Marathon Oil Company
Medicare Supplement Plan

Amended and Restated
Effective January 1, 2017

Marathon Oil Corporation

Medicare Supplement Plan

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Medicare Supplement Plan

Introduction and Purpose

Marathon Oil Company, (referred to as "Company") has established and maintains the Medicare Supplement Plan of Marathon Oil Company (the "Plan"). The purpose of the Plan is to reimburse Eligible Retirees, and certain Eligible Dependents, for Eligible Medical Expenses, which are not otherwise reimbursed. The Plan is intended to qualify as a self-insured medical reimbursement plan for purposes of Sections 105 and 106 of the Internal Revenue Code of 1986, as amended (**"Code"**), as well as a health reimbursement arrangement as defined in IRS Notice 2002-45.

This document serves as both the Plan document and the summary plan description and contains the terms and provisions of the Plan and information to explain the rights and obligations of certain former employees who are Plan participants. This Plan is designed to comply with the summary plan description disclosure requirements of the Employee Retirement Income Security Act of 1974, as amended (ERISA).

This document is a restatement of the Plan and is effective as of January 1, 2017. This document supersedes any previous version of the Plan, and formulate Plan continues to be an HRA-based defined contribution plan design.

Note that capitalized terms used in this Plan are defined the first time they are used or are defined in the Plan Information Appendix or Plan Terms at the end of this document. Please note that "you," "your" and "my" when used in this Plan refer to you, the Eligible Retiree.

Questions

If you have any questions about the Plan, you should contact the Third Party Administrator or the Plan Administrator. Contact information for the Third Party Administrator and the Plan Administrator is provided in the section titled Plan Information Appendix.

Part I

Plan Terms

Section 1 — Eligibility and Participation

A. Eligible Retiree and Surviving Spouse Participants

A retiree is an **"Eligible Retiree"** if:

- He or she has attained age 65 (or, for the first calendar month of participation as provided in Section 6, will attain age 65 during the month) and (a) for former employees hired before January 1, 2008, he or she retired from the Company or a member of its controlled group of corporations after attaining age 50 or (b) for former employees hired on or after January 1, 2008 but before January 1, 2015, he or she retired from the Company or a member of its controlled group of corporations after attaining age 55;
- As of his or her date of retirement, he or she was eligible for coverage under either the Health Plan of Marathon Oil Company or the International Medical Plan; and
- He or she has at least ten years of actual service under the Employee Service Plan.

Note: Those employees who were hired on or after January 1, 2008 and before 2015 and their dependents are limited to 10 years of total combined retiree coverage in this Plan or the Health Plan of Marathon Oil Company.

Former Retiree Participants who are rehired will be able, upon subsequent termination of employment, to return to their prior Retiree Participant status and subsidy level (no credit will be given for additional service for subsidy purposes).

For purposes of determining eligibility for Retiree Participant coverage, past service which has been granted to an otherwise eligible employee under the Employee Service Plan as a result of an acquisition, merger or other corporate transaction supported by a signed definitive agreement signed on or after March 1, 2004, will count towards eligibility to be a Retiree Participant provided the signed definitive agreement governing the merger, acquisition or other corporate transaction specifically provides for the recognition of service under the Employee Service Plan for the purpose of determining eligibility and benefit accrual for retiree medical benefits.

Employees hired after 2014 and their dependents are not eligible to participate in this Plan.

This plan is intended to qualify as a "retiree only" plan for purposes of the Affordable Care Act. If an individual is actively working as an employee of Marathon Oil Company or another member of its controlled group (as defined for purposes of section 414 of the Code), then neither he or she, nor his or her Eligible Dependent, can receive benefits under this Plan for the period of his or her active employment.

1. **Retiree Participant**

   You become a **"Retiree Participant"** in this Plan if you are an Eligible Retiree and you meet the requirements described below:

   - You are eligible for and enrolled in Medicare;
   - You have obtained an individual health insurance policy through OneExchange (or any of its approved affiliates) by enrolling through OneExchange; and
   - You have completed any enrollment forms or procedures required by the Plan Administrator for enrollment in the Plan.

2. **Surviving Spouse Participant**

   The surviving Eligible Dependent of an individual who died while an active employee of the Company shall be eligible to participate as a **"Surviving Spouse Participant"** if the deceased employee was eligible for coverage in this Plan or the Health Plan of Marathon Oil Company or the International Medical Plan on the day of his or her death.

   The surviving Eligible Dependent of an individual who died while a retiree of the Company shall be eligible to participate as a **"Surviving Spouse Participant"** if the deceased retiree was eligible for coverage in this Plan or the pre-65 retiree portion of the Health Plan of Marathon Oil Company on the date of his or her death.

   A surviving Eligible Dependent of an employee or retiree who met the requirements above on his or her date of death and who is not covered under the Health Plan of Marathon Oil Company on such date of death must complete, sign and submit the proper enrollment form to Marathon Oil Company within 31 days after the date of death to begin coverage under this Plan as a Surviving Spouse Participant. Provided that the surviving Eligible Dependent properly enrolls, coverage under this Plan will be effective on the day following the date of death of the employee or retiree.

   A surviving Eligible Dependent who is covered under the Health Plan of Marathon Oil Company as a dependent spouse or domestic partner of an active employee on the employee's date of death will automatically begin coverage under this Plan as a Surviving Spouse Participant on the day following the death of the employee.

   Note: The Surviving Spouse Participant of an employee who was hired on or after January 1, 2008 and before 2015 is limited to 10 years of total combined retiree coverage in this Plan or the Health Plan of Marathon Oil Company. The surviving spouse of an employee hired after 2014 is not eligible to participate in this Plan.

