

**Marathon Oil Company
Flexible Spending Account Plan**

Effective January 1, 2014

Flexible Spending Account Plan



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I. Purpose

The purpose of this Marathon Oil Company Flexible Spending Account Plan is to permit employees of Marathon Oil Company and other Participating Employers make contributions to Health Care Spending Accounts, Limited Health Care Spending Accounts and Dependent Care Spending Accounts on a pre-tax basis and to be reimbursed for Eligible Expenses from such accounts. This document serves as both the plan document and the summary plan description for the Plan.

II. Definitions

When used in this Plan, the following terms shall have the meaning ascribed below:

“COBRA” means the Consolidated Omnibus Budget Reconciliation Act of 1986, as amended.

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

“Company” means Marathon Oil Company.

“Controlled Group” means Marathon Oil Corporation and any other entity or organization required to be aggregated with Marathon Oil Corporation pursuant to Section 414(b), (c), (m), (n) or (o) of the Code.

“DCSA” means the Dependent Care Spending Account, which is a type of FSA used for reimbursement of Eligible Dependent Care Expenses.

“Dependent” means a tax dependent under Section 152 of the Code.

“Eligible Dependent Care Expenses” means expenses incurred for the care of a Qualified Dependent, which are eligible for reimbursement in accordance with the terms of this Plan and the Code.

“Eligible Expenses” means Eligible Dependent Care Expenses and Eligible Health Care Expenses.

“Eligible Health Care Expenses” means medical and dental expenses for any Participant, which are eligible for reimbursement in accordance with the terms of this Plan and the Code.

“ERISA” means the Employee Retirement Income Security Act of 1974, as amended.

“HCSA” means the Health Care Spending Account, which is a type of FSA used for reimbursement of Eligible Health Care Expenses.

“Health Plan” means the Health Plan of Marathon Oil Company, consisting of the Traditional Plan Option and the Health Investment Plan Option (referred to as the “HIP Option”).

“LHCSA” means the Limited Health Care Spending Account, which is a type of FSA for participants in the HIP Option of the Health Plan, which is used for reimbursement of Eligible Health Care Expenses for vision and dental care expenses only.

“Participant” means an individual who meets eligibility requirements and participates in the Plan.

“Participating Employer” means Marathon Oil Company, Marathon Oil Corporation or Marathon Service Company, which collectively are referred to as “Participating Employers.”

“Plan” means this Marathon Oil Company Flexible Spending Account Plan.

“Plan Year” means the calendar year.

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“Qualified Dependent” means a “qualifying individual” within the meaning of Section 21(b)(1) of the Code.

“Spouse” means the husband or wife of an employee or Participant, as determined under the laws of the State in which they reside except that, for purposes of the Plan, an employee or Participant will never be considered married to an individual of the same gender.

III. In General

The Plan consists of three FSAs that allow a Participant to make pre-tax contributions from his or her earned income, which can then be used to reimburse Eligible Expenses. Each Participant can elect to participate in the DCSA and either the HCSA (for participants in the Traditional Option of the Health Plan) or the LHCSA (for participants in the HIP Option of the Health Plan).

Each Plan Year, if a Participant elects to contribute to an HCSA, LHCSA and/or DCSA, he or she can receive reimbursement from the appropriate account for Eligible Expenses that are not otherwise reimbursed. Contribution levels are set forth as described under the Section, *Contributions*.

IV. Eligibility

Who is Eligible

The following individuals are eligible to contribute to an FSA under the Plan:

- A regular part-time Employee who is scheduled to work at least 20-35 hours per week, or
- A regular full-time Employee who is scheduled to work at least 40 hours per week.

If a Participant is enrolled in the HIP Option of the Health Plan for medical coverage, he or she is **not** eligible for the HCSA. **Participants in the HIP Option may enroll in the LHCSA, which can be used to reimburse Eligible Expenses for vision and dental care only.**

When Participants May Enroll

Eligible individuals may elect to participate in the Plan during their first 30 days of employment or during any subsequent annual benefits open enrollment period.

An eligible individual who does not elect to participate in the Plan during his or her first 30 days of employment must wait until the next annual benefits open enrollment period to elect to participate in the Plan, unless such individual experiences a qualified change in status, as described below in the Section, *Changing Contribution Amounts*. Participants will need to enroll in the FSAs each year, even if they elected to contribute to an FSA the year before.



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V. FSA Contributions

Participants elect to participate in an FSA by completing an enrollment form and submitting it to the Marathon Oil Benefits Department. The Participant must specify the amount, in pre-tax dollars, that he or she wishes to contribute to the (1) HCSA or LHCSA or (2) the DCSA, or both.

