that require that the appeal be sent in writing to the Plan Administrator, the address is:

Marathon Oil Company Dental Plan Appeals
Plan Administrator of the MOC Dental Plan
Benefits Department
5555 San Felipe Street
Houston, TX 77056

An appeal form can be found on www.MROBenefits.com under "Forms." The completed form should be sent to:

CIGNA Dental Appeals Unit
7555 Goodwin Road
Chattanooga, TN 37421

Telephone: 1-800-244-6224

A. Pre-Service Claim Appeal

If a request for dental care is denied by CIGNA before the care is rendered (such as a result of a pretreatment estimate) the covered individual may appeal by following the pre-service claim appeal procedures.

Pre-service claims may be urgent or non-urgent. An urgent claim appeal is a claim for medical care or treatment where withholding immediate treatment could jeopardize the life or health of the patient, or would jeopardize the functionality that existed prior to the onset of the current condition or, in the opinion of a physician with knowledge of the patient's medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

1. Urgent Pre-Service Claim Appeal

A covered individual or designated representative may appeal a denial decision of an urgent pre-service claim by phone or in writing. There is no time limit for the covered individual to make such an appeal.

To make an appeal by telephone or facsimile contact the Benefits department at 1-855-652-3067. A written appeal should be sent to the Plan Administrator.

A determination by the Plan Administrator, or others delegated authority to hear final appeals by the Plan Administrator, will be made within 72 hours of the Plan Administrator receiving the appeal request. The appeal determination will be sent to the individual making the appeal at the telephone number and address provided in the appeal.

Note: A pre-service claim that is "urgent" when it is initially filed with CIGNA, will cease to be an "urgent" pre-service claim and will become a non-urgent pre-service claim if, between the date of the claim denial and the date the appeal is made, the health care services are actually rendered and the only decision to be made is who will pay for the services.

2. Non-Urgent Pre-Service Claim Appeal

The covered individual or designated representative is encouraged to first telephone CIGNA to request that the claim be reviewed. While this request for review is not required under the Plan's claims procedures, many claims are satisfactorily resolved in this manner without the need for a formal appeal.

A covered individual who disagrees with the handling and disposition of the claim is entitled to submit a written appeal to CIGNA. (It is suggested that a copy of the written appeal to CIGNA also be sent to the Plan Administrator at the address stated at the beginning of this section.) The appeal will be reviewed in accordance with the CIGNA's internal appeal procedures. The written appeal must be received by CIGNA within 180 days of the initial denial. CIGNA must respond to a Non-Urgent Pre-Service claim within 15 days, which can be extended for an additional 15 days if such extension is necessary for reasons beyond the Plan's control and the participant or authorized representative is notified prior to the end of the original 15-day period.

If, after receiving CIGNA's response to the written appeal, the covered individual continues to disagree with the handling and disposition of the claim, the covered individual or designated representative may appeal the denial decision. Such appeal must be in writing and must be received by the Plan Administrator within 60 days of the date of the denial of the first appeal by CIGNA.

The covered individual, or their designated representative, is to send the appeal to the Plan Administrator at the address stated at the beginning of this Article IX. A determination by the Plan Administrator, or others delegated authority to hear final appeals by the Plan Administrator, will be made within 15 days of the Plan Administrator receiving the appeal request. The appeal determination will be sent to the individual making the appeal at the address provided in the appeal.

B. Post-Service Claim Appeal

The covered individual or designated representative should first telephone CIGNA to request that the claim be reviewed. While this request for review is not required under the Plan's claims procedures, many claims are satisfactorily resolved in this manner without the need for a formal appeal.

If, after the claim has been reviewed in response to the telephone call, the covered individual continues to disagree with the handling and disposition of the claim, the covered individual or designated representative is entitled to submit a written appeal to CIGNA. (It is suggested that a copy of the written appeal also be sent to the Plan Administrator at the address stated at the beginning of this section.) The appeal will be reviewed in accordance with CIGNA's internal appeal procedures. The written appeal must be received by CIGNA within 180 days of the initial denial. CIGNA must respond to a Post-Service Claim Appeal within 30 days, which can be extended for an additional 15 days if such extension is necessary for reasons beyond the Plan's control and the participant or authorized representative is notified prior to the end of the original 30-day period.