   The surviving Eligible Dependent should contact One Exchange at 1-844-686-0481.

For purposes of deciding eligibility under this Plan, the Company's determination of whether an individual is classified as a "retiree" shall be determinative. In the event that service during any period of time an individual was classified as an independent contractor or other non-employee of the Company is subsequently determined to have been employment with the Company or a member of its controlled group, such service shall be disregarded for purposes of determining eligibility or calculation of the HRA contribution to which an individual is entitled under this Plan.

B. Eligible Dependents

Your Eligible Dependent may be covered under the Plan, but no individual may be covered as both a dependent and another type of Participant. **"Eligible Dependent"** includes:

1. Spouse

The Spouse of a Retiree Participant or retiree of the Company who participates in the pre-65 retiree portion of the Health Plan of Marathon Oil Company is an Eligible Dependent under the Plan, provided that the Spouse has attained age 65 or will attain age 65 during the calendar month.

2. Domestic Partner

The qualified domestic partner of a Retiree Participant or retiree of the Company who participates in the pre-65 retiree portion of the Health Plan of Marathon Oil Company is an Eligible Dependent under the Plan, provided that the domestic partner has attained age 65 or will attain age 65 during the calendar month. Domestic partners must meet the requirements established in the Marathon Oil Company Affidavit of Domestic Partner Relationship form prior to benefit enrollment.

Each Retiree Participant or retiree may have only one Eligible Dependent during his or her lifetime. In the event of divorce/separation or death of a Spouse or Domestic Partner, a Retiree Participant or retiree's subsequent Spouse or Domestic Partner will not be considered an Eligible Dependent. A Surviving Spouse Participant may not have an Eligible Dependent.

An Eligible Dependent is eligible to participate in this Plan on the earlier of (a) the date the Eligible Retiree becomes a Participant or (b) the first of the month in which the Eligible Dependent attains age 65. In order to enroll an Eligible Dependent, the Eligible Retiree to whom the Eligible Dependent is related must complete any enrollment forms or procedures required by the Plan Administrator.

C. Ceasing Participation

If you are a Retiree Participant or Surviving Spouse Participant in the Plan, you will cease being a Participant in the Plan on the earliest of:

- If you are a Retiree Participant, the date you cease to be an Eligible Retiree for any reason;
- If you are a Surviving Spouse Participant, the date you remarry;
- The date you are hired or rehired by the Company as an active employee or first perform services for the Company as a common law employee, whether or not you are classified as an employee of the Company;
- The date you cease to be eligible for Medicare;
- The date your individual health insurance policy through OneExchange (or any of its approved affiliates) is terminated for any reason;
- Your date of death;
- The effective date of any amendment terminating your eligibility under the Plan; or
- The date the Plan is terminated.

If you are an Eligible Dependent who is participating in the Plan, you will cease participation in the Plan on the earliest of:

- The date you cease to be an Eligible Dependent for any reason;
- The date the individual with whom your participation is associated ceases being a Participant or a participant in the pre-65 retiree portion of the Health Plan of Marathon Oil Company or in this Plan, except on account of the individual's death;
- The date you cease to be eligible for Medicare;
- The date your individual health insurance policy through OneExchange (or any of its approved affiliates) is terminated for any reason;
- The effective date of any amendment terminating your eligibility under the Plan; or
- The date the Plan is terminated.

You may not obtain reimbursement of any Eligible Medical Expenses incurred after the date your participation ceases. You have 180 days after your participation ceases, however, to request reimbursement of Eligible Medical Expenses you incurred before your participation ceased.

In addition, an Eligible Dependent who ceases to be eligible under this Section 1 may be eligible to continue coverage under the Plan beyond the date that his or her coverage would otherwise end if coverage is lost for certain reasons. The continuation of coverage rights and responsibilities are described in Section 8, "Continuation of Coverage."

Section 2 — Who Is Not Eligible

An individual is not eligible for coverage under this Plan if such individual is either (a) eligible for medical coverage under another group health plan maintained in the United States, toward which Marathon Oil Company or a member of its controlled group contributes, unless the individual's spouse is in a group health plan to which Marathon Oil Company or another member of its controlled group contributes that requires such individual to be covered (i.e., coverage cannot be waived); or (b) eligible for medical coverage under another group health plan sponsored by a non-participating member of the controlled group which includes Marathon Oil Company.

Dependent children are not eligible for coverage under this Plan.

Section 3 — Participants

A Retiree Participant, Surviving Spouse Participant or Eligible Dependent who is properly enrolled in this Plan and for whom the Company provides a Benefit Credit is a **"Participant"** in the Plan.

Section 4 — Account Structure

An account (referred to as a Health Reimbursement Arrangement, or **"HRA"**) will be established for each Participant. The Company has elected a joint account structure. When both an Eligible Retiree and his or her Eligible Dependent become Participants in this Plan, only one HRA will be established for the couple, and all credits for both Participants will be credited to such HRA.

Section 5 — Amount of Benefit Credits

Each Retiree Participant is entitled to a Benefit Credit in the amount shown for such Retiree Participant's service in the Benefit Credit Appendix below. In addition, if a Retiree Participant's Eligible Dependent also participates in the Plan, then the Benefit Credit for such Eligible Dependent shall be equal to the amount of the Benefit Credit to which the Retiree Participant is entitled.

Effective January 1, 2017, Benefit Credits credited to HRAs of Participants are frozen at established amount levels (amended January 1, 2016) as described in the Benefit Credit Appendix below and shall not increase.

