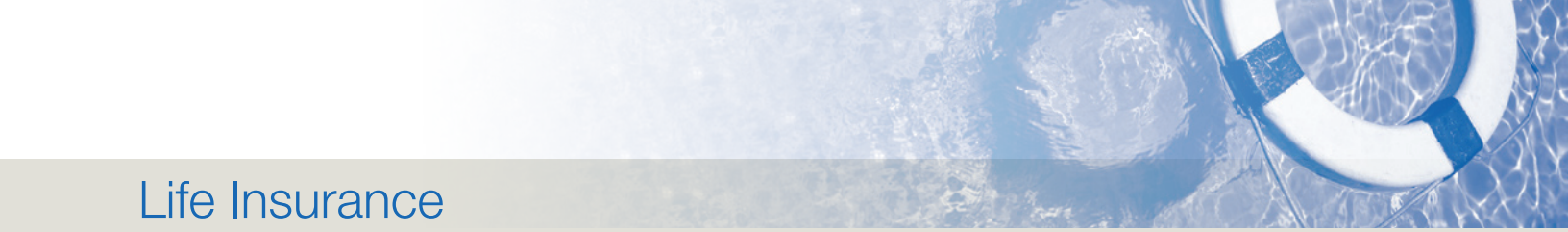
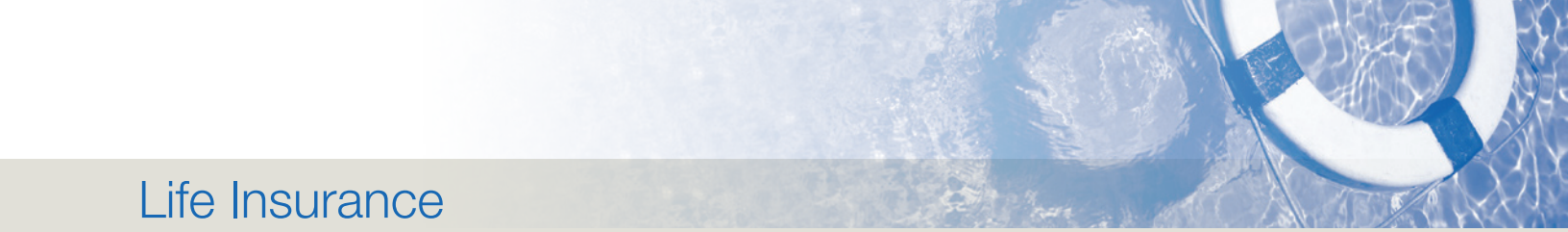


Life Insurance

Marathon Oil Company
Life Insurance Plan

Amended and Restated as of January 1, 2014

Marathon Oil Corporation



Life Insurance

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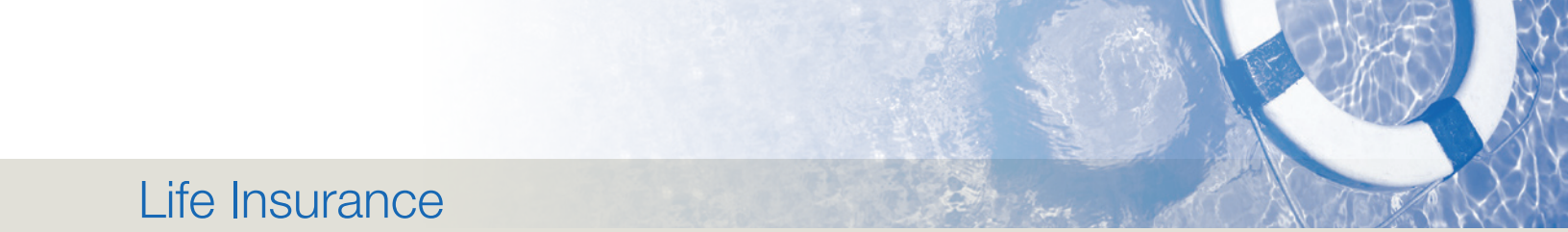


Life Insurance

This document serves both as the Plan instrument and the Summary Plan Description (SPD) for the Marathon Oil Company Life Insurance 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. Introduction

Life Insurance is a means of providing a measure of financial protection in the event of your death or the death of a dependent. The Marathon Oil Company Life Insurance Plan ("Plan") has no savings feature or accumulated cash value. If your coverage terminates for any reason, protection ceases and there are no refunds due. The Plan offers two types of coverage: Basic Non-Contributory coverage and Optional Contributory coverage for employees as described herein. In addition, coverage for your dependents is offered as described in Appendix A.

II. Eligibility

A. Basic Non-Contributory Coverage

If you are classified as a Regular Full-time or Regular Part-time employee, you are eligible for Basic Non-Contributory coverage.

B. Optional Contributory (Age-Based Premium) Coverage

If you are classified as a Regular Full-time or Regular Part-time employee on U.S. Payroll and do not participate in the Level Premium Life Insurance Plan, you are eligible to enroll for Optional Contributory (Age-Based Premium) Coverage.

Regular Full-time means you have a normal work schedule with the Company of at least 40 hours per week or at least 80 hours on a bi-weekly basis. However, if your work schedule is reduced to 20 hours or more per week to accommodate a bona fide health problem or disability, you will nonetheless be considered to be employed on a Regular Full-time basis for purposes of Plan eligibility.

Regular Part-time means you are 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.

You are not eligible for this Plan if you are:

- A casual or common law employee who has not been designated by the Company as a Regular Full-time or Regular Part-time employee;
- A member of an employee group for whom another life insurance plan (other than the Level Premium Plan) has been established and towards which the Company makes contributions;
- An individual who has signed an agreement, or has otherwise agreed, to provide services to the Company as an independent contractor, regardless of the tax or other legal consequences of such an arrangement; or
- A leased employee compensated through a leasing entity, whether or not you fall within the definition of "leased employee" as defined in Section 414(n) of the Internal Revenue Code.

III. Amount of Coverage

A. Basic Non-Contributory Coverage

This coverage is provided by the Company at no cost to you. The amount of your Basic Non-Contributory coverage is equal to two times your Covered Compensation, rounded to the nearest $1,000 (an even $500 is rounded upward). The maximum amount of your Basic Non-Contributory coverage is $1,500,000.