If the written appeal is denied, the covered individual or designated representative may send the appeal to the Plan Administrator. Such appeal must be in writing. The appeal must be received by the Plan Administrator within 60 days of the date of the denial of the first appeal by CIGNA.

A determination by the Plan Administrator, or others delegated authority to hear final appeals by the Plan Administrator, will be made within 60 days of the Plan Administrator receiving the appeal request. The appeal determination will be sent to the individual making the appeal at the address provided in the appeal.

X. Continuation of Coverage Privilege (COBRA)

Federal law ("COBRA") requires that Plan Members and dependents be permitted to elect to continue coverage under this Plan in accordance with such law. The continuation provisions are included in the Plan as Appendix A.

Employees who are terminated within 24 months following a Change of Control, as defined in the Change in Control Severance Benefits Plan (including terminated retirement eligible employees) will be eligible to receive extended coverage, at current employee rates, under the Marathon Oil Company Dental Plan, or successor plans, for a period of 18 months as described in Appendix A.

XI. Extended Benefits

Dental coverage for an employee and covered dependents ceases immediately upon the employee's termination of employment or retirement. However, if dentures or other supplies or materials have been ordered prior to, and are installed within 30 days following, termination of employment or retirement, benefits will be extended to cover these items. For orthodontia, however, only expenses incurred for services rendered and supplies received prior to date of termination or retirement are covered.

XII. Participation by Associated Companies and Organizations

Upon specific authorization and subject to such terms and conditions as it may establish, Marathon Oil Company may permit subsidiaries and affiliated organizations to participate in this Plan. Currently, these participating companies include Marathon Oil Company, Marathon Oil Corporation, and Marathon Service Company. The terms "Company," "Employer," "Employee," "Member," and words of similar import as used in this Plan shall be deemed to include Marathon Oil Company and such subsidiaries and affiliated organizations and their employees.

XIII. American Jobs Creation Act of 2004

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

XIV. Modification and Termination of Plan

Marathon Oil Company reserves the right to 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 Marathon Oil Company, to any or all types of Participants and their Eligible Dependents. If the Plan should be terminated, this will not affect any claim for covered expenses incurred prior to the termination of the Plan.

Marathon Oil Company ("the Company") may exercise its reserved rights of amendment, modification or termination (i) by written resolution by the Board of Directors of the Company, (ii) by written resolution by the Executive Committee of Marathon Oil Corporation (the "Executive Committee"), or (iii) by written actions exercised by any other entity or person to which or to whom the Board of Directors of the Company or the Executive Committee has specifically delegated rights of amendment, modification, or termination.

The Executive Committee has further delegated to the Vice President of Human Resources & Administrative Services the ability to amend or modify (but not to terminate) this Plan to the extent that such amendment or modification is not a material Plan design change. This authority delegated to the Vice President of Human Resources & Administrative Services shall be exercised in writing.

In addition to other methods of amending the Plan which have been authorized, or may in the future be authorized, by the Marathon Oil Company Board of Directors, the Company's Vice President of Human Resources & Administrative Services may (i) make technical amendments to the Plan, with the opinion of legal counsel, which are required by applicable laws and regulations; (ii) make amendments to the Plan, with the opinion of legal counsel, that are clarifications of Plan provisions; (iii) make amendments to the Plan in connection with a signed definitive agreement governing a merger, acquisition or divestiture such that the needed Plan changes are specifically described in the definitive agreement, or if not specifically described in the definitive agreement, the needed changes are in keeping with the intent of the definitive agreement.

XV. The Use and Disclosure of Protected Health Information

The Plan is required by federal law (known as the "HIPAA Privacy Rules") to maintain the privacy of participants' "Protected Health Information" (PHI) and to provide participants with notice of its legal duties and privacy practices regarding PHI. HIPAA stands for the Health Insurance Portability and Accountability Act of 1996.