Each Surviving Spouse Participant is entitled to a Benefit Credit equal to the amount shown in the Benefit Credit Appendix below that the Surviving Spouse Participant's deceased spouse or domestic partner would have received as a Retiree Participant.

The Plan is unfunded. Although HRAs are established as bookkeeping accounts with respect to Participants and Eligible Dependents, the HRAs are merely a bookkeeping convenience. Benefit Credits are notional amounts that remain a liability of the Company to be satisfied from its general assets. HRAs are unfunded, and the Company has no obligation to fund the HRAs or to segregate any assets for the purpose of funding HRAs. Any liability or obligation of the Company to any Participant shall be based solely on the contractual obligations that may be created by this Plan, and no such liability or obligation of the Company shall be deemed to be secured by any pledge or other encumbrance on the property of the Company. Neither the Company nor the Plan Administrator shall be deemed to be a trustee of any cash or other benefit to be paid under this Plan.

Section 6 — Timing of Benefit Credit

Benefit Credits will be credited to HRAs by the Company in the amount and at the times determined by the Company, as described more fully below. Benefit Credits will be reduced from time to time by the amount of any Eligible Medical Expenses for which a Participant is reimbursed under the Plan. At any time, a Participant may receive reimbursement for Eligible Medical Expenses up to the amount in the HRA. Except as provided in Section 8, "Continuation of Coverage," Participants are not permitted to make any contributions to their HRAs.

Except as otherwise provided in this Section 6, Benefit Credits will be credited to HRAs of Participants in January of each plan year. However, when an Eligible Retiree or Eligible Dependent first attains age 65, he or she will become a Participant on the first day of the month in which he or she attains age 65 and will receive a pro-rated Benefit Credit for the remainder of the year based on the number of months of participation in the Plan during the year.

Section 7 — Eligible Medical Expenses

"Eligible Medical Expenses" include medical, dental and vision insurance premiums and all eligible medical expenses under Code section 213(d). Please note that over-the-counter medicines or drugs (other than insulin) are not considered eligible medical expenses unless they are prescribed.

Only expenses that have not been or will not be reimbursed by any other source may be Eligible Medical Expenses (to the extent all other conditions for Eligible Medical Expenses have been satisfied). You must first submit any claims for medical or pharmacy expenses to the other plan or plans in which you participate before submitting the expenses to this Plan for reimbursement.

Some common examples of Eligible Medical Expenses include, but are not limited to:

- Premiums for medical and prescription drug insurance coverage;
- Premiums for dental and vision insurance coverage;
- Insulin;
- Dermatology;
- Physical therapy;
- Contact lenses or glasses used to correct a vision impairment;
- Chiropractor treatments;
- Hearing aids; and
- Wheelchairs.

Some examples of common items that are not Eligible Medical Expenses include:

- Baby-sitting and child care;
- Long-term care services;
- Over-the-counter medicines or drugs (other than insulin) unless they are prescribed;
- Cosmetic surgery or similar procedures (unless the surgery is necessary to correct a deformity arising from a congenital abnormality, accident or disfiguring disease);
- Funeral and burial expenses;
- Household and domestic help;
- Massage therapy;
- Custodial care;
- Health club or fitness program dues; and
- Cosmetics, toiletries, toothpaste, etc.

For more information about what items are and are not Eligible Medical Expenses, consult IRS Publication 502, “Medical and Dental Expenses,” under the headings “What Medical Expenses Are Includible” and “What Expenses Are Not Includible.” If you need more information regarding whether an expense is an Eligible Medical Expense under the Plan, contact the Third Party Administrator as provided in the Plan Information Appendix.

Only Eligible Medical Expenses incurred while you are participating in the Plan may be reimbursed from your HRA. Eligible Medical Expenses are “incurred” when the medical care is provided, not when the Participant is billed, charged or pays for the expense. Thus, an expense that has been paid but not incurred (e.g. pre-payment to a physician) will not be reimbursed until the services or treatment giving rise to the expense has been provided.

The following expenses may not be reimbursed from an HRA:

- Expenses incurred for qualified long term care services;
- Expenses incurred prior to the date that a Participant began participating in the Plan;
- Expenses incurred after the date that a Participant ceases to participate in the Plan; or
- Expenses that have been reimbursed by another plan or for which a Participant plans to seek reimbursement under another health plan.

Section 8 — Continuation of Coverage

Under federal law, an Eligible Dependent participating in the Plan who is the spouse or former spouse of a retiree or Retiree Participant may elect to continue coverage under the Plan for a limited time after the date he or she would otherwise lose coverage because of a divorce or legal separation from the retiree or Retiree Participant, which is a "qualifying event."

Note that the spouse or former spouse is required to notify the Plan Administrator in writing (which may include notification by e-mail) of a divorce or legal separation within 31 days after the later of the date the qualifying event occurs, and the date on which the qualified beneficiary loses coverage under the terms of the Plan or he or she will lose the right to continue coverage under the Plan.

If a spouse or former spouse elects to continue coverage, he or she is entitled to the level of coverage under the Plan in effect immediately preceding the qualifying event.

In order to continue coverage, the qualified beneficiary must pay a monthly premium equal to 102% of the cost of the coverage, as determined by the Plan Administrator. The Plan Administrator will notify qualified beneficiaries of the applicable premium at the time of a qualifying event.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to the qualified beneficiary. For COBRA purposes, a Domestic Partner will not qualify as a "qualified beneficiary" and will have no equivalent right to elect COBRA continuation coverage.