B. Optional Contributory (Age-Based Premium)

This coverage is paid by you. The amount of your Optional Contributory coverage can be one, two, three, four, five, or six times your Covered Compensation. Your coverage amount is rounded to the nearest $1,000 (an even $500 is rounded upward) after your Covered Compensation is multiplied by the level selected. The maximum amount of your Optional Contributory coverage is $3,500,000.

Covered Compensation is defined as the greater of:

- Annual Gross Pay in the twelve-month period of time from October 1 to September 30 immediately prior to each Benefits Open Enrollment Period, with no adjustments applied for partial year earnings; or
- Annualized Base Rate as of September 30 immediately prior to each Benefits Open Enrollment Period.

Gross pay as used in this Plan shall mean the compensation paid to an employee by the Company under rules uniformly applicable to all employees similarly situated; however, bonuses, suggestion awards, military pay, travel pay, location premiums, or other similar special payments shall be excluded.

Gross pay shall include contributions to the:

- Thrift Plan Pre-Tax Account;
- Contribution Conversion Plan (CCP);
- Health Care Spending Account (HCSA);
- Limited Health Care Spending Account (LHCSA); or
- Dependent Care Spending Account (DCSA).

IV. Effective Date of Coverage

A. Basic Non-Contributory Coverage

You become insured on the first day of your employment as a Regular employee.

B. Optional Contributory Coverage

1. Timely Enrollment

   Coverage will be effective on your first day of employment, provided your election is made online or your paper enrollment form is received by the Benefits Department or signed and dated by a Company representative on your first or second day of employment. If you make a benefit enrollment election after your second day of employment, you will be enrolled as of the date your election is made online or your paper enrollment form is received by the Benefits Department and not retroactive to date of hire; however, the election must be made within 31 days of your date of hire. (If you are applying for coverage in excess of $750,000, you are required to furnish evidence of insurability satisfactory to the insurance company before coverage becomes effective. Coverage exceeding $750,000 becomes effective on the date coverage is approved by the insurance company.)

2. Late Enrollment

   If you do not submit your properly completed application within 30 days after your initial eligibility date, you will only be permitted to apply for Optional Contributory Coverage at one times your Covered Compensation during the Benefits Open Enrollment Period that is held in the fall of each year. Refer to “Increasing or Decreasing Coverage” below.

3. Increasing or Decreasing Coverage

   During the Benefits Open Enrollment Period you may elect to increase or decrease your Optional Contributory Coverage. You may increase your coverage by one times Covered Compensation (e.g., from 2 to 3 times) or if you are not currently enrolled for Optional Contributory Coverage, you may enroll for one times Covered Compensation. If you have elected to increase your coverage and the new coverage amount you are requesting exceeds $750,000, you will be required to furnish evidence of insurability satisfactory to the insurance company before the new coverage amount will become effective.

   The effective date of your new or increased coverage amount will generally be the January 1 that immediately follows the Benefits Open Enrollment Period. Coverage exceeding $750,000 becomes effective on the later of the January 1 immediately following Benefits Open Enrollment Period or the date coverage is approved by the insurance company. However, if you are not actively at work on the date any new or increased multiple of coverage would normally become effective, coverage will become effective as described in Section V., Actively at Work.

   You may decrease coverage by any multiple during Benefits Open Enrollment Period. Decreased coverage becomes effective on the January 1 immediately following Benefits Open Enrollment Period, even if you are not actively at work.

   You can elect to terminate your Optional Contributory Coverage at any time. The effective date of the cancellation will be the date on which your request to terminate coverage is received by the Company.

4. Changing from Level Premium Plan to Optional Contributory Coverage

   The Benefits Open Enrollment Period is the time at which employees who are covered under the Level Premium Plan can elect to change to Optional Contributory Coverage. You may select a multiple of one, two or three times your Covered Compensation. The effective date of your Optional Contributory Coverage will be the January 1 that immediately follows the Benefits Open Enrollment Period, unless your coverage amount exceeds $750,000 and you have selected a multiple of three times your Covered Compensation. If your coverage amount exceeds $750,000, you will be required to furnish evidence of insurability satisfactory to the insurance company before your requested change to Optional Contributory Coverage will become effective. Coverage exceeding $750,000 becomes effective on the later of the January 1 immediately following Benefits Open Enrollment Period or the date coverage is approved by the insurance company. However, if you are not actively at work on the date your increased multiple of coverage would normally become effective, coverage will become effective as described in Section V., Actively at Work.

5. Transferring Among Participating Employers

   If you transfer employment among participating employers, you will remain a participant in this Plan.

If you enroll for coverage when first eligible (Timely Enrollment) or enroll for coverage after your initial eligibility period (Late Enrollment) and the amount of coverage elected requires evidence of insurability, any physical examinations or tests the insurance company requires will be paid by the insurance company, provided such exam or test is performed by a firm that is approved by the insurance company. For all evidence of insurability purposes, any physical examinations or test performed by a physician of your choosing will be at your own expense if the insurance company does not approve the provider.

V. Actively At Work

If you are not at work on the date your new or increased multiple of coverage would normally become effective, coverage will become effective on the day following completion of ten workdays since the most recent paid or unpaid sick day in the new calendar year. (Decreased coverage becomes effective on January 1, regardless of this actively at work provision.)

A workday is defined as follows:

1. A workday is considered any day where an employee is actively performing their assigned responsibilities in accordance with their regular schedule;
2. A workday cannot have any paid/unpaid time off within the employee's schedule; otherwise, the day will not be considered a workday;
3. Leave of absence time (including any time while on Intermittent Leave, regardless of the reason for the leave), will not be considered a workday;
4. Workdays do not need to be consecutive;
5. A sick day is one whereby the employee is absent for their entire daily schedule;
6. Reduced work schedules approved by the Company Medical Director are not considered a workday.

VI. Contributions

A. Basic Non-Contributory Coverage

The Company pays the full cost of Basic Non-Contributory coverage. If the amount of your Basic Non-Contributory coverage exceeds $50,000, you may have imputed income and be subject to federal income taxes. You may also have imputed income under state and local tax laws. If this applies to you, the reportable amount of imputed income will be indicated on the W-2 form provided to you by the Company.

B. Optional Contributory Coverage

You pay for Optional Contributory coverage based upon your age-class and amount of coverage, as follows:

Age-Class	Employee Rate Per $1,000 of Coverage Per Month
< 25	$0.034
25 – 29	$0.041
30 – 34	$0.054
35 – 39	$0.061
40 – 44	$0.068
45 – 49	$0.103
50 – 54	$0.157
55 – 59	$0.293
60 – 64	$0.450
65 – 69	$0.865
70 & Over	$1.495

Age will be determined as of January 1 of the Plan Year new coverage becomes effective or of the Plan Year a New Hire/Rehire is employed. Age as of January 1, will be frozen for the entire Plan Year.