To elect to participate in an FSA, Participants may call the Marathon Oil Benefits Department or log onto SAP Online within 30 days of the date they first become eligible to participate in the Plan. If a Participant does not enroll within 30 days, he or she will need to wait until the next annual benefits open enrollment to participate in the Plan, unless such individual experiences a qualified change in status, as described below in the Section, *Changing Contribution Amounts*.

Each year during annual benefits open enrollment, Participants have the opportunity to review and change the amount of pre-tax dollars they wish to contribute to the HCSA or LHCSA, the DCSA, or both. Any changes Participants make during benefits open enrollment will become effective the following January 1.

The amount each Participant elects to contribute to an FSA remains in Marathon Oil Company's general assets until claims are reimbursed. These amounts are not held in trust and no amounts are allocated to individual Participants.

Participants may contribute to (1) either the HCSA or LHCSA or (2) the DCSA, or both, however, amounts contributed to one account cannot be used to reimburse expenses under the other account. Participants should carefully estimate their Eligible Health Care and Eligible Dependent Care Expenses for the upcoming Plan Year because any unused funds remaining in either account after the end of the Plan Year will be forfeited.

Participants have until March 31 of the year immediately following the Plan Year to request reimbursement for Eligible Expenses incurred during the Plan Year.

Participants may elect to contribute between \$0 and \$2,500 to either the HCSA or LHCSA for a Plan Year.

Participants may each elect to contribute between \$0 and \$5,000 to the DCSA for a Plan Year. However, a Participant who is married and filing separately for federal income tax purposes may only elect to contribute up to \$2,500 for a Plan Year. If the earned income of a Participant or his or her Spouse is less than \$5,000 per year, the amount that such Participant can contribute is reduced to the amount of the Participant's or Spouse's earned income, whichever is less. (Note, however, that for this purpose, a Spouse who is a full-time student or who is incapable of caring for himself or herself is deemed to have some income under Code section 21(d) as described below.)

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VI. Changing Contribution Amounts

FSA Contribution Amounts

Applicable tax law does not permit a Participant to stop or change the amount contributed to an FSA during the Plan Year, unless such Participant meets one of the following conditions:

- A. With regard to both (1) the HCSA or LHCSA and (2) the DCSA, one of the following changes in status events occurs:
- An event that results in a change in the Participant's legal marital status, including marriage, the death of the Participant's Spouse, or divorce, legal separation or annulment.
 - An event that results in a change in the number of the Participant's dependents, including birth, adoption, placement for adoption or death of a dependent.
 - An event that results in a change in the employment status of the Participant, the Participant's Spouse or dependent, including termination or commencement of employment, a strike or lockout, the commencement of or return from an unpaid leave of absence.
 - An event that causes a Participant's dependent to satisfy or cease to satisfy eligibility requirements due to the attainment of age, change in student status or any similar circumstances, as provided in the applicable section of this Plan.
- B. For Participants who participate in the HCSA or LHCSA, the following additional events will enable a Participant to change his or her HCSA or LHCSA election:
- If the Participant becomes entitled to Medicare or Medicaid, he or she may elect to revoke HCSA or LHCSA coverage. If the Participant loses coverage under Medicare or Medicaid, the Participant may increase his or her coverage.
 - If Marathon Oil Company or another Participating Employer receives a judgment, decree or order resulting from a Participant's divorce, legal separation, annulment or change in legal custody that requires group health coverage for such Participant's dependent child then the FSA Plan Administrator and/or Marathon Oil Company may:
 - Change the Participant's election to provide coverage for that child, if the order requires the Participant to provide coverage for the child under the HCSA or LHCSA, or
 - Permit the Participant to cancel his or her child's coverage under the HCSA or LHCSA, if the order requires the Participant's former spouse to provide coverage.
- C. For Participants who participate in a DCSA, the following events, in addition to those in (A.) above will enable a Participant to change his or her election:
- A change in the Participant's dependent care provider.
 - A significant increase or decrease in the cost of the dependent care, but only if the dependent care provider that imposes the cost change is not related to the Participant.

The Participant must notify Marathon Oil Company within 31 days of any of the above change in status events to request a change in coverage. No change in election will be permitted after 31 days.



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The above rules are intended to be consistent with Sections 125 and 129 of the Code and any accompanying Treasury Regulations or other applicable guidance issued by the Internal Revenue Service, and to the extent there is any inconsistency between the Plan and the Code, Treasury Regulations or other applicable guidance issued by the Internal Revenue Service, the Code, Treasury Regulations or other applicable guidance issued by the Internal Revenue Service shall control.