COBRA continuation coverage is a temporary continuation of coverage. Coverage may continue for up to 36 months following the qualifying event, but will end earlier upon the occurrence of any of the following events:

- The date the qualified beneficiary notifies the Plan Administrator that he or she wishes to discontinue coverage;
- Any required monthly premium is not paid when due or during the applicable grace period;
- The date, after the date of the qualified beneficiary's election to continue coverage, that he or she becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of the qualified beneficiary; or
- The Company ceases to provide any group health plan.

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code by the plan sponsor can be a qualifying event. If such a proceeding in bankruptcy is filed, and that bankruptcy results in the loss of coverage of any retired employee's spouse or surviving spouse, such spouse or surviving spouse will be qualified beneficiaries with respect to the Plan if bankruptcy results in the loss of their coverage under the Plan.

Section 9 — Receiving Reimbursement under the Plan

There are three methods to submit a claim: auto-reimbursement, recurring claim form or completion of a manual reimbursement request. If your claim for reimbursement is approved, you will be provided reimbursement as soon as reasonably possible following the determination. Claims are generally paid in the order in which they are received by the Claims Submission Agent.

A. Auto-reimbursement

Enrollment into the auto-reimbursement program occurs during the initial Medicare enrollment call with the OneExchange. No paper forms need to be completed. A Participant pays his or her premium directly to the insurance carrier, which then sends an auto-reimbursement file to the Claims Submission Agent, and reimbursement is sent to the Participant. The initial set-up for auto-reimbursement may take up to three months, which delays initial reimbursements. During this time, a Participant may choose to submit manual reimbursement requests if he or she does not want to experience this initial set-up delay. Not all carriers participate in auto-reimbursement.

B. Recurring Claim Form

A recurring claim form can be submitted annually or more frequently if the Participant changes carriers or insurance products. By using a recurring claim form, the Participant can receive his or her initial reimbursement more quickly than using the auto-reimbursement method (due to the initial set-up delay with auto-reimbursement). Assuming that premium payments are Eligible Medical Expenses, the recurring claim form can be used as long as the premium payments are recurring.

C. Manual Reimbursement Request

A Participant may complete a reimbursement form and mail or fax it to PayFlex Systems USA, Inc., which is the Claims Submission Agent, as provided in the Plan Information Appendix, along with a copy of documents to substantiate that reimbursement is being requested for an Eligible Medical Expense. Examples of such documents are an insurance premium bill, an “explanation of benefits” or “EOB,” or, if no EOB is provided, a written statement from the service provider. The written statement from the service provider must contain the following: (a) the name of the patient, (b) the date service or treatment was provided, (c) a description of the service or treatment; and (d) the amount incurred. Reimbursement request forms can be obtained from the Third Party Administrator identified in the Plan Information Appendix.

D. Time for Claim Submission

Your claim is deemed filed when it is received by the Claims Submission Agent. (Do not mail your form to the Third Party Administrator as this may result in a delay in processing. The address to which the claim form should be mailed will be noted on the claim form you will receive from the Claims Submission Agent.) Claims must be submitted no later than 180 days after a Participant ceases participation in this Plan.

Section 10 — Denial of a Claim for Benefits

If your claim for a benefit under this Plan is wholly or partially denied, you may appeal the denial. In order to appeal the denial of a claim, you will need to follow the claims procedures in the Claim Procedures Appendix.

Section 11 — Overpayment from the Plan

If it is later determined that a Participant received an overpayment or a payment was made in error (e.g., you were reimbursed from your HRA for an expense that is later paid by another medical plan), the Participant will be required to refund the overpayment or erroneous reimbursement to the Plan.

If you do not refund the overpayment or erroneous payment, the Plan Administrator reserves the right to offset future reimbursements equal to the overpayment or erroneous payment. Alternatively, the Company may withhold such funds from any amounts due to you from the Company, which shall reimburse the Plan. If all other attempts to recoup the overpayment/erroneous payment are unsuccessful, the Plan Administrator may treat the overpayment as a bad debt, which may be taxable as income to you.

Section 12 — Carryover of Accounts

Credits remaining in an HRA at the end of a Plan Year (after the expiration of the claims run-out period) shall be carried over to the following Plan Year to reimburse Participants for Eligible Medical Expenses incurred during subsequent Plan Years.

Section 13 — Death

The Plan provides for a Joint Account structure, as reflected in Section 4, such that if a Retiree Participant dies, the HRA continues to be available to the Participant's Spouse or Domestic Partner enrolled in the Plan upon the Participant's death. Similarly, if a Spouse or Domestic Partner dies, the Joint Account balance remaining in the HRA continues to be available to the Retiree Participant. Additionally, the deceased Participant's estate or representatives may submit claims for Eligible Medical Expenses incurred by a Participant before his or her death. Claims must be submitted within 180 days of the Participant's death.

Following the death of a Retiree Participant, the Retiree Participant's Spouse or Domestic Partner can continue to participate in the Plan as a Surviving Spouse Participant, and the Company will continue providing Benefit Credits as described in Section 5, such that the Eligible Dependent may retain the HRA and submit claims for Eligible Medical Expenses in the normal course.

In the event that a Surviving Spouse Participant dies, then his or her HRA shall be forfeited, but the deceased Surviving Spouse Participant's estate or representatives may submit claims for Eligible Medical Expenses incurred by the Surviving Spouse Participant before the Surviving Spouse Participant's death. Claims must be submitted within 180 days of his or her death.

In the event an unmarried Retiree Participant dies, his or her HRA shall be forfeited, but the deceased Retiree Participant's estate or representatives may submit claims for Eligible Medical Expenses incurred by the Retiree Participant before the Retiree Participant's death. Claims must be submitted within 180 days of his or her death.