The Company pays all costs of Optional Contributory Coverage over and above the member contributions. The total cost of the plan is ultimately determined by claims experience and administrative costs.

VII. Exclusions

A. Basic Non-Contributory Coverage

There are no exclusions that apply to Basic Non-Contributory coverage.

B. Optional Contributory Coverage

There are no exclusions that apply to Optional Contributory coverage.

VIII. Payment of Benefits

At the time you enroll in the Plan, you must designate a beneficiary to receive the benefit payable upon your death. You may change your beneficiary at any time. Beneficiary designations and changes must be made through Minnesota Life's online beneficiary management system or by calling Minnesota Life at 1-866-293-6047 to request a form.

If using the online method to **create or update** a beneficiary record, please follow these instructions:

1. Access the Beneficiary Designation website at www.LifeBenefits.com.
2. Your user ID is the letters MOC followed by your 8-digit employee ID number.
3. If this is your first visit to the LifeBenefits site, your password is your 8-digit date of birth (mmddyyyy) followed by the last four digits of your social security number. You will need to change this to another password for future visits.
4. Complete the site's Welcome steps.
5. For initial beneficiary designations click on the "Begin" button.
6. If you already have a beneficiary designation on file, click on "View Beneficiary" to see it. You may then click on "Update Designation" to make any changes.
7. Complete all the Beneficiary Designation steps.
8. Minnesota Life will mail you a confirmation letter after you complete your designations.

No change in the beneficiary designation shall be effective until it has been received by Minnesota Life. The amount of your coverage upon your death will be payable to the last properly designated beneficiary according to Minnesota Life's records.

If there is no beneficiary designated or if your designated beneficiary is not surviving when a benefit becomes payable (date of death), benefits will be paid by survivor class, in the following order to your:

- Spouse;
- Children (either natural born or adopted through a final adoption order issued by a court of competent jurisdiction prior to the date of the member's death) but specifically excluding step-children;
- Parents;
- Brothers and sisters; or
- Executors or administrators of the insured person's estate.

After the claim is approved the beneficiary(ies) will receive payment from the insurance company in a lump sum check.

IX. Continuation of Coverage

As described below, during certain absences your Basic Non-Contributory coverage may be continued. You may continue your Optional Contributory coverage by payment of your monthly contributions in advance of the period of coverage provided you do not become eligible to participate in a similar group plan as an employee of another employer. Advance contributions must be paid on or before the last day of each month and, at a minimum, must be in an amount equal to the premium for the following month's coverage plus any unpaid premium for coverage up to and including the due date. If such contributions are not paid in advance or you become eligible to participate in another employer's group plan, your Optional Contributory coverage ceases at the end of the period for which contributions have been made.

Upon commencement of a leave of absence, your coverage and contribution amounts will be based on the amount of coverage in force immediately prior to the beginning of your leave. Coverage and contribution amounts thereafter, will be calculated in the same manner as for active employees, as described in Sections III and VI.

A. If you are temporarily laid off, your Basic Non-Contributory coverage will terminate but you may continue your Optional Contributory coverage for three months.

B. If you are granted a Sick Leave, your Basic Non-Contributory coverage will be continued and you may continue your Optional Contributory coverage for one year. Any further extension must be approved by the Plan Administrator. As long as you are receiving compensation while on leave, your contributions for Optional Contributory coverage will be deducted. If you are not eligible for compensation while on leave, you may continue coverage by payment of your contributions in advance.

C. If you are on a Sick Leave while receiving LTD benefits, your Basic Non-Contributory coverage will be continued and your Optional Contributory coverage may be continued provided contributions are paid monthly in advance.

D. If you are on an Educational Leave or Personal Leave your Basic Non-Contributory coverage will terminate. However, you may continue your Optional Contributory coverage for up to 2 years by payment of your contributions in advance.

E. If you are on Family Leave of 12 workweeks or less, your Basic Non-Contributory coverage will be continued. Your Optional Contributory coverage may be continued by payment of your contributions in advance. If you choose not to retain your coverage or if the Company discontinues your Optional Contributory coverage as a result of your non-payment of premiums while you are on a Family Leave of 12 workweeks or less, upon your return to work, your coverage will be restored to at least the same level and terms as were provided when your Family Leave began, subject to any changes in benefit levels that may have taken place during the leave affecting the entire work force, unless otherwise elected by you. Therefore, you will not be required to meet any qualification requirements such as a waiting period, a pre-existing condition exclusion, waiting for open enrollment or passing a medical exam.

F. If you are on a Family Leave in excess of 12 workweeks, your Basic Non-Contributory coverage will be continued for up to 2 years. Your Optional Contributory coverage may be continued for up to 2 years by payment of your contributions in advance.

G. If you are granted a Military Leave to perform service in the uniformed services, your Basic Non-Contributory coverage will be continued. You may continue your Optional Contributory coverage during your Military Leave, provided the required monthly premiums are paid in advance of the period of coverage. If you choose not to retain coverage or if the Company discontinues your Optional Contributory coverage as a result of your non-payment of premiums while you are on Military Leave, upon your return to work, your coverage will be restored to at least the same level and terms as were provided when your Military Leave began, subject to any changes in benefit levels that may have taken place during the Military Leave affecting the entire work force, unless otherwise elected by you. Therefore, you will not be required to meet any qualification requirements such as a waiting period, a pre-existing condition exclusion, waiting for open enrollment or passing a medical exam.

H. If you are on a Leave of Absence for the reason of caring for a sick or injured family member, you are permitted to enroll in or increase your own level of coverage during Benefits Open Enrollment.

If you separate from Company service after the first day of a month and elect to retire the first day of the following month, your Basic Non-Contributory coverage and Optional Contributory coverage will be continued during the period between your actual separation and the effective date of your retirement at the amount in effect at time of separation.

X. Termination of Coverage

Your Basic Non-Contributory and Optional Contributory coverage will terminate with any of the following events:

- On the date you cease to be an eligible employee;
- Upon your retirement;
- On the first day of the month following the month in which the premium is due and not paid, unless such premium is received by the Company within 31 days after the due date; or
- As specified in the “Continuation of Coverage” section.