The Marathon Oil Company Dental Plan will use protected health information (PHI) to the extent of, and in accordance with, the uses and disclosures permitted by HIPAA. Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations, as described more fully in the "Notice of Privacy Practices for Marathon Oil Corporation and its Subsidiaries Benefit Plans Affected by the Privacy and Confidentiality Requirements of the Health Insurance Portability and Accountability Act (HIPAA). The most current version of this Notice is available on MROBenefits.com, or you can obtain a copy by e-mailing mrobenefitshelp@marathonoil.com or by calling 1-855-652-3067.

If you believe the Plan has violated your privacy rights, you may file a complaint with the Plan, the plan's Privacy Officer or the Plan Administrator. Complaints to the plan or to the Privacy Officer should be filed in writing with:

HIPAA Privacy Officer
5555 San Felipe St.
Houston, TX 77056

Phone: 1-855-652-3067

Email: mrobenefitshelp@marathonoil.com

You will not be penalized in any way for filing such a complaint.

XVI. Plan Administration

The Plan Administrator or the Plan Administrator's designee will make all final determinations concerning eligibility for benefits under this Plan.

The Company has appointed Deanna L. Jones as Plan Administrator of the Dental Plan. The Company shall appoint assistant administrators as may be deemed necessary. The Plan Administrator shall be the named fiduciary under the Plan.

In determining the eligibility of Members and other individuals for benefits and in construing the Plan's terms, the Plan Administrator (or a Third Party Administrator in cases where a Third Party Administrator has the authority to make determinations concerning eligibility for benefits) has the power to exercise discretion in the construction 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 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 made with respect to the Plan, in the form of a written administrative ruling which, until revoked, or until superseded by Plan amendment or by a different administrative ruling, shall thereafter be followed in the administration of the Plan. All decisions of the Plan Administrator (or a Third Party Administrator in cases where a Third Party Administrator has the authority to make determinations concerning eligibility for benefits) made on all matters within the scope of this authority shall be final and binding upon all persons, including the Company, all participants and beneficiaries, and their heirs and personal representatives. It is intended that the standard of judicial review to be applied to any determination made by the Plan Administrator (or by a Third Party Administrator in cases where a Third Party Administrator has the authority to make determinations concerning eligibility for benefits) shall be the "arbitrary and capricious" standard of review. Any discretionary

acts taken under this Plan by the Plan Administrator or the Company, shall be uniform in their nature and shall be applicable to all Members similarly situated, and shall be administered in a nondiscriminatory manner in accordance with the provisions of the Employee Retirement Income Security Act of 1974, as amended, (ERISA) and the Internal Revenue Code (the Code).

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

The formal name of the Plan is the Marathon Oil Company Dental Plan. The employer of the employees covered by the Plan is the Plan Sponsor Marathon Oil Company, 5555 San Felipe Street, Houston, Texas 77056. The Plan is self-insured, and is administered through an administrative services only contract with CIGNA Dental Health, Hartford, Connecticut 06152. Marathon's employer identification number is 25-1410539 and the Plan number is 509. Plan documents may be inspected by submitting a request to your local Human Resources Office or to Marathon Oil Company, Benefits Department, 5555 San Felipe Street, Houston, Texas, 77056. The Plan year ends on December 31, and the Plan's records are kept on a calendar year basis.

XVII. Your Rights Under Federal Law

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

Receive Information About Your Plans and Benefits

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

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plans, including insurance contracts, and copies of the latest annual reports (Form 5500 Series) and updated summary plan descriptions. The administrator may make a reasonable charge for the copies.

Receive a summary of the plans' annual financial reports. The plan administrator is required by law to furnish each participant with a copy of the summary annual reports.