Section 14 — Tax Treatment of Benefits

The Plan is intended to meet requirements of U.S. federal tax law, under which the benefits you receive under the Plan are not taxable to you. As a result, reimbursements for Eligible Medical Expenses paid by the Plan generally are excludable from the Participant's taxable income.

To the extent that any benefit under this Plan is determined to be deferred compensation under Code section 409A, the Plan shall be construed to comply with section 409A, including specifically the requirement that any reimbursements of expenses not exempt from tax shall be made on or before the last day of the year following the taxable year in which the expense was incurred.

The Company does not guarantee the tax treatment to any given Participant, as individual circumstances may produce different results. If there is any doubt, you should consult your own tax advisor.

Section 15 — Opt-Out Election

Any individual who is eligible to be a Participant but who does not elect coverage through OneExchange shall not participate in this Plan during the Plan Year for which he or she has not elected coverage through OneExchange, and any balance in such individual's HRA shall be permanently forfeited effective July 1 of the Plan Year during which the individual is not participating in this Plan. If, during a subsequent benefits open enrollment period, such individual elects coverage through OneExchange, such individual shall again be eligible to participate in this Plan, but his or her forfeited account balance shall not be restored.

Section 16 — Governing Law

This Plan is subject to ERISA. To the extent not preempted by ERISA, the Plan is governed by the law of the state of Texas, without regard to conflict of law provisions.

Section 17 — Company Right to Amend or Terminate the Plan

Marathon Oil Company has the right to modify or terminate the Plan at any time for any reason, including the right to change the classes of persons eligible for participation, the amount credited to HRAs or to reduce or eliminate any amounts currently credited to a Participant's HRA.

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

A company other than Marathon Oil Company that is a member of the controlled group of companies that includes Marathon Oil Company may become a participating employer in the Plan with the advance written consent of Marathon Oil Company. Marathon Oil Company may terminate any other participating employer's participation in the Plan, or a participating employer may terminate its own participation in the Plan at any time upon 60 days' written notice to the Plan Administrator.

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

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

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

Section 18 — Authority of Plan Administrator

In determining the eligibility of individuals to be Participants and the eligibility of Participants for benefits and in construing the Plan's terms, the Plan Administrator 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 he or she 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 or she may make 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 made on all matters within the scope of 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.

Part II

ERISA Rights

This Plan is an employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA provides that Participants in the Plan will be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan 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 all documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. The Plan Administrator may apply a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Plan Coverage

Continue Plan coverage for your eligible spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. However, your spouse or your dependents may have to pay for such coverage. Review this Plan and the documents governing the Plan for the rules governing COBRA continuation coverage rights.

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 employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and beneficiaries. No one, including your Company, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit from the Plan, or from exercising your rights under ERISA.

Enforcement of Your Rights

If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan 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 that is denied or ignored in whole or in part, you may file suit in a state or federal court after you have exhausted the Plan's claims procedures. 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 (e.g., if it finds your claim is frivolous).

Assistance with Your Questions

If you have any questions about the 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 obtaining documents from the Plan Administrator, you should contact the nearest office of the U.S. Department of Labor, Employee Benefits Security Administration listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., 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.

Part III

Health Insurance Portability and Accountability Act

1. **Definitions.** All terms not specifically defined in this section shall have the meaning ascribed to them in the Privacy Rule and the Security Rule.
   a. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.
   b. "Privacy Rule" and "Security Rule" mean HIPAA's implementing regulations at 45 CFR Parts 160, 162, and 164.
   c. "Workforce members" means employees, volunteers, trainees and other persons whose conduct, in the performance of work for the Company, is under the direct control of the Company, whether or not they are paid by the Company.
2. **Disclosure to the Company.**
   a. For the purpose of conducting Plan Administration Functions on behalf of the Plan, which functions must be consistent with HIPAA and the Privacy Rule, the Company shall be entitled to receive Protected Health Information ("PHI") from: (i) the Plan; (ii) any business associate of the Plan; (iii) any person or entity that contracts with such business associate; (iv) any person or entity that contracts with the Company to provide services to or on behalf of the Plan; (v) any health insurer or health insurance issuer or HMO that provides health benefits coverage or services to or on behalf of the Plan; (vi) any health care clearinghouse that provides services to or on behalf of the Plan or with respect to Plan Participants; and (vii) any other person or entity that maintains, or has the authority to direct the disclosure of, PHI related to any Plan Participant.
   b. None of the foregoing shall disclose PHI to the Company unless the Notice of Privacy Practices distributed to the Plan Participants explains that the Company is entitled to receive PHI.
   c. None of the foregoing shall disclose PHI to the Company for the purpose of employment-related actions or decisions or in connection with any other employee benefit or employee benefit plan of the Company.
   d. The Plan may disclose Summary Health Information to the Company for the specific purposes allowed by HIPAA.
   e. The Plan may disclose to the Company information on whether an individual is participating in the Plan, or is enrolled or has disenrolled from a particular coverage options within the Plan.
3. **Restrictions on the Company's Use and Disclosure of PHI.**
   a. The Company will not use or disclose Plan Participants' PHI, except as Required by Law, or as permitted or required by the Plan.
   b. The Company will ensure that any agent to whom it provides Plan Participants' PHI, agrees to the restrictions and conditions of this section with respect to Plan Participants' PHI.
   c. The Company will not use or disclose Plan Participants' PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Company.

d. The Company will comply with the requirements of the HITECH Act and its implementing regulations to provide notification to affected individuals, HHS, and the media (when required) if the Company or one of its business associates discovers a breach of unsecured PHI.

e. Promptly upon learning of any use or disclosure of Plan Participants' PHI that is inconsistent with the uses and disclosures allowed under this section, the Company will report such inconsistent use or disclosure to the Plan.

