Health Plan of Marathon Oil Company (Core Document)

Amendment and Restatement
Effective January 1, 2017

Marathon Oil Corporation

Health Plan

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Health Plan

Article I — Plan Overview

This Plan is sponsored by Marathon Oil Company ("Marathon" or the "Company") for employees and pre-65 retirees of Marathon Oil Company and employees and pre-65 retirees of certain other parent and subsidiary entities. It is effective January 1, 2016. This amended and restated document along with the Marathon Oil Company Protected Health Information Policy and the following summary plan descriptions constitutes the Plan document:

- Medical summary plan descriptions, each of which describes a medical plan option in which active and inactive employees and pre-age 65 retirees and their respective Dependents may participate:
  - Traditional Option,
  - Health Investment Plan Value Option,
  - Health Investment Plan Plus Option,
  - Out of Area Traditional Option,
  - Out of Area Health Investment Plan Value Option, or
  - Out of Area Health Investment Plan Plus Option.
- Employee Assistance Program
- Prescription Drug Program
- Wellness Program

Other employers eligible to participate in this Plan are Marathon Oil Corporation, Marathon Service Company, and other entities as authorized by the Plan Administrator (each such entity an "Employer"). The Plan Administrator also has authority to add and remove entities as participating employers.

Article II — Eligibility

Each summary plan description sets for eligibility requirements which apply specifically to the arrangement described in that summary plan description. However, if (i) your employment terminated as a result of the reduction in force initiated in November 2015 and (ii) you were entitled to a severance benefit under the Termination Allowance Plan (as determined by the Plan Administrator of the Termination Allowance Plan), and (iii) you were within six months of reaching age 50 or 10 years of service, you will be eligible to participate in this Plan as a Retired Pre-65 employee. If you are not otherwise eligible to participate in this Plan but you become eligible as a result of being deemed to have additional age or service provided by this paragraph, your costs will be calculated based on the lowest level of employer subsidy for Retired Pre-65 employees.

Article III — COBRA Continuation Coverage

Continuing Coverage Through COBRA

Continuation coverage under the Consolidated Budget Reconciliation Act of 1985 (COBRA) is available for this Plan.

Continuation Coverage Under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Plan Administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary." A Qualified Beneficiary is any of the following persons who were covered under the Plan on the day before a qualifying event:

- an employee of an Employer ("Employee");
- an Employee's enrolled dependent ("Dependent"), including with respect to the Employee's children, a child born to or placed for adoption with the Employee; or
- an Employee's former spouse, as spouse is defined in the applicable summary plan description ("Spouse").

A domestic partner, who is not a Spouse as defined in the applicable summary plan description, or a child of a domestic partner is not a Qualified Beneficiary for purposes of electing continuation coverage under COBRA.

Qualifying Events for Continuation Coverage Under COBRA

The following table outlines situations in which you may elect to continue coverage under COBRA for yourself and your Dependents, and the maximum length of time you can receive continued coverage. Your Dependents may also have independent election rights. These situations are considered qualifying events.

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
Your work hours are reduced	18 months	18 months[3]	18 months[3]
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage[1]	29 months	29 months	29 months
You die	N/A	36 months[3]	36 months[3]
You divorce (or legally separate)	N/A	36 months[3]	36 months[3]
Your child is no longer an eligible family member (e.g., reaches the maximum age limit)	N/A	N/A	36 months
Marathon Oil Company files for bankruptcy under Title 11, United States Code[2]	36 months[4]	36 months[5]	36 months[5]

[1] Subject to the following conditions: (i) the Qualified Beneficiary is determined to be disabled under Title II or Title XVI of the Social Security Act at any time during the first 60 days of COBRA continuation coverage, (ii) notice of the disability must be provided to the Plan Administrator within 60 days after the determination of the disability and before the end of the original 18-month maximum coverage period; (ii) the Qualified Beneficiary must agree to pay any applicable increase in the required premium for the additional 11 months over the original 18 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of disability extension continuation coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

[2] In the case of qualifying event that is a bankruptcy of the employer, a qualifying event includes a substantial elimination of coverage within one year before or after the date the bankruptcy proceeding commences for a covered Employee who had retired on or before the date of the substantial elimination of Plan coverage, or for any spouse, surviving spouse or dependent child of such individual if, on the day before the bankruptcy qualifying event, the spouse, surviving spouse or dependent child is a beneficiary under the Plan.