Obtain a statement specifying whether you have a right to receive a pension at your normal retirement age, as defined in this summary plan description, and if so, what your benefits would be at your normal retirement age if you stop working under the plan now. If you do not have a right to a pension, the statement will tell you how many more years you must work to earn a right to a pension. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. The plan must provide the statement free of charge.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance With Your Questions

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

Marathon Oil Company has caused its name to be hereunto subscribed to by Deanna L. Jones, Vice President of Human Resources & Administrative Services, Marathon Oil Company.

MARATHON OIL COMPANY

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Deanna L. Jones

Appendix A

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, (COBRA) requires that most employers sponsoring group health plans offer plan Members and their covered dependents the opportunity for a temporary extension of health coverage (continuation of coverage) at group rates in certain instances where plan coverage would otherwise end. This Appendix A explains how the provisions of COBRA apply to the Members of the Marathon Oil Company Dental Plan (the "Plan").

I. Group Covered

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

II. Qualifying Events and Maximum Length of Continuation Periods

A. If an Employee Member of the Plan loses coverage:

1. Because of termination of employment (including retirement), either voluntary or involuntary, for reasons other than gross misconduct;

2. Because of a reduction of work hours (that is, a change from regular to casual status); or

3. Because of layoff;

then the Member and currently covered eligible dependents will be entitled to elect continuation of coverage for a maximum of 18 months from the date of the qualifying event.

B. If the covered spouse of an Employee Member of the Plan loses coverage:

1. Because of the death of the Employee Member;

2. Because of divorce or legal separation from an Employee Member; or

3. Because the Employee Member becomes entitled to benefits under Medicare;

then the spouse, and any other currently covered eligible dependents who lose coverage, will be entitled to elect continuation of coverage for a maximum of 36 months from the date of the qualifying event.

C. If an eligible Dependent Child of an Employee Member of the Plan loses coverage:

1. Because of the death of the Employee Member;

2. Because the dependent no longer meets the Plan's definition of an eligible Dependent Child; or

3. Because the Employee Member becomes entitled to benefits under Medicare;

then the eligible Dependent Child will be entitled to elect continuation of coverage for a maximum of 36 months from the date of the qualifying event.

III. Extension of Maximum Length of Continuation Periods

In the case of a loss of coverage due to termination of employment or reduction of hours, the maximum 18-month period will be extended to a maximum of 29 months for an individual (employee or eligible dependent) if that individual is determined to have been disabled for Social Security purposes at any time during the first 60 days of continuation coverage. In addition, the extension from 18 months to 29 months will apply not only to the particular disabled individual but also to all of the individuals in the same family who elected continuation of coverage due to the termination or reduction in hours of employment. In order for this extension to apply, however, the disabled individual must notify the Plan Administrator of the Social Security determination before the end of the 18-month period and within 60 days of the date of the determination. The disabled individual must also notify the Plan Administrator within 30 days of any final determination that the individual is no longer disabled. (Refer to Article VII of this Appendix A for the cost of coverage during the 19th through 29th month.)

Eligible dependents of the Employee Member who are entitled to a maximum 18-month period will have that period extended to a maximum of 36 months from the date of the first qualifying event if any of the following subsequent qualifying events occur during the maximum 18-month period (or during the maximum 29-month period, if applicable):

A. The death of the Employee Member;

B. The divorce or legal separation of the Employee Member;

C. The Dependent Child no longer meets the Plan's definition of an eligible dependent;

D. The Employee Member becomes entitled to benefits under Medicare.

In case of events 2. and 3. above, however, the period will be extended only if notice of the event is provided to the Plan Administrator by the Member or dependent in accordance with Article V. "Notification Procedure" of this Appendix A.

In addition, if an Employee Member becomes entitled to benefits under Medicare and the Member's covered eligible dependents properly elect continuation coverage due to a qualifying event which occurs on or after the date of such entitlement to Medicare, the eligible dependents will be eligible for a minimum of 36 months of continuation of coverage measured from the date of entitlement to benefits under Medicare.