f. The Company will make PHI available to the Plan Participant who is the subject of the information, in accordance with 45 CFR § 164.524.

g. The Company will make Plan Participants' PHI available for amendment, and will incorporate any amendments to Plan Participants' PHI in accordance with 45 CFR § 164.526.

h. The Company will track its disclosures of Plan Participants' PHI, in order to provide the information necessary for the Plan to provide an accounting of disclosures in accordance with 45 CFR § 164.528 and the HITECH Act and its implementing regulations.

i. The Company will make its internal practices, books, and records (as they relate to its use and disclosure of Plan Participants' PHI) available to the U.S. Department of Health and Human Services for the purpose of determining compliance with 45 CFR Parts 160-64.

j. If feasible, the Company will return or destroy all Plan Participants' PHI that the Company still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Company will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

4. **Adequate Separation between the Company and the Plan.**

a. The Company shall ensure that adequate separation between the Plan and the Company have been established. The following workforce members or classes of workforce members may be given access to Plan Participants' PHI by the Company:

- Benefits Personnel of Marathon Oil Company;
- Benefits Accounting Personnel of Marathon Oil Company;
- Select IT Personnel of Marathon Oil Company (as designated by the HIPAA Privacy Officer, from time to time, as having job-related duties that may involve access to PHI, including HRIT, IT Security, IT Infrastructure and Information Data Management);
- Internal Legal Counsel of Marathon Oil Company Who Have Job-Related Duties with Respect to the Plan; and
- The Vice President of Human Resources & Administrative Services of Marathon Oil Company.

b. The workforce members listed above will have access to Plan Participants' PHI only to perform the Plan Administration Functions that the Company conducts for the Plan.

c. The workforce members listed above will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Company, for any use or disclosure of Plan Participants' PHI in violation of the provisions of this section. The Company will promptly report such violation to the Plan, as required by other provisions of this section, and will cooperate with the Plan in order to: correct the violation; impose appropriate disciplinary action or sanctions on each person causing the violation; and mitigate any negative effect of the violation on any Participant, the privacy of whose PHI may have been compromised by the violation.

5. **Uses and Disclosures of PHI by the Company.**
   a. **Permitted Uses and Disclosures.** The Company is entitled to use and disclose any PHI obtained pursuant to this section only for the purposes of Plan Administration Functions.
   b. **Required Uses and Disclosures.** The Company shall be required to use and/or disclose PHI: (i) to an individual, when requested under and required by 45 CFR § 164.524 in order to provide an individual with access to his or her own PHI; (ii) to an individual, when requested under and required by 45 CFR § 164.528 in order to provide an individual with an accounting of disclosures of that individual's PHI; and (iii) when required by the Secretary of the Department of Health and Human Services or those acting under the authority or at the direction of the Secretary to investigate or determine the Plan's compliance with the Privacy Rule.
6. **Minimum Necessary.** The Company must make reasonable efforts to limit its use or disclosure of PHI to the minimum information necessary to accomplish the intended purpose of the use or disclosure. When requesting PHI from another party, the Company must make reasonable efforts to limit its request to the minimum information necessary to satisfy the purpose of the request.
7. **The Company's Certification of Compliance.** Neither the Plan, nor any health insurance issuer or business associate providing services to the Plan, will disclose Plan Participants' PHI to the Company unless the Company certifies that the Plan Documents have been amended to incorporate this section and agrees to abide by this section.
8. **Security Provisions.** The Company will:
   a. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
   b. Ensure that the adequate separation required by § 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
   c. Ensure that any agent to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
   d. Report to the Plan any security incident of which it becomes aware.

Part IV

Notice of Creditable Coverage

Please read this Part IV of the Plan carefully and keep this Plan document where you can find it. This Part IV has information about your coverage under this Plan and about your options under Medicare's prescription drug coverage.

There are three important things you need to know about your coverage under this Medicare Supplement Plan and Medicare's prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- **Marathon Oil Company has determined that the prescription drug coverage offered under the Medicare Supplement Plan is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore coverage under this Plan by itself is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan than if you rely solely on this Plan and do not enroll in a Medicare drug plan. This is also important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.**
- You can keep your current coverage under the Medicare Supplement Plan. However, because your current coverage under this Plan by itself is non-creditable coverage, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage depending on if and when you join a Medicare prescription drug plan. When you enroll in an individual insurance policy with OneExchange (or potentially make a different decision), you should compare the drugs that are covered with the coverage and cost of other plans offering Medicare prescription drug coverage in your area. **Some individual health insurance policies that you can choose to enroll in through OneExchange provide creditable coverage, and you should ask whether you are enrolling in such a policy before you make a final enrollment decision.**

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you decide to drop your current coverage with Marathon Oil, since it is employer or union sponsored group coverage, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however, you may pay a higher premium (a penalty) if you did not have creditable coverage through the individual health insurance policy you selected with OneExchange because the Medicare Supplement Plan, by itself, does not provide you with creditable coverage.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

If you do not enroll in a plan (either with OneExchange or elsewhere) that provides creditable coverage, you will not have creditable coverage. Depending on how long you go without creditable prescription drug coverage, you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but did not join, if you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Marathon Oil Company coverage will not be affected.

Your current Medicare Supplement Plan requires enrollment in an individual health insurance policy with OneExchange and may pay for other health expenses. Your benefits under the Medicare Supplement Plan are as described above in this Plan document and do not change based on whether you choose to join a Medicare drug plan. **You are encouraged, however, to consider whether the individual health insurance policy you may choose to enroll in through OneExchange is a Medicare drug plan providing creditable coverage.**

If you do decide to join a Medicare drug plan and drop Medicare Supplement Plan coverage, be aware that you and your dependent will not be able to get this coverage back until January 1st of the next year following the annual open enrollment opportunity, and any HRA balance that you forfeit will not be restored.

