Health Plan of Marathon Oil Company Prescription Drug Program — Health Investment Plan Option

This summary plan description constitutes part of the Health Plan of Marathon Oil Company plan document along with the Health Plan of Marathon Oil Company Core Document and other associated Summary Plan Descriptions, agreements with third party administrators, and appendices to the Core Document. You can access the Core Document at www.MRObenefits.com or by requesting a paper copy by written request to the Plan Administrator.

January 1, 2014

Marathon Oil® Corporation

Prescription Drug Program

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I. Prescription Drug Program

The Prescription Drug Program (the "Prescription Program") of the Health Plan of Marathon Oil Company (the "Plan") has a Retail Pharmacy component and a Mail-Order component. Both are administered by Express Scripts. All coverage under the Prescription Program is subject to medical necessity determination and other Plan limitations.

A. Coverage

1. To Receive Coverage

To receive coverage under the Plan, outpatient prescription drugs (see below for a definition of Outpatient Prescription Drugs) must be purchased through the Retail Pharmacy component (through a participating Express Scripts retail pharmacy) or through the Mail-Order component (from the Express Scripts' mail-order pharmacy) of the Prescription Program. Network pharmacies (both Retail and Mail-Order pharmacies) offer discounted drug prices, drug utilization review to protect individuals from potentially dangerous drug interactions, and no claim forms to submit.

Except for certain exception situations explained in the Plan text, there is no coverage for outpatient prescription drugs that are not purchased through a Retail or Mail-Order Network pharmacy.

Coverage levels vary depending on whether you use the Retail Pharmacy component or Mail-Order component.

2. Outpatient Prescription Drugs

a. Outpatient Prescription Drugs are prescription drugs which are:

i. Prescribed to be administered when the covered individual is not confined to a hospital as an inpatient (includes certain specialty medications — injectable medications administered either by the covered individual or a health care professional).

ii. Not billed by a home health agency, hospice agency, or sub-acute care facility (extended care facility).

iii. Federal legend drugs (prescription drugs), state restricted drugs, compounded medications, and oral contraceptives.

iv. Insulin with a prescription only and covered diabetic supplies with a prescription only. Covered diabetic supply items are syringes (including needles), test strips, lancets, and glucometers. (An insulin pump, as well as tubing and needles for the pump, are covered under the durable medical equipment provisions of the Medical/Surgical portion of the Plan and are not covered as a diabetic supply item under the Prescription Program.)

b. Not covered under the Prescription Program but subject to the provisions of the Medical/ Surgical portion of the Plan are:

   i. Supply items (other than diabetic supplies), therapeutic devices, and durable medical equipment (durable medical equipment includes an insulin pump as well as tubing and needles for the pump); and

   ii. Prescription drugs and covered diabetic supplies billed by a home health agency, hospice agency, or sub-acute care facility (extended care facility).

3. Patient Protection and Affordable Care Act Drugs

The Patient Protection and Affordable Care Act (PPACA) requires the Prescription Program to cover certain preventive items and services at 100 percent and ensure these items and services are not subject to deductibles or other cost-sharing limitations.

The following list of preventive medications should be used as a guide. It cannot be considered a comprehensive listing of medications available or covered without cost-sharing. Coverage of any of the listed medications (including over-the-counter (OTC) medications) requires a prescription from a licensed health care provider.

This list is subject to change as ACA guidelines are updated or modified.

For specific questions about your coverage, please call the phone number printed on your ID card. You can get more information and updates at the Express Scripts website www.express-scripts.com.

Aspirin products

Aspirin 81 MG and 325 MG

Fluoride products

Fluoride Chewable Tablet
0.25 MG and 0.5 MG

Fluoride Drops
0.125, 0.25 MG and 0.5 MG

Multivitamin with Fluoride
Chewable 0.25 MG and 0.5 MG
Drops 0.25 MG and 0.5 MG

Iron Supplements

Iron (various strengths)
Drops, Liquid, Suspension, Granules

Multivitamin with Iron
Drops, Liquid, Suspension

Folic Acid Products

Folic Acid Tablet 0.4 MG and 0.8 MG

Prenatal Vitamins with Folic Acid
Multivitamins with Folic Acid

Contraceptive Methods

Covered products include OTC contraceptive methods (female condom, spermicides, etc.), oral contraceptives (including emergency contraception), and contraceptive devices (diaphragms, skin patch systems, injectable contraception, intrauterine systems, and implants).

Brand name contraceptives that have a generic equivalent are available at zero cost share only when the physician indicates that the brand product must be dispensed.

Smoking Cessation Products

Bupropion SR 150 MG

Chantix

Nicotine gum, Lozenge and Patch (Over-the-Counter products only)

Vitamin D Supplements

Vitamin D 1,000 units or less per dose unit

Calcium with Vitamin D

Bowel Preps (limit of 2 prescriptions per year)

Bisacodyl

Magnesium Citrate

Milk of Magnesia

PEG 3350 – Electrolyte

B. Prescription Drug Benefit Levels

1. The table below describes how coverage works under the HIP option. Note that eligible preventive drugs are covered differently than non-preventive drugs. For a list of eligible preventive drugs, visit www.MRObenefits.com or call 1-855-652-3067.