Any new election hereunder must be on account of and correspond with the change in status event that affects eligibility for coverage. This means that there must be a logical relationship between the event that occurs and the election change the Participant is requesting (i.e., if a Participant divorces, it would not be logical to increase his or her HCSA election).

Changes in contribution amounts made during the Plan Year are effective as of the effective date of the change in status provided that the Participant timely notifies Marathon Oil Company of his or her change in status.

VII. Health Care Spending Account

Eligible Health Care Expenses

To be eligible for reimbursement from an HCSA, the health care expenses must be:

- Incurred for medical care, defined in Section 213(d) of the Code for amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body including prescription medicine and drugs and over-the-counter medicine and drugs prescribed by a health care provider.
- Incurred while the Participant is participating in the HCSA.
- Incurred during the Plan Year.
- Not reimbursed or paid under any other benefit plan or arrangement, including a Spouse's group health plan or a Dependent's group health plan.

Below is a partial list of the types of health care expenses eligible for reimbursement from an HCSA. Generally, Eligible Health Care Expenses are those for which a Participant could have claimed a tax deduction on an itemized federal income tax return (without regard to any threshold limitation) including any copayment, coinsurance or deductible amounts. Additional guidance regarding what constitutes an Eligible Health Care Expense is provided in IRS Publication 502.

Eligible Medical Expenses

- Copayments, Coinsurance and Deductible amounts;
- Routine physical exams;
- Routine lab and X-rays performed for medical reasons;
- Birth control items prescribed by a health care provider;
- Childbirth classes;
- Cardiac rehabilitation classes;



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- Drug abuse treatment centers;
- Sterilization unless prohibited by law; and
- Other qualified Code Section 213(d) medical expenses not covered by the underlying medical plan.

Eligible Vision Expenses

- Routine eye examinations;
- Eye glasses; and
- Contact lenses, including all necessary supplies and equipment.

Eligible Hearing Expenses

- Routine hearing examinations;
- Hearing aids and repairs; and
- Cost and repair of special telephone equipment for the deaf.

Eligible Dental Expenses

- Copayments, Coinsurance and Deductible amounts;
- Preventive Care;
- Exams, cleanings, X-rays, root canals and bridges; and
- Dentures and fillings.

Eligible Prescription Drugs

- Copayments, Coinsurance and Deductible amounts; and
- Cost for allowable prescription drugs.

Ineligible Expenses

The partial list below includes examples of expenses that are not eligible for reimbursement:

- Expenses incurred for cosmetic surgery or other similar procedures, unless the procedure is necessary to improve deformities directly related to a congenital condition, a personal injury or a disfiguring disease.
- Expenses for custodial care in a nursing home.
- Insurance premiums, including Medicare Part B premiums, long term care premiums, and other payments or contributions for health coverage (such as contributions for coverage under an employer-sponsored group health plan or HMO or other health plan).
- Expenses incurred for general good health (such as vitamins and other dietary supplements, and toothpaste).

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- Expenses incurred before the effective date of a Participant's election.
- Over the counter non-prescription drugs and medicines incurred for medical care (such as allergy medicines, antacids, cold medicines and pain relievers), unless prescribed by a health care provider. (Note, however, that the cost of prescribed OTC medicines is an Eligible Expense.)

In addition, as with any other expense reimbursed under an employer-sponsored medical or dental plan, health expenses reimbursed through an HCSA cannot be claimed as deductions on the Participant's income tax return.

VIII. Limited Health Care Spending Account

Eligible Dental and Vision Expenses

To be eligible for reimbursement from a LHCSA, the eligible expenses must be:

- Incurred for dental and vision care that meets the definition of medical care in Section 213(d) of the Code. Incurred while the Participant is participating in the LHCSA.
- Incurred during the Plan Year.
- Not reimbursed or paid under any other benefit plan or arrangement, including a Spouse's group health plan or a Dependent's group health plan.

Below is a partial list of the types of vision and dental expenses eligible for reimbursement from an LHCSA. Generally, eligible dental and vision expenses are those for which a Participant could have claimed a tax deduction on an itemized federal income tax return (without regard to any threshold limitation) including any copayment, coinsurance or deductible amounts. Additional guidance regarding what constitutes an Eligible Health Care Expense for purposes of the LHCSA is provided in IRS Publication 502.

Eligible Vision Expenses

- Routine eye examinations;
- Eye glasses; and
- Contact lenses, including all necessary supplies and equipment.

Eligible Dental Expenses

- Copayments, Coinsurance and Deductible amounts;
- Preventive Care;
- Exams, cleanings, X-rays, root canals and bridges; and
- Dentures and fillings.