IV. Termination of Continued Coverage

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

A. The date the Continued Member (or continued dependent) first becomes covered after the date of their COBRA election, by another group health plan which does not contain any exclusion or limitation with respect to any preexisting condition of that individual, either as an employee, retiree, dependent or otherwise;

B. The date the Continued Member (or continued dependent) first becomes entitled, after the date of their COBRA election, to benefits under Medicare;

C. The last day of coverage for which timely premiums have been paid;

D. The date on which the applicable 18-, 29-, or 36-month period ends;

E. For an individual (employee or eligible dependent) who has had their maximum period of continued coverage extended from 18 months to 29 months due to a determination of disability for Social Security purposes, and who later receives a final determination that they are no longer disabled for Social Security purposes, the later of a) the first day of the month that begins more than 30 days after the date of the final determination, and b) the end of the 18-month period;

F. The first date on which no member of the controlled group which includes the Company provides any group health plan to any of its employees.

V. Notification Procedure

A. If coverage terminates due to the Employee Member's layoff, reduction in work hours, termination of employment (for reasons other than gross misconduct), or becoming entitled to benefits under Medicare:

1. The Company will notify the Plan Administrator of such event within 30 days; and

2. The Plan Administrator will notify the employee/dependents of their rights under COBRA within 14 days after receiving notice from the Company.

B. In the event of the divorce or legal separation of the Employee Member and spouse, or in the event that a Dependent Child no longer meets the Plan's definition of eligible dependent:

1. The employee or dependent must notify the Plan Administrator in writing of the effective date of that event within 60 days after that date. (This information can be submitted to the Plan Administrator through the Company's Human Resources office or Benefits Administration in Houston, Texas); and

2. The Plan Administrator or representative will inform the employee/dependent of their rights under COBRA at the time of such notification, or mail the information within 14 days. Notification to the spouse will serve as notification for all dependents residing with the spouse.

C. The employee/dependent must elect to continue coverage within a specified election period. This period begins on the **earlier** of:

1. The date notification is given to the employee/dependent; or

2. The date of termination of coverage;

and ends on the **later** of 60 days from:

1. The date of the notice from the Plan Administrator, if applicable; or

2. The date of termination of coverage.

D. If no election is made within the election period, coverage ceases at the time of the qualifying event.

E. The first premium payment must be made within 45 days of the election and, if the premium payment is made after the qualifying event, the payment must be sufficient to cover not only the advance premium amount, but also the premium amount for the period beginning on the date coverage would have otherwise ceased and ending on the first date covered by the advance premium amount.

VI. Type of Coverage

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

A. Move From Family to Single Status

A Continued Member may elect to decrease their coverage and move from family to single status.

B. Addition for Eligible Dependents

1. Eligible Dependents at Time of Qualifying Event

A Continued Member may elect to cover any eligible dependents whom the Member did not cover at the time the Member lost their coverage due to the qualifying event, by changing from single to family coverage as permitted by the terms of the Plan.

2. Eligible Dependents Acquired After Qualifying Event

a. A Continued Member or a covered eligible dependent who elected continuation coverage may add any eligible dependents whom they acquire after their qualifying event, as permitted by the terms of the Plan.

b. Eligible dependent children who are added for continuation of coverage by a Continued Member who was formerly an Employee Member of the Plan, and who are either:

(i) A child that is a blood descendent of the first degree of the covered employee who is born during a period of COBRA continuation of coverage; or

(ii) A child that has been "placed for adoption" with the covered employee during a period of COBRA continuation of coverage

shall be treated for COBRA continuation of coverage purposes as if they were covered eligible dependent children of the Continued Member at the time of the qualifying event except they will not be eligible to begin COBRA continuation of coverage until the date of birth or the date of their placement for adoption with the Continued Member, whichever is applicable.

C. Any amendments to the Plan applicable to similarly situated non-continued Members will also be applicable to similarity situated Continued Members.

D. For individuals enrolled in the Plan on the date of their qualifying event, any amounts accumulated towards the deductible by an individual or family before the qualifying event, will be carried over and used towards satisfying the deductible as a Continued Member for the remainder of the calendar year. However, in all instances where the original family unit is split (i.e., divorce or loss of dependent status), the amounts accumulated by the original family unit will also be credited to the new unit, and the original family unit's amounts will not be reduced because of the loss of the Continued Member from the family unit.