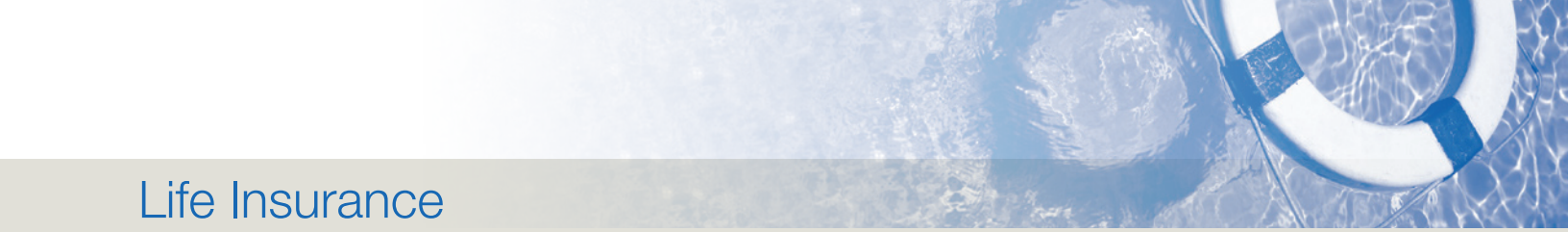
XI. Extension of Coverage

If you die within 31 days following termination of your coverage, the amount of Basic Non-Contributory coverage and Optional Contributory coverage in force at the time of the termination will be paid to the beneficiary.

If you die within one year following the termination of your coverage and have been totally disabled since the date of this termination, the amount of your Basic Non-Contributory coverage and Optional Contributory coverage in force at the time of termination will be paid to the beneficiary.

XII. Continuation, Conversion and Portability

The Plan provides several methods of allowing you to continue life insurance coverage after your coverage ends. Depending on where you reside and/or the reason your coverage ends, you may have the opportunity to either apply for continuation coverage (for Minnesota residents only), conversion coverage, or portability coverage. The following briefly describes the continuation, conversion and portability features of the Plan. Keep in mind you cannot convert and port the same type of coverage.



Life Insurance

A. Continuation (Minnesota residents, only)

Continuation coverage for Minnesota residents is the same group life insurance you had under the Plan, except you must pay the entire monthly premium cost (including your share and the Company's share). This continuation coverage is available if your employment with the Company has ended or your work hours have been reduced below the level required for life insurance eligibility. However, this continuation coverage is not available if your employment ends because of your gross misconduct.

If you are eligible and choose continuation coverage under Minnesota law, you must complete and return the form(s) and the initial premium to the insurance company within 60 days after the end of your group coverage under the Plan. If you do not return your form(s) and premium by that date, the option to continue your Life Insurance coverage will no longer be available.

Minnesota continuation coverage is a temporary continuation of existing life insurance coverage until you obtain coverage under another group term life insurance policy, or for a period of 18 months, whichever is shorter. That period will end earlier if the required monthly premiums are not paid on time, or if the Plan ends.

When your continuation period ends, you may port or convert your coverage as described in Sections B and C below.

For more information or to request application forms for continuation, call the insurance company at 1-866-293-6047.

B. Conversion

If your Basic Non-Contributory or Optional Contributory coverage ends, you may convert your life insurance to an individual policy. Coverage can be converted without providing evidence of insurability. The maximum amount that you can convert is the amount you are insured for under the Plan. You may convert a lower amount of life insurance.

You must apply for individual life insurance under this life conversion privilege and pay the first premium within 31 days after the date:

- Your employment terminates; or
- You are no longer eligible to participate in the coverage of the Plan.

If you convert your coverage to an individual life policy, then return to work, and wish to become insured under the Plan, all amounts are subject to evidence of insurability unless you surrender the individual policy when you enroll for coverage upon your return to work.

Upon your request, the insurance company will send you information about the converted policy and premium cost. The policy will be one of the plans the insurance company offers, but may not provide the same benefits or coverage as the group Plan. The premium cost of the converted policy will reflect your age, class of risk and amount of coverage.

For more information or to request application forms for conversion, call the insurance company at 1-866-293-6047.

C. Portability

If your Basic Non-Contributory coverage or Optional Contributory coverage ends you may be eligible to "port" your coverage if you were actively at work on the day before your coverage terminated. (For purposes of this Portability provision, the phrase, "actively at work" does not preclude eligibility for an individual who is on an approved leave of absence or an individual who retired within the last 30 days.) The maximum amount of insurance you can port is the lesser of:

- The amount you are insured for under this Plan (Basic and Optional combined); or
- $1,000,000 (if you are age 65, coverage is reduced to 65% of the amount of your portable coverage up to a maximum of $650,000).

The minimum amount of coverage that can be ported is $10,000.

You must apply for portability and pay the first premium within 31 days after the date:

- Your employment terminates; or
- You are no longer eligible to participate in the coverage of the Plan.

You are not eligible to apply for portable coverage if:

- You are not actively at work on the day before your employment terminates or the date you are no longer eligible to participate in the Plan;
- You are age 70 or over;
- The policy is cancelled;
- You converted your insurance to an individual policy; or
- You failed to pay the required premium under the terms of the Plan.

Age	Monthly Premium Rates for Portable Term Life Insurance Cost Per $1,000 of Coverage
< 25	$0.108
25 – 29	$0.129
30 – 34	$0.171
35 – 39	$0.195
40 – 44	$0.216
45 – 49	$0.324
50 – 54	$0.495
55 – 59	$0.927
60 – 64	$1.425
65 – 69	$2.739

Port rates are subject to change to reflect claims experience and other charges. The right to elect portable coverage is in lieu of the conversion privilege.

For more information or to request application forms for portability, call the insurance company at 1-866-293-6047.

XIII. Assignment of Benefits

You may assign your life insurance by completing and submitting the applicable form to the Company. No assignment will be in effect until a copy is filed with the Company.

An assignment will transfer your interest and that of any beneficiary to the assignee. If you assign your insurance, you irrevocably relinquish all ownership rights, including the right to change beneficiaries, increase coverage, decrease coverage and cancel coverage.

Once assigned, the assignee is given the right to make changes in the coverage. Assignees can make changes during Benefits Open Enrollment Period by providing a notarized statement that specifies the desired change in coverage, the insured's name, social security number or employee number and the assignee's name, address, telephone and social security number.