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Ineligible Expenses

The partial list below includes examples of expenses that are not eligible for reimbursement:

- Expenses incurred for cosmetic surgery or other similar procedures, unless the procedure is necessary to improve deformities directly related to a congenital condition, a personal injury or a disfiguring disease.
- Expenses incurred for medical services.

In addition, as with any other expense reimbursed under an employer-sponsored medical or dental plan, expenses reimbursed through an LHCSA cannot be claimed as deductions on the Participant's income tax return.

IX. Dependent Care Spending Account

Eligible Dependent Care Expenses

Eligible Dependent Care Expenses that can be reimbursed from a DCSA are expenses incurred for household and dependent care services that enable the Participant and (if married) the Participant's Spouse to be gainfully employed, which generally means working or actively looking for work.

If a Participant's Spouse has no earned income, the Participant cannot use a DCSA unless his or her Spouse is physically or mentally incapable of caring for himself or herself, is looking for work or is a full-time student for at least five months during the Plan Year.

To qualify for reimbursement, Dependent Care Expenses cannot exceed the Participant's earned income or, if married, the lesser of the Participant's earned income or his or her Spouse's earned income. Earned income (including any self-employment earnings) is generally the remaining salary after all pre-tax salary reductions have been made. If a Participant is married and his or her Spouse is physically or mentally incapable of caring for himself or herself or is a full-time student, the Spouse is deemed to have monthly earned income of \$250 (as adjusted from time to time) if the Participant has one dependent, or \$500 (as adjusted from time to time) if the Participant has two or more dependents, for each month that the Spouse is either incapable of caring for himself or herself or is a full-time student.

Dependent Care Expenses must be incurred for a Qualified Dependent. Qualified Dependents are determined under Section 21(b)(1) of the Code but are generally:

- A dependent under federal tax law who is a child under age 13; or
- A Participant's Spouse, if the Spouse is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the Participant for more than one-half of such taxable year; or
- A dependent under federal tax law who is physically or mentally incapable of caring for himself or herself; provided that such dependent lives in the Participant's home for more than one-half of the year, if the Participant provides over one-half of the dependent's support for the taxable year.

Eligible Dependent Care Expenses include, but are not limited to, the following expenses if not otherwise excluded:



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- Expenses for care at a day care center and day care transportation that complies with all applicable state and local regulations.
- Expenses for licensed nursery school fees.
- Expenses for care provided by a housekeeper, babysitter or other person in the Participant's home who primarily cares for eligible children or an eligible adult dependent.
- Expenses for care provided by a relative who cares for a Participant's Qualified Dependents, so long as that relative is over the age of 19 and is not the Participant's dependent under federal tax law.
- Expenses for care for a dependent age 13 or over, including a Spouse or adult dependent, who is physically or mentally incapable of caring for himself or herself. If a Participant is claiming reimbursement for care outside his or her home for such dependent, the dependent must spend at least 8 hours each day in the Participant's home.
- Expenses for care at a day camp to which a Participant sends his or her children (under age 13) during school vacations so that the Participant and his or her Spouse, if the Participant is married, can be gainfully employed or attend school full-time.

Dependent Care Tax Credit vs. Dependent Care Spending Account

Some employees may be eligible to claim a dependent care tax credit on their federal income tax returns. This credit is available for the same types of expenses as the DCSA. However, the IRS requires that the dependent care tax credit be reduced, dollar for dollar, by the amount reimbursed under a dependent care flexible spending account. In other words, a Participant cannot use expenses reimbursed through the DCSA to claim the tax credit.

More information about how the dependent care tax credit works is provided in IRS Publication No. 503. In addition, because each employee's situation is different, an employee may want to consult his or her tax advisor before deciding whether to use the tax credit or the DCSA.

X. Payments From an FSA

Payments from an FSA may be made either under the procedures described in the Section, *Requesting a Reimbursement from an FSA*, or when a Participant uses a Health Care Spending Card Debit MasterCard® to pay for certain Eligible Expenses directly from his or her HCSA or LHCSA.

XI. Health Care Spending Card Debit MasterCard®

Each Participant will be provided with a Health Care Spending Card Debit MasterCard® that may be used to pay for certain Eligible Expenses directly from his or her HCSA or LHCSA. The Health Care Spending Card Debit MasterCard® allows for direct payment to qualified locations and providers that accept MasterCard®. Use of the Health Care Spending Card Debit MasterCard® is voluntary.

Participants who decide not to use the Health Care Spending Card Debit MasterCard® can be reimbursed for Eligible Expenses by completing a paper reimbursement form available from Marathon Oil Company or found on www.myuhc.com and as described under Section, *Requesting a Reimbursement from an FSA*.