[3] For individuals who are qualifying beneficiaries covered for an 18-month or 29-month continuation coverage period, the original period is extended to 36 months for those individuals who are still qualifying beneficiaries at the time of the death or divorce. In addition, if a covered Employee becomes entitled to Medicare benefits before the occurrence of a qualifying event that is a termination of employment or a reduction of hours of employment, the maximum period of continuation coverage for a Qualified Beneficiary of such covered Employee will be the later of 18 months (or 29 months if there is disability extension) from the date of the qualifying event or 36 months of the date on which the covered Employee becomes entitled to Medicare benefits.

[4] In the case of qualifying event that is a bankruptcy of the employer, the maximum coverage period for a qualified beneficiary who is a retired covered employee ends on the earlier of death or attainment of age 65.

[5] From the date of the Employee's death if the Employee dies during the continuation coverage period.

Getting Started

You or your Dependents will be notified by mail if you or they become eligible for COBRA coverage. The notification will give you instructions for electing COBRA coverage, and advise you of the monthly cost. Except as provided in paragraphs A and B below, your monthly cost is the full cost, including both Employee and Employer costs, plus a 2% administrative fee or other cost as permitted by law. Under certain circumstances, the Plan may require payment of up to 150% of the Employer and Employee costs for COBRA continuation coverage during a disability extension.

If (i) your employment either terminated during September 2015 or terminates on or after November 16, 2015 and (ii) you are entitled to receive a severance benefit under the Termination Allowance Plan (as determined by the Plan Administrator of the Termination Allowance Plan), then you and your eligible Dependents can elect COBRA coverage at active employee rates for the first 90 days following your termination of employment. After 90 days, your monthly cost will be the cost described in the immediately preceding paragraph. This 90-day period of COBRA coverage provided at active employee rates does not extend the duration of the period for which you and your Dependents are eligible for COBRA coverage.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a provider, inform that provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a participant in the medical Plan under COBRA, you have the right to change your coverage election:

- during annual benefits open enrollment; and
- following a change in family status, as described in the applicable summary plan description.

Notification Requirements

If your covered Dependents lose coverage due to divorce, legal separation, or loss of Dependent status, you or your Dependents must notify the Plan Administrator within 60 days of the latest of:

- the date of the divorce, legal separation or an enrolled Dependent's loss of eligibility as an enrolled Dependent;
- the date your enrolled Dependent would lose coverage under the Plan; or
- the date on which you or your enrolled Dependent are informed of your obligation to provide notice and the procedures for providing such notice.

You or your Dependents must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

If you or your Dependents fail to notify the Plan Administrator of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If you are continuing coverage under federal law, you must notify the Plan Administrator within 31 days of the birth or adoption of a child.

Once you have notified the Plan Administrator, you will then be notified by mail of your election rights under COBRA.

Notification Requirements for Disability Determination

If you extend your COBRA coverage beyond 18 months because you or another Qualified Beneficiary are eligible for disability benefits from Social Security, you must provide Marathon Oil Benefits Center with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in the summary plan description for the Choice Option, Choice Plus with HRA Option, or Out of Area Option for Active, Pre-65 Retirees, and Inactive Employees, as applicable. The contents of the notice must be such that the Plan Administrator is able to determine the covered Qualified Beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

Trade Act of 2002

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Employees who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or "alternative trade adjustment assistance" under a federal law called the Trade Act of 1974. These Employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If an Employee qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The Employee must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Employee will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

When COBRA Ends

COBRA coverage will end before the maximum continuation period shown above if:

- you or your covered Dependent becomes covered under another group medical plan, as long as the other plan doesn't limit your coverage due to a preexisting condition; or if the other plan does exclude coverage due to your preexisting condition, your COBRA benefits would end when the exclusion period ends;
- you or your covered Dependent becomes entitled to, and enrolls in, Medicare after electing COBRA;
- the first required premium is not paid within 45 days;
- any other monthly premium is not paid within 30 days of its due date;
- the entire Plan ends; or
- coverage would otherwise terminate under the Plan as described in the beginning of this section.