For More Information about This Notice or Your Current Prescription Drug Coverage...

Call **1-855-652-3067** for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Marathon Oil Company changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

IN WITNESS WHEREOF, this Plan has been executed this _____ day of December, 2016 to be effective as indicated above.

Marathon Oil Company

By: _____

Plan Information Appendix

Name of Plan:	Marathon Oil Company Medicare Supplement Plan
Effective Date:	January 1, 2017 (as amended and restated)
Name, address, and telephone number of the Plan Sponsor:	Marathon Oil Company 5555 San Felipe St Houston, TX 77056 (713) 629-6600
Participating Employers (other than Sponsor):	Marathon Oil Corporation, Marathon Service Company
Name, address, and telephone number of the Plan Administrator:	Deanna Jones, Vice President, Human Resources & Administrative Services 5555 San Felipe St Houston, TX 77056 (713) 629-6600
Agent for Service of Legal Process:	Legal process may be served on the Plan Administrator.
Sponsor's federal tax identification number:	25-1410539
Plan Number:	531
Plan Year:	Calendar year (January 1 – December 31)
Third Party Administrator:	One Exchange 10975 South Sterling View Drive, Suite A-1 South Jordan, UT 84905 (855) 653-9836 www.OneExchange.com
Claims Submission Agent: All reimbursement forms, and supporting documentation, must be provided to the Claims Submission Agent. *Forms should not be mailed to the Third Party Administrator.*	PayFlex Systems USA, Inc. OneExchange HRA P.O. Box 3039 Omaha, NE 68103-3039 Fax: (402) 231-4310
Source of Benefits:	General Assets of the Plan Sponsor

Claim Procedures Appendix

If your claim for benefits is denied, then you have the right to be notified of the denial and to appeal the denial, both within certain time limits. The rules regarding denied claims for benefits under the Plan are discussed below.

A. When must I receive a decision on my claim?

You are entitled to notification of the decision on your claim within 30 days after the Claims Submission Agent's receipt of the claim. This 30-day period may be extended by an additional period of up to 15 days if the extension is necessary due to conditions beyond the control of the Claims Submission Agent. The Claims Submission Agent is required to notify you of the need for the extension and the time by which you will receive a determination on your claim. If the extension is necessary because of your failure to submit the information necessary to decide the claim, then the Claims Submission Agent will notify you regarding what additional information you are required to submit, and you will be given at least 45 days after such notice to submit the additional information. If you do not submit the additional information, the Claims Submission Agent will make the decision based on the information that it has.

B. What information will a notice of denial of a claim contain?

If your claim is denied, the notice that you receive from the Claims Submission Agent will include the following information:

- Information about your claim, including the date of service, health care provider, claim amount, and any diagnosis and treatment code and their corresponding meanings, to the extent such information is available;
- The specific reason for the denial;
- A reference to the specific Plan provision(s) on which the denial is based;
- Any denial code (and its corresponding meaning) that was used in denying the claim;
- A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;
- A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA § 502(a) following a denial on review; and
- If the Claims Submission Agent relied on an internal rule, guideline, protocol, or similar criteria in making its determination, either a copy of the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request.

C. *Do I have the right to appeal a denied claim?*

Yes, you have the right to an appeal.

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from the Plan Administrator within 60 days from receipt of the first level appeal determination.

Note: Upon written request and free of charge, any Participant may examine documents relevant to his or her claim and/or appeals and submit opinions and comments. The Claims Submission Agent will review all claims and initial appeals in accordance with the rules established by the U.S. Department of Labor, and the Plan Administrator will review all second level initial appeals in accordance with the rules established by the U.S. Department of Labor.

D. *Do I have to appeal a denied claim before I can go to court?*

You will not be allowed to take legal action against the Plan, the Company, or any other entity to whom administrative or claims processing functions have been delegated unless you exhaust your appeal rights.

E. *What are the requirements of my appeal?*

Your initial appeal must be in writing, must be provided to the Claims Submission Agent, and must include the following information:

- Your name and address;
- The fact that you are disputing a denial of a claim or the Claims Submission Agent's act or omission;
- The date of the notice that the Claims Submission Agent informed you of the denied claim; and
- The reason(s), in clear and concise terms, for disputing the denial of the claim or the Claims Submission Agent's act or omission.

You should also include any documentation that you have not already provided to the Claims Submission Agent.

If you do not agree with the determination on your initial appeal, you may submit a second level appeal to the Plan Administrator. This appeal must also be in writing, must be provided to the Plan Administrator, and must include the following information:

- Your name and address;
- The fact that you are disputing the denial of an initial appeal;
- The date of the notice that the Claims Submission Agent informed you of the denied claim; and
- The reason(s), in clear and concise terms, for disputing the denial of the initial appeal.

You should also include any documentation that you have not already provided to the Claims Submission Agent.

F. Is there a deadline for filing my appeal?

Yes. Your initial appeal must be delivered to the Claims Submission Agent within 180 days after receiving the denial notice or the Claims Submission Agent's act or omission. *If you do not file your initial appeal within this 180-day period, you lose your right to appeal.* Your initial appeal will be reviewed and decided by the Claims Submission Agent (or its designee).

Your second level appeal must be delivered to the Plan Administrator within 60 days after receiving the denial notice of your initial appeal. *If you do not file your second level appeal within this 60-day period, you lose your right to appeal.* Your appeal will be reviewed and decided by the Plan Administrator (or his or her designee).