Any such assignment will remain in force until changed by the assignee. Minnesota Life is not responsible for the validity or sufficiency of any assignment.

Since individual situations differ and tax laws are subject to change, the Company recommends you seek qualified tax advice before you assign any insurance.

XIV. Terminal Illness Benefit (Accelerated Benefit)

If you become terminally ill while insured under this Plan, you may elect to receive a Terminal Illness Benefit (Accelerated Benefit) of up to 100% of your total of your Basic Non-Contributory and Optional Contributory coverage, up to a maximum of $1,000,000.

Your right to exercise this option and to receive payment is subject to the following:

- You request this election, in writing;
- You have not previously assigned your coverage;
- Your physician must certify, in writing, that you are terminally ill and your life expectancy has been reduced to less than 12 months;
- The physician's certification must be deemed satisfactory to the insurance company; and
- You must be terminally ill at the time of payment of the Terminal Illness Benefit;

The Terminal Illness Benefit is available on a voluntary basis. Therefore, you are not eligible for benefits if:

- You are required by law to use this benefit to meet the claims of creditors, whether in bankruptcy or otherwise; or
- You are required by a government agency to use this benefit in order to apply for, get, or otherwise keep a government benefit or entitlement.

Premium payments must continue to be paid on the remaining amount of your life insurance coverage.

An election to receive a Terminal Illness Benefit will have the following effect on other benefits:

- The death benefit payable will be reduced by any amount of Terminal Illness Benefit that has been paid; and
- Any amount of life insurance that may be available under the conversion privilege will be reduced by the amount of the Terminal Illness Benefit paid. The remaining life insurance amount will be paid according to the terms of the Plan subject to any reduction and termination provisions.

Benefits may be taxable. Minnesota Life is not responsible for any tax or other effects of any benefit paid. As with all tax matters, you should consult your personal tax advisor to assess the impact of this benefit.

XV. Miscellaneous Services

Refer to Appendix B for additional services that are part of the Marathon Oil Company Life Insurance Plan.

XVI. Benefit Claim Procedures

To file a claim, you or your survivor should contact the Plan Administrator. The Plan Administrator will then assist you (or your survivor) with the claim filing process with Minnesota Life. Minnesota Life shall notify you of the claim determination within 45 days of the receipt of your claim. This period may be extended by 30 days if such an extension is necessary due to matters beyond the control of the Plan. A written notice of the extension, the reason for the extension and the date by which the Plan expects to decide your claim, shall be furnished to you within the initial 45-day period. This period may be extended for an additional 30 days beyond the original 30-day extension if necessary due to matters beyond the control of the Plan. A written notice of the additional extension, the reason for the additional extension and the date by which the Plan expects to decide on your claim, shall be furnished to you within the first 30-day extension period if an additional extension of time is needed. However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination by Minnesota Life will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which Minnesota Life receives your response to the request for additional information.

If your claim for benefits is denied, in whole or in part, you or your authorized representative will receive a written notice from Minnesota Life of your denial. The notice will be written in a manner calculated to be understood by you and shall include:

- The specific reason(s) for the denial;
- References to the specific Plan provisions on which the benefit determination was based;
- A description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary;
- A description of Minnesota Life's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following your appeals; and

- If an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request.

XVII. Appeals of Denied Claims

If your claim for benefits is denied or if you do not receive a response to your claim within the appropriate time frame (in which case the claim for benefits is deemed to have been denied), you or your representative may appeal your denied claim in writing to Minnesota Life within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. You may submit with your appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted by Minnesota Life, utilizing individuals not involved in the initial benefit determination. This review will not accord any deference to the initial benefit determination.

Minnesota Life shall make a determination on your claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Minnesota Life determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that Minnesota Life expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which Minnesota Life receives your response to the request for additional information.

If the claim on appeal is denied in whole or in part, you will receive a written notification from Minnesota Life of the denial. The notice will be written in a manner calculated to be understood by the applicant and shall include:

- The specific reason(s) for the adverse determination;
- References to the specific Plan provisions on which the determination was based;
- A statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to your benefit claim upon request,
- A description of Minnesota Life's review procedures and applicable time limits;
- A statement that you have the right to obtain upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination; and
- A statement describing any appeals procedures offered by the Plan, and your right to bring a civil suit under ERISA.

If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

If the appeal of your benefit claim is denied or if you do not receive a response to your appeal within the appropriate time frame (in which case the appeal is deemed to have been denied), you or your authorized representative may make a second, voluntary appeal of your denial in writing to Minnesota Life within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. You may submit with your second appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

Minnesota Life shall make a determination on your second claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Minnesota Life determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date by which Minnesota Life expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Your decision to submit a benefit dispute to this voluntary second level of appeal has no effect on your right to any other benefits under this Plan. If you elect to initiate a lawsuit without submitting to a second level of appeal, the Plan waives any right to assert that you failed to exhaust administrative remedies. If you elect to submit the dispute to the second level of appeal, the Plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that the appeal is pending.

If the claim on appeal is denied in whole or in part for a second time, you will receive a written notification from Minnesota Life of the denial. The notice will be written in a manner calculated to be understood by the applicant and shall include the same information that was included in the first adverse determination letter. If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

XVIII. Administration

Important Plan Administration Information	
Plan Name	Marathon Oil Company Life Insurance Plan
Plan Administrator (Agent for service of legal process)	Deanna L. Jones P.O. Box 3128 5555 San Felipe Street Houston, TX 77056 Phone: 1-713-629-6600
Employer Identification Number	25-1410539
Type of Plan	Welfare Benefit Plan
Plan Sponsor	Marathon Oil Company P.O. Box 3128 5555 San Felipe Street Houston, TX 77056
Plan Number	524
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	Ends on December 31, and its records are kept on a calendar year basis.
Insurance Company	The Minnesota Life Insurance Company 400 Robert Street North St. Paul, MN 55101-2098
Policy/Contract Number	34034G

XIX. Further Information

This text along with the more detailed provisions of the insurance contract issued to the Company provide the exact terms of the coverage of this Plan. The insurance contract with Minnesota Life Insurance Company is incorporated by reference as part of this Plan Document. The terms of the Minnesota Life contracts prevail in the event of a conflict with any other Plan provision or other document. Minnesota Life will make all determinations concerning eligibility for benefits under the Plan.