Note: If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed in this section, whichever is earlier.

Article IV — Qualified Medical Child Support Orders

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If the Plan Administrator determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Article V — Plan Funding and Administration

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 is funded by participant and Company contributions. Each summary plan description provides information on how the cost of coverage is allocated between the Company and participants.

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. 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 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 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.

All benefits paid or otherwise provided under this Plan are intended to be exempt from or to comply with the requirements of Code section 409A, and this Plan shall be interpreted and administered in accordance with this intent. To the extent that benefits due to a Participant under the terms of this Plan are not exempt from taxation under Code section 105 or Code section 106, such benefits will be provided or reimbursement of eligible expenses will be made on or before the last day of the Participant's taxable year following the taxable year in which the expense was incurred.

Article VI — Subrogation and Reimbursement

Each of the summary plan descriptions contains provides a description of how subrogation and reimbursement rights of the Plan specifically apply to the arrangement described in such summary plan description.

Article VII — Claims and Appeals

Each of the summary plan descriptions contains a claims and appeals procedure which must be followed for the arrangement described in such summary plan description. Any claimant must complete the claims and appeals process on a timely basis before commencing any legal action with respect to the Plan, and any legal action must be commenced within three years of the final denial of the claimant's claim. Any such legal action must be brought in the U.S. District Court for the Southern District of Texas, where the Plan is administered.

Article VIII — Choice of Law

The Plan shall be construed, whenever possible, to be in conformity with the requirements of the Code and ERISA. To the extent not in conflict with the preceding sentence, and to the extent not preempted by ERISA, the construction of the Plan shall be governed by the laws of the State of Texas.

Article IX — Right to Modify and/or Discontinue 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 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 may exercise its reserved rights of amendment, modification or termination (i) by written resolution by the Board of Directors of Marathon Oil 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 Marathon Oil 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 Company's Vice President of Human Resources shall be exercised in writing.

Article X — 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 can continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the Plan documents to understand the rules governing your COBRA continuation coverage rights.

You will be provided a certificate of creditable coverage in writing, free of charge, from UnitedHealthcare:

- when you lose coverage under the Plan;
- when you become entitled to elect COBRA;
- when your COBRA coverage ends;
- if you request a certificate of creditable coverage before losing coverage; or
- if you request a certificate of creditable coverage up to 24 months after losing coverage.

You may request a certificate of creditable coverage by calling the toll-free number on your ID card.

If you have creditable coverage from another group health plan, you may receive a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan. Without evidence of creditable coverage, Plan benefits for the treatment of a preexisting condition may be excluded for 12 months (18 months for late enrollees) after your enrollment date in your coverage. In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of the Plan. The people who operate your Plan, who are called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

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. See Section 9, *Claims Procedures*, for details.

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.

Article XI — Plan Privacy and HIPAA

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 Plan will use 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 incorporation into the Plan by reference and is available on www.MROBenefits.com, or you can obtain a copy by e-mailing mrobenefitshelp@marathonoil.com or by calling 1-855-652-3067. You should also read any relevant provisions in other portions of the Plan text including, specifically, information under the heading "Information and Records" in the Section titled "Other Important Information" in the relevant medical summary plan descriptions for each medical option listed in Article I above.

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.

Marathon Oil Company has caused its name to be hereunto subscribed to by Deanna L. Jones, Vice President, Marathon Oil Company.

Marathon Oil Company

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Deanna L. Jones
Vice President, Human Resources &
Administrative Services
Marathon Oil Company