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

VII. Cost

The Continued Member will be charged the entire cost applicable to any other Member or family with the same coverage, including the portion formerly paid by the Company, plus 2% of this total premium amount. In the case of an individual (employee or eligible dependent) who has had their maximum period of continued coverage extended from 18 months to 29 months due to a determination of disability for Social Security purposes, the charge for the 19th through 29th months will be based on a 50% addition to the entire premium amount instead of a 2% addition. The rates will be established prior to their effective date, and be frozen at that level for a minimum of 12 months.

Members or spouses with no dependents, and each former eligible Dependent Child who, because of losing Dependent Child status, elects continuing coverage, will be charged the single rate. Current rates are available from the Company's local Human Resources office or the Benefits Department in Houston or by clicking on the applicable link available here: http://www.mrobenefits.com/documents/tip-sheets/cobra-guidelines.htm.

VIII. Surviving Spouse and Surviving Dependents

Continuing coverage under COBRA will be offered to these individuals if:

A. The remarriage or failure to satisfy the eligible dependent requirements of the Plan occurs within 36 months of the date of death; and

B. None of the events which would have terminated the 36-month period of COBRA continuation coverage (which otherwise would have been provided if not for the Company-subsidized coverage under the Plan) have occurred.

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

IX. Administration

The continuation of coverage under the Plan is administered by CIGNA. After an election is made to continue coverage, CIGNA will bill the Continued Member for the first premium payment.

The premium for the succeeding months' coverage will be billed by CIGNA on a monthly basis. The succeeding premium payments are due on the first of the month for the month of coverage, i.e., in advance of the period of coverage.

Continued Members should mail their claims for benefits, under the continuation coverage, directly to CIGNA for processing. After continuation coverage is elected, CIGNA will advise Continued Members of CIGNA's address to which claims should be mailed and to which requests for additional claim forms should be sent.

X. Special Continuing Circumstances

A. When coverage would have ceased because of a qualifying event, except for the fact that the Company, through the operation of the Plans or otherwise, has at its discretion extended coverage for a specific period of time after the qualifying event under conditions more beneficial than COBRA requires, then COBRA coverage elected after such period expires will not extend longer than the applicable 18, 29, or 36 months from the date of the original qualifying event.

B. Change In Control

Employees who are eligible for a cash severance benefit under the Marathon Oil Company Change in Control Severance Benefits Plan and who satisfy all the requirements for Change in Control benefits will be eligible to receive extended coverage for 18 months as follows:

Eligible terminated employees (including those eligible to retire at the time of termination) and their eligible dependents who, immediately prior to termination were Members of the Dental Plan, have the opportunity to continue coverage under the terms and conditions of the Dental Plan as applied to active employees for a period of 18 months, provided the terminated employee is eligible for and timely elects continuation of such coverage in accordance with COBRA. The terminated employee shall pay the active employee rate applicable to Regular full-time Employee Members with respect to coverage during the eighteen (18) months following the termination date and, thereafter (if applicable), the full COBRA rate with respect to such coverage.

If coverage is elected under this Change in Control provision and the eligible terminated employee should die during the 18 months of extended active employee coverage, the survivor continuation provisions otherwise provided to active employees will apply.

The period of coverage provided under this section shall constitute continuation coverage required by COBRA. The eligibility of the terminated employee to continue such coverage at both the active employee rate and full COBRA rate shall not exceed a period of eighteen (18) months, unless a longer period is required by COBRA. Such benefits shall be governed by and subject to (i) the terms and conditions of the plan documents providing such benefits, including the reservation of the right to amend or terminate such benefits under those plan documents at any time provided that, for a period of two (2) years following a Change in Control, the Plan may not be amended in an adverse manner solely for employees eligible for benefits under this section; and (ii) the provisions of COBRA.