In determining the eligibility of participants for benefits and in construing the Plan's terms, the Plan Administrator (or the insurance company in cases where it 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 they deem it to be appropriate, the Plan Administrator may evidence:

- The exercise of such discretion; or
- Any other type of decision, directive or determination made with respect to the Plan, in the form of written administrative rulings 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 the insurance company in cases where it has the authority to make determinations concerning eligibility for benefits) made on all matters within the scope of their authority shall be final and binding upon all persons, including the Company, any trustee, all participants, their heirs and personal representatives, and all labor unions or other similar organizations representing participants. It is intended that the standard of judicial review to be applied to any determination made by the Plan Administrator shall be the "arbitrary and capricious" standard of review.

XX. Modification and Termination of the 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.

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;

(iii) By 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 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 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 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.

XXI. 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.

Except for purposes of Section XX, the term "Company" and other similar words shall include Marathon Oil Company and such other participating employers. The term "employee" and other similar words shall include any eligible employee of these companies.

XXII. 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.

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 welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a 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 Morris R. Clark, Vice President and Treasurer, Marathon Oil Company.

MARATHON OIL COMPANY

Morris R. Clark
Vice President and Treasurer
Marathon Oil Company

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Note: At any given time, amendments to this Plan (including the insurance contract) may have been adopted by the Company which have not yet been reflected in these written documents. Copies of any such amendments will be sent to you if you send a written request for them addressed to the Plan Administrator. In addition, from time to time the Plan Administrator may evidence the exercise of his discretion on Plan matters in the form of written "Administrative Rulings." Copies of any such ruling will also be sent to you if you send a written request for them addressed to the Plan Administrator.

The Plan Administrator may assess a reasonable charge to provide any requested copies.

Appendix A

Dependent Life Insurance

I. Introduction

The Marathon Oil Company Life Insurance Plan ("Plan") offers Dependent Life Insurance coverage for spouses and children and has no savings feature or accumulated cash value. If coverage terminates for any reason, protection ceases and there are no refunds due.

II. Eligibility

MOC employees who participate in Marathon Oil Company Optional Life Insurance or Marathon Oil Company Level Premium Life Insurance may elect coverage for their dependents. If, at the time of a covered loss you are enrolled in Spouse and/or Child(ren) coverage, a benefit becomes payable provided at the time of the covered loss your covered dependent(s) are eligible under the terms of this Plan, as defined below:

A. Spouse — Your wife or husband.

B. Dependent Child —

- Your child up to 26 years of age who is one of the following:
  a. Your blood descendent to the first degree;
  b. Your legally adopted child (including a child living with you during the period of probation);
  c. Your stepchild whose permanent residence is with you; or
  d. A child, whose parents are both deceased, and for whom you have legal custody as determined by a court of competent jurisdiction and whose permanent residence is with you.
- Your unmarried child, of any age, who is mentally retarded or physically handicapped and primarily dependent upon you for support.

First born benefit: If your first eligible child dies within 31 days of birth but prior to you enrolling in child life coverage, Minnesota Life will pay a benefit of $10,000 (subject to eligibility rules).

Your dependents are not eligible for Dependent Life coverage under this MOC Plan if enrolled for Dependent Life or Employee Optional Life coverage sponsored by an employer of the controlled group to which Marathon Oil Company belongs.

III. Amount of Coverage

A. Spouse

You may purchase coverage for your spouse in $10,000 increments up to the Plan maximum of $100,000. However, the maximum coverage you may elect for your spouse at initial enrollment is $50,000. Spouse coverage may not exceed the sum of your Basic and Optional or Basic and Level Premium coverage, whichever is applicable.

B. Dependent Child(ren)

You may purchase coverage for your children in $10,000 increments up to the Plan maximum of $30,000. The coverage amount elected applies to each child, regardless of the number of children you have. Child coverage may not exceed the sum of your Basic and Optional or Basic and Level Premium coverage, whichever is applicable.

IV. Effective Date of Coverage

Once you are enrolled in the Plan, any changes in coverage and contributions take effect on the later of:

- January 1 that immediately follows Benefits Open Enrollment Period;
- The date you return to active employment; or
- The date your eligible dependent(s) are free from confinement, as described below in C.

A. Timely Enrollment

New hires/rehires: Coverage will be effective on your first day of employment, provided your election is made online or your paper enrollment form is received by the Benefits Service Center or signed and dated by a Company representative on your first or second day of employment. Benefit Enrollment elections made after the second day of employment will be enrolled as of that date and not retroactive to date of hire; however, the election must be made within 30 days of your date of hire.

Gain of dependent: Coverage will be effective on the date your Benefit Change Form is received by the Benefits Department or signed and dated by a Company representative, but not earlier than the date of the event and not later than 31 days of the event initial eligibility date (marriage date, or gain of child), provided your covered dependent(s) are “free from confinement,” as described in this Appendix Section V., Actively at Work.

B. Late Enrollment

If you do not submit your properly completed application within 30 days after your initial eligibility date, as described above in A., you will only be permitted to apply for Dependent Life Coverage during the Benefits Open Enrollment Period that is held in the fall of each year. Refer to “Increasing or Decreasing Coverage” below.

C. Increasing or Decreasing Coverage

During the Benefits Open Enrollment Period you may elect to increase or decrease your Dependent Life Coverage. Increases in spouse coverage may be made by one $10,000 increment if currently enrolled or if you are not currently enrolled for Spouse Coverage, employees may enroll for $10,000 coverage. Child coverage may be elected at $10,000, $20,000 or $30,000 levels. Coverage may be decreased to any coverage level. New or increased coverage will not become effective until the later of the January 1 immediately following Benefits Open Enrollment Period, the date the employee meets the Actively at Work provision described in Section V. of this Appendix, or the date your dependent(s) are "free from confinement," as described in Section V. of this Appendix.

You can elect to terminate coverage at any time. The effective date of the cancellation will be the date on which your request to terminate coverage is received by the Company.

D. Employment Transfers

Participants transferred among participating employers will continue contributions and maintain current election levels. Transfers from non-participating employers to participating employers may make new coverage elections, provided timely enrollment occurs, as described in A., above.

V. Actively At Work

New or increased coverage becomes effective on the later of:

- the date your dependent's new or increased coverage would normally become effective;
- the day following completion of ten workdays following the date you return to active work*; or
- the date your eligible dependent(s) are free from confinement**.