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Using the Health Care Spending Card Debit MasterCard®

The HCSA, LHCSA and card are regulated by the IRS, therefore **Participants should retain all itemized receipts generated from the Health Care Spending Card Debit MasterCard®, because certain payments must be verified and UnitedHealthcare may request this receipt to ensure that payment was made for a qualified health care expense. Credit card receipts that do not itemize expenses are not sufficient to verify payment. Amounts paid that cannot be verified may be considered taxable income to the Participant.**

XII. Requesting a Reimbursement From an FSA

A Participant who does not use his or her card will need to submit a reimbursement form, called a request for withdrawal, to be reimbursed from an HCSA or LHCSA and/or DCSA for the Eligible Expenses that have been incurred. A request for withdrawal form is available from Marathon Oil Company or can be found on www.myuhc.com.

For reimbursement from an HCSA or LHCSA, the Participant must include proof of the expenses incurred. Proof can include a bill, invoice, or an Explanation of Benefits (EOB) from any group medical/dental/vision plan under which the Participant or a Dependent is covered. An EOB will be required if the expenses are for services usually covered under group medical, dental and vision plans, for example, charges by surgeons, doctors and hospitals. In such cases, an EOB will verify what the Participant's out-of-pocket expenses were after payments under other group medical/dental/vision plans are made.

For reimbursement from a DCSA, the Participant must submit proof of the services rendered, such as a bill, receipt, or invoice and Social Security or Tax Identification Number of the care provider.

Only expenses which are incurred while the Participant is a Participant in the Plan may be reimbursed from an FSA. In addition, expenses which are incurred during one Plan Year cannot be reimbursed from funds contributed to an HCSA, LHCSA or DCSA during another Plan Year. An expense is considered incurred when services are provided, not when the Participant is billed or when the Participant pays for care.

A Participant can submit a reimbursement form at any time. The Participant will be reimbursed for Eligible Expenses as long as the amount requested from either account is at least \$25, except for reimbursement with respect to the last month of the Plan Year. Amounts below \$25 will be accumulated and processed with future payments.

If a Participant has established an HCSA or LHCSA, the Participant's total annual contribution amount is available immediately. The Participant can request reimbursement for Eligible Expenses up to his or her annual contribution amount as soon as such Eligible Expenses have been incurred.

If a Participant has established a DCSA, only the amounts actually contributed to the account are available for reimbursement. If the Participant requests reimbursement for more than the amount in the DCSA, the Participant will receive only the amount in the account. As additional contributions are made to the account, outstanding reimbursements will be processed automatically.

Requests for withdrawal will be accepted and processed through March 31 of the following year for expenses incurred during the Plan Year.

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Amounts contributed to an HCSA, LHCSA or DCSA during the Plan Year but remaining in the account at the end of the processing period (March 31 of the following year) cannot be returned or used to reimburse expenses incurred in a subsequent Plan Year. These amounts are forfeited.

XIII. FSA Claims Procedures

Claim Denials and Appeals

If a Claim is Denied

If a claim for HCSA or LHCSA benefits is denied in part or in whole, a Participant may call UnitedHealthcare at the number on his or her Health Care Spending Card Debit MasterCard® card before requesting a formal appeal, but this is not required. UnitedHealthcare will try to resolve the issue over the phone; however, if the Participant is not satisfied, he or she has the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If a Participant wishes to appeal a denied claim, the Participant must submit the appeal in writing within 180 days of receiving the denial. This written communication should include:

- the patient's name and ID number as shown on the ID card;
- the provider's name (if applicable);
- the date of medical service (if applicable);
- the reason the Participant thinks the claim should be paid; and
- any documentation or other written information to support the Participant's request.

A Participant, a Dependent or the personal representative of a Participant or Dependent may send a written request for an appeal to the Plan Administrator. Written requests for an appeal should be sent to:

Plan Administrator
Marathon Oil Company Benefits Department
Attn: Health and Welfare Appeals – Room 2639
5555 San Felipe Street
Houston, TX 77098

The Plan Administrator must notify the Participant of the benefit determination within 30 days after receiving the completed appeal.

Note: Upon written request and free of charge, any Participant may examine documents relevant to their claim and/or appeals and submit opinions and comments. The Plan Administrator will review all claims in accordance with the rules established by the U.S. Department of Labor. The Plan Administrator's decision will be final.

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Failure to make written request for appeal within the 180-day period after the receipt of notice of denial of a claim shall render the original decision regarding the claim final, binding and conclusive on all parties. The decision on appeal shall be in writing and shall include the specific reason(s) for the decision and the specific reference(s) to the pertinent Plan provisions on which the decision is based.