G. How will my appeal be reviewed?

Any time before the appeal deadline, you may submit copies of all relevant documents, records, written comments, testimony, and other information to the Claims Submission Agent or Plan Administrator, as applicable. The Plan is required to provide you with reasonable access to and copies of all documents, records, and other information related to the claim. When reviewing your appeal, the Claims Submission Agent or Plan Administrator will take into account all relevant documents, records, comments, and other information that you have provided with regard to the claim, regardless of whether or not such information was submitted or considered in the initial determination or initial appeal.

If the Claims Submission Agent or Plan Administrator receives new or additional evidence that it considered, relied upon, or generated in connection with the claim, other than evidence that you have provided to it, you will be provided with this information and given a reasonable opportunity to respond to the evidence before the due date for the Claims Submission Agent's or Plan Administrator's notice of adverse benefit determination. Similarly, if the Claims Submission Agent or Plan Administrator identifies a new or additional reason for denying your claim, that new or additional reason will be disclosed to you and you will be given a reasonable opportunity to respond to that new rationale before the due date for the Claims Submission Agent's or Plan Administrator's notice of adverse benefit determination.

The initial appeal determination will not afford deference to the initial determination and will be conducted by a fiduciary of the Plan who is not: (1) the individual who made the original determination; (2) an individual who is a subordinate of the individual who made the initial determination; or (3) an individual whose terms and conditions of employment are affected by the results of his or her decision.

The second level appeal determination will not afford deference to the initial appeal determination and will be conducted by the Plan Administrator (or his or her designee). The Plan Administrator (or his or her designee) is not (1) the individual who made the original determination or the determination on initial appeal; (2) an individual who is a subordinate of the individual who made the initial determination or determination on initial appeal; or (3) an individual whose terms and conditions of employment are affected by the results of his or her decision.

If the appeal determination will be based on the medical judgment of a health care professional retained by the Claims Submission Agent or Plan Administrator, the health care professional retained for purposes of the appeal will not be an individual who was consulted in connection with the determination that is being appealed or any subordinate of that individual.

H. When will I be notified of the decision on my appeal?

The Claims Submission Agent must notify you of the decision on your initial appeal within 30 days after receipt of your request for review.

The Plan Administrator must notify you of the decision on your second level appeal within 30 days after receipt of your request for review.

I. What information is included in the notice of the denial of my appeal?

If your appeal is denied, the notice that you receive from the Claims Submission Agent or Plan Administrator will include the following information:

- Information about your claim, including the date of service, health care provider, claim amount, and any diagnosis and treatment code and their corresponding meanings, to the extent such information is available;
- The specific reason for the denial upon review;
- A reference to the specific Plan provision(s) on which the denial is based;
- Any denial code (and its corresponding meaning) that was used in denying the claim;
- A statement providing that you are required to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits;
- If an internal rule, guideline, protocol, or similar criterion was relied upon in making the review determination, either the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the review determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request; and
- A statement of your right to bring a civil action under ERISA § 502(a).

Benefit Credit Appendix

Subsidy %	Retiree	Retiree and Spouse
100	$1,982	$3,964
99	$1,962	$3,924
98	$1,942	$3,885
97	$1,923	$3,845
96	$1,903	$3,805
95	$1,883	$3,766
94	$1,863	$3,726
93	$1,843	$3,687
92	$1,823	$3,647
91	$1,804	$3,607
90	$1,784	$3,568
89	$1,764	$3,528
88	$1,744	$3,488
87	$1,724	$3,449
86	$1,705	$3,409
85	$1,685	$3,369
84	$1,665	$3,330
83	$1,645	$3,290
82	$1,625	$3,250
81	$1,605	$3,211
80	$1,586	$3,171
79	$1,566	$3,132
78	$1,546	$3,092
77	$1,526	$3,052
76	$1,506	$3,013
75	$1,487	$2,973
74	$1,467	$2,933
73	$1,447	$2,894
72	$1,427	$2,854
71	$1,407	$2,814
70	$1,387	$2,775
69	$1,368	$2,735
68	$1,348	$2,696
67	$1,328	$2,656

(continued)

Subsidy %	Retiree	Retiree and Spouse
66	$1,308	$2,616
65	$1,288	$2,577
64	$1,268	$2,537
63	$1,249	$2,497
62	$1,229	$2,458
61	$1,209	$2,418
60	$1,189	$2,378
59	$1,169	$2,339
58	$1,150	$2,299
57	$1,130	$2,259
56	$1,110	$2,220
55	$1,090	$2,180
54	$1,070	$2,141
53	$1,050	$2,101
52	$1,031	$2,061
51	$1,011	$2,022
50	$991	$1,982
49	$971	$1,942
48	$951	$1,903
47	$932	$1,863
46	$912	$1,823
45	$892	$1,784
44	$872	$1,744
43	$852	$1,705
42	$832	$1,665
41	$813	$1,625
40	$793	$1,586
39	$773	$1,546
38	$753	$1,506
37	$733	$1,467
36	$714	$1,427
35	$694	$1,387
34	$674	$1,348
33	$654	$1,308
32	$634	$1,268
31	$614	$1,229

(continued)

Subsidy %	Retiree	Retiree and Spouse
30	$595	$1,189
29	$575	$1,150
28	$555	$1,110
27	$535	$1,070
26	$515	$1,031
25	$496	$991
24	$476	$951
23	$456	$912
22	$436	$872
21	$416	$832
20	$396	$793
19	$377	$753
18	$357	$714
17	$337	$674
16	$317	$634