* *If you are not at work on the date your new or increased multiple of coverage would normally become effective, coverage will become effective on the day following completion of ten workdays since the most recent paid or unpaid sick day in the new calendar year. (Decreased coverage becomes effective on January 1, regardless of active at work provision.)*

A workday is defined as follows:

1. *A workday is considered any day where an employee is actively performing their assigned responsibilities in accordance with their regular schedule;*
2. *A workday cannot have any paid/unpaid time off within the employee's schedule; otherwise, the day will not be considered a workday;*
3. *Leave of absence time (including any time while on Intermittent Leave, regardless of the reason for the leave), will not be considered a workday;*
4. *Workdays do not need to be consecutive;*
5. *A sick day is one whereby the employee is absent for their entire daily schedule;*
6. *Reduced work schedules approved by the Company Medical Director are not considered a workday.*

** *Confinement means the individual has been advised or ordered by a medical doctor to remain at his or her home, hospital or other place of residence.*

VI. Contributions

A. Spouse Coverage

You pay the full cost of Spouse coverage. Your contributions are based upon your spouse's age-class and amount of coverage, as follows:

Spouse Coverage	
Age-Class	**Monthly Rate Per $1,000 of Coverage**
< 25	$0.034
25 – 29	$0.041
30 – 34	$0.054
35 – 39	$0.061
40 – 44	$0.068
45 – 49	$0.103
50 – 54	$0.157
55 – 59	$0.293
60 – 64	$0.450
65 – 69	$0.865
70 & Over	$1.495

Your spouse's age will be determined as of January 1, and will be frozen for the entire Plan Year.

B. Child Coverage

You pay the full cost of Child coverage, as follows:

Child(ren) Coverage	
Coverage	**Cost Per Month**
$30,000	$2.37
$20,000	$1.58
$10,000	$0.79

The cost of coverage is the same regardless of the number of eligible children you have. For example, an employee with one child and $20,000 coverage will pay $1.58 per month; which is the same monthly cost for an employee with five children each with $20,000 coverage.

VII. Exclusions

There are no exclusions that apply to Dependent coverage.

VIII. Beneficiary

You are the designated beneficiary of any benefits payable resulting from Dependent Life Insurance coverage under the Plan.

If you are not surviving when a dependent's life benefit becomes payable, benefits will be paid to the executors or administrators of your estate.

After the claim is approved benefits will be paid to you in a lump sum check.

IX. Continuation of Coverage

As described below, during certain absences Dependent Life Insurance may be continued. Dependent Life Insurance coverage may be continued by payment of your monthly contributions in advance of the period of coverage, provided you do not become eligible to participate in a similar group plan as an employee of another employer. Advance contributions must be paid on or before the last day of each month and, at a minimum, must be in an amount equal to the premium for the following month's coverage plus any unpaid premium for coverage up to and including the due date. If such contributions are not paid in advance or you become eligible to participate in another employer's group plan, Dependent Life Insurance coverage ceases at the end of the period for which contributions have been made.

Upon commencement of a leave of absence, coverage and contribution amounts will be based on the amount of coverage in force immediately prior to the beginning of your leave.

A. If you are temporarily laid off, Dependent Life Insurance may be continued for three months, provided your monthly contributions are paid in advance of the period of coverage. Coverage will be based on the amount of Dependent Life Insurance in force at the time of your layoff.

B. If you are granted a Sick Leave, Dependent Life Insurance may be continued for one year. Any further extension must be approved by the Plan Administrator. As long as you are receiving compensation while on leave, your contributions for Dependent Life Insurance will be deducted. If you are not eligible for compensation while on leave, Dependent Life Insurance may be continued, provided your monthly contributions are paid in advance of the period of coverage. Coverage will be based on the amount of Dependent Life Insurance in force at the time your leave commences.

C. If you are on a Sick Leave while receiving LTD benefits, Dependent Life Insurance may be continued, provided your monthly contributions are paid in advance of the period of coverage. Coverage will be based on the amount of Dependent Life Insurance in force at the time your leave commences.

D. If you are on an Educational Leave, Personal Leave or Family Leave in excess of 12 workweeks, Dependent Life Insurance may be continued for up to 2 years, provided your monthly contributions are paid in advance of the period of coverage. Coverage will be based on the amount of Dependent Life Insurance in force at the time your leave commences.

E. If you are on a Family Leave of 12 workweeks or less, Dependent Life Insurance may be continued, provided your monthly contributions are paid in advance of the period of coverage. Coverage will be based on the amount of Dependent Life Insurance in force at the time your leave commences. If you choose not to retain coverage or if the Company discontinues your Dependent Life Insurance as a result of your non-payment of premiums while you are on a Family Leave of 12 workweeks or less, upon your return to work, your coverage will be restored to at least the same level and terms as were provided when Family Leave began, subject to any changes in benefit levels that may have taken place during the leave affecting the entire work force, unless otherwise elected by you. Therefore, you will not be required to meet any qualification requirements such as a waiting period, pre-existing condition exclusion, waiting for open enrollment or passing a medical exam.

F. If you are granted a Military Leave to perform service in the uniformed services under "Operation Enduring Freedom," Dependent Life Insurance coverage may be continued, provided your monthly contributions are paid in advance of the period of coverage. Coverage will be based on the amount of Dependent Life Insurance in force at the time your leave commences. If you choose not to retain coverage or if the Company discontinues your Dependent Life coverage as a result of your non-payment of premiums while you are on Military Leave, upon your return to work, your coverage will be restored to at least the same level and terms as were provided when your Military Leave began, subject to any changes in benefit levels that may have taken place during the Military Leave affecting the entire work force, unless otherwise elected by you. Therefore, you will not be required to meet any qualification requirements such as a waiting period, pre-existing condition exclusion, waiting for open enrollment or passing a medical exam.

G. If you are on a Leave of Absence for the reason of caring for a sick or injured family member, you are permitted to make the following Life Insurance changes:

1. Enroll an eligible Spouse or Child during Benefits Open Enrollment, provided the eligible Spouse or Child is not the family member being cared for; and

2. Enroll an eligible Spouse or Child as a result of a qualifying change in family or employment status, provided the eligible Spouse or Child is not the family member being cared for.

If you separate from Company service after the first day of a month and elect to retire the first day of the following month, your Dependent Life Insurance coverage will be continued during the period between your actual separation and the effective date of your retirement at the amount in effect at the time of separation.