Questions regarding any the procedures discussed above may be directed to the Marathon Oil Benefits Department.

XIV. When Participation Ends

A Participant will cease to participate in the Plan as of the earlier of:

- The date on which the Plan terminates.
- The date a Participant's employment with the Company ends.
- The date a Participant ceases to be an eligible employee.
- The date a Participant fails to make a required contribution under the terms of the Plan.

Health Care Spending Account

A Participant may submit a claim for reimbursement of Eligible Expenses which were incurred during the Plan Year of employment termination, as long as those expenses were incurred prior to the date of termination. Any such claims must be submitted on or before March 31 of the next Plan Year.

HCSAs and LHCSAs are subject to COBRA as described in the Section, *Optional Continuation Coverage Under the HCSA or LHCSA (COBRA)*.

Optional Continuation Coverage Under the HCSA or LHCSA (COBRA)

This provision is intended to comply with Section 4980B of the Code and the associated Treasury Regulations and other applicable guidance, and its interpretation is governed by and shall be consistent with them.

In general, COBRA continuation coverage must be offered with respect to a Participant's HCSA or LHCSA if the Participant has a positive balance in such account at the time of a qualifying event such as termination of employment (other than by reason of gross misconduct) or reduction in work hours. A "positive balance" for this purpose generally means that the contributions made to the account prior to the qualifying event exceed the eligible claims for reimbursement submitted prior to the qualifying event. If this COBRA continuation coverage is available to a Participant who experiences a qualifying event and continuation coverage is elected by the Participant, such coverage will cease at the end of the Plan Year in which the qualifying event occurs and coverage cannot be continued into the next Plan Year. Premiums for such continuation coverage (i.e., contributions to the account) will be paid by the Participant on an after-tax basis plus a 2% administrative fee or other cost as permitted by law.

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Group Covered

All Participants of the Plan (other than nonresident aliens with no U.S.-source earned income) are eligible for continuation of coverage, subject to these COBRA provisions.

Qualifying Events and Maximum Length of Continuation Periods

If a Participant ceases to be eligible to participate in the HCSA or LHCSA:

- because of termination of employment (including retirement), either voluntary or involuntary, for reasons other than gross misconduct; or
- because of a reduction of work hours (e.g., change from regular to Casual status or layoff);

then the Participant will be entitled to elect continuation of coverage for the remainder of the Plan Year in which the qualifying event occurred.

Termination of Continued Coverage

A Participant's continued coverage will end on the earlier of the date when the balance of the Participant's HCSA or LHCSA is zero or the last day of the Plan Year in which the qualifying event occurred.

Notification Procedure

If coverage terminates, then Marathon Oil Company will notify the Plan Administrator of such event within 30 days, and the Plan Administrator will notify the Participant of his or her rights under COBRA within 14 days after receiving notice from Marathon Oil Company.

The Participant must elect to continue coverage within a specified election period. This period begins on the **earliest** of:

- a. the date notification is given to the Participant; or
- b. the date of termination of coverage;

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

- c. the date of the notice from the Plan Administrator, if applicable; or
- d. the date of termination of coverage.

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

The first COBRA continuation payment must be made within 45 days of the election and, if the payment is made after the qualifying event, the payment must be sufficient to cover all continuation payment amounts for the period beginning on the date coverage would have otherwise ceased and ending on the first date covered by the advance continuation payment amounts.

Continued coverage offered will be a continuation of the HCSA or LHCSA benefits currently being provided under the Plan to other similarly situated Participants with respect to whom a qualifying event has not occurred. Any amendments to the Plan applicable to non-continued Participants will also be applicable to similarly situated continued Participants.

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Uniformed Services Employment and Reemployment Rights Act

An employee who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the employee and the employee's dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Service" or "Military Service" mean service in the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, employees may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution (i.e., contributions to the account) for the HCSA or LHCSA. If an employee's Military Service is for a period of time less than 31 days, the employee may not be required to pay more than the regular contribution amount (i.e., contributions to the account), for continuation of the HCSA or LHCSA.

An employee may continue Plan coverage under USERRA for up to the lesser of:

- the 24 month period beginning on the date of the employee's absence from work; or
- the day after the date on which the employee fails to apply for, or return to, a position of employment.

Regardless of whether an employee continues the HCSA or LHCSA, if the employee returns to a position of employment, the employee's HCSA or LHCSA balance will be reinstated under the Plan. No exclusions or waiting period may be imposed on an employee or the employee's eligible dependents in connection with this reinstatement, unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of Military Service.