X. Termination of Coverage

Dependent Life Insurance coverage will terminate on the earliest of:

- The date you cease to be an eligible employee;
- The date your dependent(s) are no longer eligible dependents, as defined in Section II of this Appendix A;
- Your retirement;
- The first day of the month following the month in which the premium is due and not paid, unless such premium is received by the Company within 31 days after the due date; or
- As specified in the "Continuation of Coverage" section.

XI. Extension of Coverage

If a dependent dies within 31 days following termination of coverage, the amount of Dependent Life Insurance coverage in force at the time of the termination will be paid according to Section VIII of this Appendix A .

XII. Continuation, Conversion and Portability

The Plan provides several methods to continue life insurance coverage after dependent coverage ends. Depending on state of residence and/or the reason coverage ends, your eligible dependents may have the opportunity to either apply for continuation coverage (for Minnesota residents only), conversion coverage, or portability coverage. The following briefly describes the continuation, conversion and portability features of the Plan. Keep in mind the same type of coverage cannot be converted and ported.

A. Continuation (Minnesota residents, only)

Continuation coverage for Minnesota residents is the same dependent life insurance you had under the Plan, except you must pay the entire monthly premium cost (including your share and the Company's share). This continuation coverage is available if your employment with the Company has ended, your work hours have been reduced below the level required for life insurance eligibility, or dependent coverage terminates. However, continuation coverage is not available if your employment ends because of your gross misconduct.

If you are eligible and choose continuation coverage under Minnesota law, you must complete and return the form(s) and the initial premium to the insurance company within 60 days after your group coverage ends under the Plan. If you do not return the form(s) and premium by that date, the option to continue dependent coverage will no longer be available.

Minnesota continuation coverage is a temporary continuation of existing life insurance coverage until coverage is obtained under another group term life insurance policy, or for a period of 18 months, whichever is shorter. That period will end earlier if the required monthly premiums are not paid on time, or if the plan ends.

For more information or to request application forms for continuation, call the insurance company at 1-866-293-6047.

B. Conversion

If your dependent coverage ends, your dependents may convert their life insurance to an individual policy. Coverage can be converted without providing evidence of insurability. The maximum amount that can be converted is the amount insured for under the Plan. A lower amount of life insurance may be converted.

Individual life insurance must be applied for under this life conversion privilege and pay the first premium within 31 days after the date:

- Your employment terminates; or
- You and/or your dependents are no longer eligible to participate in the coverage of the Plan.

If coverage is converted to an individual life policy, then you return to work, and wish to become insured under the Plan, all amounts are subject to evidence of insurability unless the individual policy is surrendered when you enroll for coverage upon your return to work.

Upon request, the insurance company will send information about the converted policy and premium cost. The policy will be one of the plans the insurance company offers, but may not provide the same benefits or coverage as the group Plan. The premium cost of the converted policy will reflect the covered person's age, class of risk and amount of coverage.

For more information or to request application forms for conversion, call the insurance company at 1-866-293-6047.

C. Portability

If your dependent coverage ends you may be eligible to apply for portable, term life coverage, provided you port your own coverage. The maximum amount of dependent insurance that can be ported is:

- The amount of dependent coverage you are insured for under this Plan when your coverage terminates, not to exceed $150,000 for a spouse (if your spouse is age 65, coverage is reduced to 65% of their portable amount).

There is no minimum coverage amount that must be ported.

You must apply for portability and pay the first premium within 31 days after the date:

- Your employment terminates; or
- You and/or your dependents are no longer eligible to participate in the coverage of the Plan.

You are not eligible to apply for portable coverage if:

- You are not actively at work on the day before your employment terminates or the date you are no longer eligible to participate in the Plan;
- You are not enrolled for coverage;
- You do not become covered under the Portability Plan for your own life insurance coverage;
- You are age 70 or over;
- The policy is cancelled;
- You applied for an individual conversion policy; or
- You failed to pay the required premium under the terms of the Plan.

If you are eligible to apply for portable dependent life coverage, as described above, your covered dependents must meet the following additional requirements in order to be eligible for coverage:

- Your dependent spouse is less than age 70;
- Your dependent child is less than 26.

If your dependent coverage terminates due to your death, your spouse will have the right to apply for portable term life coverage for all your covered dependents, subject to the above requirements. If your dependent coverage terminates due to your divorce, your spouse will have the right to apply for portable term life coverage, subject to the above requirements. Children cannot port coverage on their own. Your spouse must be under age 70 in order to be eligible to port coverage.

Age	Monthly Premium Rates for Portable Term Life Insurance Cost Per $1,000 of Coverage
< 25	$0.108
25 – 29	$0.129
30 – 34	$0.171
35 – 39	$0.195
40 – 44	$0.216
45 – 49	$0.324
50 – 54	$0.495
55 – 59	$0.927
60 – 64	$1.425
65 – 69	$2.739

Port rates are subject to change to reflect claims experience and other charges. The right to elect portable coverage is in lieu of the conversion privilege.

For more information or to request application forms for portability, call the insurance company at 1-866-293-6047.

XIII. Assignment of Benefits

Dependent Life Insurance may not be assigned.

XIV. Terminal Illness Benefit

Terminal Illness Benefit is available with Dependent coverage.

Appendix B

Miscellaneous Services

(The Miscellaneous Services described in this Appendix B are part of the Life Insurance Plan and are included in the cost of coverage.)

Travel Assistance

Global Rescue provides 24-hour travel assistance, emergency medical and security transport services, and pre-travel resources to employees and retirees covered under the group life insurance plan. The spouses and dependent children of those covered under the group life plan may also access the services. Global Rescue's services are available when traveling for business or pleasure 100 or more miles away from home.

Contact Global Rescue at **1-855-516-5433** (toll free U.S. and Canada), **+1-617-426-6603** (international), or visit www.LifeBenefits.com/travel.

Beneficiary Financial Counseling

Beneficiaries who receive at least $25,000 in policy benefits may choose to use independent beneficiary counseling services from PricewaterhouseCoopers LLP (PwC). PwC advisors do not sell insurance or investment products, and no information will be given to PwC without your beneficiary's written consent. There is no additional cost for this service. Resources available to eligible beneficiaries include:

- PwC Beneficiary Guide
- PwC eAdvisor
- 12-month subscription to Your Money, Your Future

Legacy Planning Services

Employees, spouses and dependents can access resources designed to help individuals and families work through end-of-life issues when dealing with the loss of a loved one or planning for their own passing. These resources are available at www.LegacyPlanningServices.com.