Dependent Care Spending Account

A Participant may submit claims for the Eligible Expenses he or she has incurred during that Plan Year before the date of his or her termination of employment against what is in the Participant's DCSA when the Participant leaves employment. Any such claims must be submitted on or before March 31 of the next Plan Year.

XV. Modification and Termination of the Plan

Marathon Oil Company reserves the right to amend, modify or terminate the Plan, in whole or in part, in such manner as it shall determine. If the Plan should be terminated, any benefits accrued or credited to a Participant's FSA on or prior to the effective date of the Plan's termination shall, to the extent administratively practicable, remain available for reimbursement of Eligible Expenses. Marathon Oil Company may, in its sole discretion, offer or cease at any time to offer a contribution to an FSA.

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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 the Board of Directors of the Company;
- (iii) Be written actions exercised by any other Committee, for example the Salary and Benefits Committee (the “Salary and Benefits Committee”), to which the Board of Directors of the Company or the Executive Committee of that Board has specifically delegated rights of amendment, modification or termination; or
- (iv) 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 of that Board has specifically delegated rights of amendment, modification, or termination.

In addition to the other methods of amending the Company’s employee benefit plans, policies, and practices (hereinafter referred to as “MOC Employee Benefit Plans”) 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 may approve the following types of amendments to MOC Employee Benefit Plans:

- (i) With the opinion of counsel, technical amendments required by applicable laws and regulations;
- (ii) With the opinion of counsel, amendments that are clarifications of Plan provisions;
- (iii) Amendments in connection with a signed definitive agreement governing a merger, acquisition or divestiture such that, for MOC Employee Benefit Plans, needed 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;
- (iv) Amendments in connection with changes that have a minimal cost impact (as defined below) to the Company; and
- (v) With the opinion of counsel, amendments in connection with changes resulting from state or federal legislative actions that have a minimal cost impact (as defined below) to the Company.

For purposes of the above, “minimal cost impact” is defined as an annual cost impact to the Company per MOC Employee Benefit Plan case that does not exceed the greater of:

- (i) An amount that is less than one-half of one percent of its documented total cost (including administrative costs) for the previous calendar year; or
- (ii) \$500,000.

The Board of Directors of the Company or the Executive Committee of the Board has delegated to the Salary and Benefits Committee the authority to amend, modify, or terminate this Plan at any time. This authority delegated to the Salary and Benefits Committee shall be exercised in writing.

Marathon may allow other companies to participate in the Plan from time to time as Participating Employers, and each Participating Employer shall be responsible for the expenses and liabilities associated with its participation. Such companies may choose to elect to discontinue their participation in the Plan at any time.



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XVI. Important Administrative Information: ERISA

This section includes information on the administration of the Plan.

The DCSA and the pre-tax employee contribution portions of the Plan are not subject to ERISA. Only the HCSA and LHCSA are subject to ERISA.

The Plan is funded by participant contributions.

Plan Sponsor and Administrator

Marathon Oil Company is the Plan Sponsor of the Marathon Oil Company Flexible Spending Account Plan.

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

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.

Participants may contact the Plan Administrator at:

Deanna L. Jones
Plan Administrator – Marathon Oil Company Flexible Spending Account Plan
Marathon Oil Company
5555 San Felipe Street
Houston, TX 77056
(713) 629-6600

Claims Administrator

UnitedHealthcare is the Plan's Claims Administrator. The role of the Claims Administrator is to handle the day-to-day administration of the Plan's coverage as directed by the Plan Administrator, through an administrative agreement with Marathon Oil Company.

Participants may contact the Claims Administrator by phone at the number on their ID cards or in writing at:

United HealthCare Services, Inc.
185 Asylum St.
Hartford, CT 06103-3408

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Agent for Service of Legal Process

Should it ever be necessary, a Participant or his or her personal representative may serve legal process on the agent of service for legal process for the Plan. The Plan's Agent of Service is:

Agent for Legal Process – FSA Plan
Marathon Oil Company
5555 San Felipe Street
Houston, TX 77056
(713) 629-6600

Legal process may also be served on the Plan Administrator.

Administration of the Plan

Plan Name	Marathon Oil Company Flexible Spending Account Plan
Plan Administrator (Agent for service of legal process)	Deanna L. Jones 5555 San Felipe Street Houston, TX 77056 Phone: (713) 629-6600
Employer Identification Number	25-1410539
Type of Plan	Cafeteria Plan under Section 125 of the Internal Revenue Code
Plan Sponsor	Marathon Oil Company 5555 San Felipe Street Houston, TX 77056
Plan Number	525
Inspection of Plan Documents	Plan documents may be inspected by making a request at any Company Human Resources office or by writing: Marathon Oil Company Benefits Administration 5555 San Felipe Street Houston, TX 77056
Plan Year	The Plan Year is January 1 through December 31. Records are kept on a calendar year basis.
Recordkeeper/Claims Administrator	United HealthCare Services, Inc. 185 Asylum St. Hartford, CT 06103-3408

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



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In determining the eligibility of individuals for benefits and in construing the Plan's terms, the Plan Administrator (or a third party administrator such as UnitedHealth Care 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. The Plan shall be construed, whenever possible, to be in conformity with the requirements of the Code. 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 his (or its) 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 a third party administrator, shall be uniform in their nature and shall be applicable to all participants similarly situated, and shall be administered in a nondiscriminatory manner in accordance with the provisions of the Employee Retirement Income Security Act of 1974, as amended (ERISA) and the Internal Revenue Code of 1986, as amended (the Code).

In situations in which the Plan Administrator deems it to be appropriate, the Plan Administrator may evidence (i) the exercise of such discretion, or (ii) any other type of decision, directive or determination he may make with respect to the Plan, in the form of a written administrative ruling which, until revoked, or until superseded by Plan amendment or by a different administrative ruling, shall thereafter be followed in the administration of the Plan.

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

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

In the event that a benefit provided under the Plan does not satisfy the requirements of Code Sections 105, 106 or 125 or Code Section 129, and therefore becomes taxable to the Participant, any reimbursement or benefit will be paid no later than the last day of the taxable year following the taxable year in which the expense was incurred.

To the extent not superseded by the laws of the United States, the laws of the State of Texas shall be controlling in all matters relating to the Plan.



Flexible Spending Account Plan

XVII. Further Information

Limitation Regarding Employment

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

No Interest or Earnings

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

Severability

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

Forfeitures

Any amount allocated on behalf of a Participant shall be forfeited by the Participant and restored to the applicable Participating Employer if it has not been applied to provide the elected benefit for any Plan Year by the 90th day following the end of the Plan Year for which the election was effective. Amounts so forfeited shall be applied by the applicable Participating Employer to reduce future costs or for any other proper purpose.

Treasury Regulations

You are responsible for ensuring the expenses submitted for reimbursement under this Plan meet all of the eligibility requirements set forth under the applicable provisions of the Code, Treasury Regulations or other guidance issued by the Internal Revenue Service. Deliberately providing false information could result in penalties imposed by the Internal Revenue Service.

Unclaimed Payments

If within 5 years after any amount becomes payable hereunder to a Participant, the same shall not have been claimed, provided due and proper care have been exercised by the claims administrator and the Company in attempting to make such payments by providing notice at the Participant's last known address, the amount thereof shall be forfeited and shall cease to be a liability of the Plan. In such case, the amount thereof shall be retained by the Company in its general assets. Provided that the claimant initially made a timely claim, the claimant shall have the right and responsibility to re-establish their claim for payment with the Company by providing due proof that such amount is owed to the Participant.

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XVIII. ERISA Rights Statement

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be permitted to:

- receive information about Plan benefits;
- examine, without charge, at the Plan Administrator's office and at other specified worksites, all plan documents — including pertinent insurance contracts, collective bargaining agreements (if applicable), and other documents available at the Public Disclosure Room of the Employee Benefits Security Administration; and
- obtain copies of all Plan documents and other Plan information, including insurance contracts and collective bargaining agreements (if applicable), and updated summary plan descriptions, by writing to the Plan Administrator. The Plan Administrator may make a reasonable charge for copies.

You may be eligible to continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Plan document to understand the rules governing your COBRA continuation coverage rights.

If your claim for a Plan 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 the plan document from the Plan, and do not receive it 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 for reasons beyond the control of the Plan Administrator.

If you have a claim for benefits, which is denied or ignored, in whole or in part, and you have exhausted the administrative remedies available under the Plan, 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, you may file suit in federal court. If it should happen that the Plan's 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.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or write to the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W. Washington, DC 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 at (866) 444-3272.

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XIX. Plan Privacy and HIPAA

The Plan will use protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations. More information can be obtained regarding the use of PHI under HIPAA and the establishment of a security officer at http://www.mymarathonbenefits.com/common/docs/Privacy_Notice.pdf. The Marathon Oil Company Protected Health Information Policy is incorporated as part of this Plan document.

* * * * *

Marathon Oil Company has caused its name to be hereunto subscribed to by Morris R. Clark, Vice President and Treasurer, Marathon Oil Company.

MARATHON OIL COMPANY

Morris R. Clark
Vice President and Treasurer
Marathon Oil Company