2014 Prescription Drug Benefits		
Non-Preventive Drugs — HIP Option		
Plan Feature		**Retail and Mail Order**
In-Network Deductible (combined with medical)		$1,300 individual/$2,600 family
Generic, Formulary and Non-Formulary		You pay 15% after the deductible is met
Out-of-Pocket Maximum (combined with medical)		$2,600 individual/$5,200 family
Eligible Preventive Drugs — HIP Option		
Plan Feature	**Retail**	**Mail Order**
In-Network Deductible	No deductible	No deductible
Generic	You pay 15% ($5 minimum)	You pay 15% ($10 minimum, $200 maximum)
Formulary	You pay 15% ($25 minimum)	You pay 15% ($50 minimum, $200 maximum)
Non-Formulary	You pay 50% ($35 minimum)	You pay 50% ($100 minimum)
Out-of-Pocket Maximum	$2,600 individual/$5,200 family	$2,600 individual/$5,200 family

In addition, any generic or brand name drug on the formulary that is ordered through the Mail-Order component is subject to a $200 maximum coinsurance per prescription.

2. There are certain situations where you will pay more.

   a. **Brand Name Drugs When a Generic is Available (Generic Election Provision)** — Under both the both Retail Pharmacy component and the Mail-Order component, if you purchase a brand name drug when a generic equivalent is available, the Plan Benefit will be based on the cost of the generic equivalent drug. For non-preventive drugs, once you meet the Health Plan deductible, you will pay 15% of the generic drug cost plus 100% of the difference in price between the generic drug and the brand name drug. For preventive drugs, you will pay 15% of the generic drug cost plus 100% of the difference in price between the generic drug and the brand name drug. This Generic Election Provision does not apply to insulin and covered diabetic supply items.

   b. **Maintenance Drugs (Incentive Mail-Order Provision)** — Under this Incentive Mail-Order Provision, you will pay more for a "maintenance" drug purchased using the Retail Pharmacy component instead of the Mail-Order component the fourth time you purchase the drug using the Retail Pharmacy component and each subsequent time that you purchase the "maintenance" drug using the Retail Pharmacy component.

   The first three times you fill a "maintenance" drug at a participating retail pharmacy your Benefit will be as indicated above under "Prescription Drug Benefit Levels." To encourage you to purchase "maintenance" drugs through the Mail-Order component, the fourth and later times you purchase a "maintenance" drug at a participating retail pharmacy the percentage of the cost of the "maintenance" drug that the Plan pays and you pay is as follows:

Non-preventive drugs — You must first meet the Health Plan deductible. Then the plan and you pay as follows:		
Benefit Level (Coinsurance)		
Type of Medication	**Plan Pays**	**Covered Individual Pays**
Generics	60%	40%
Generics and Brand Name Drugs on the Formulary	60%	40%
Brand Name Drugs Not on the Formulary	20%	80%

A "maintenance" drug is one taken for a long period of time and is designated by Express Scripts as a "maintenance" drug. Call Express Scripts' Customer Service at 1-800-841-3423 to find out if a prescription drug is designated as a "maintenance" drug by Express Scripts. Insulin is not categorized as a "maintenance" drug and is not subject to these "maintenance" drug provisions. The cost of prescription drugs is less when purchased through the Mail-Order component than when purchased through the Retail Pharmacy component. You are encouraged to purchase maintenance drugs through the Mail-Order component.

Obtaining a new prescription for the exact same maintenance drug will not allow you to avoid the maintenance prescription coverage provision. If you obtain a new prescription for the exact same maintenance drug, it will be treated as an extension of the previous maintenance prescription.

c. **Brand Name Drugs Not on the Formulary (Incentive Formulary Provision)** — You will pay more for brand name drugs that are **not** on the Express Scripts Preferred Prescription Formulary. Please note that the Generic Election Provision (see item a above) applies even if you purchase a brand name drug on the formulary and that brand name drug has a generic equivalent available. For non-preventive drugs, once you meet the Health Plan deductible, you will pay 15% of the generic drug cost plus 100% of the difference in price between the generic drug and the brand name drug. For preventive drugs, you will pay 15% of the generic drug cost plus 100% of the difference in price between the generic drug and the brand name drug.

   Call Express Scripts at 1-800-841-3423 to see if a drug is on the formulary or to request a copy of the formulary. You can also obtain information about the formulary online at www.express-scripts.com.

C. Using the Retail Pharmacy Component

Use the Retail Pharmacy component when a prescription is to be taken on a short term basis or for your first prescription of a medication you will be taking for a long period of time (such as 60 days or more). Prescriptions (including covered diabetic supply items) under the Retail Pharmacy component are limited to a 30-day supply maximum. Present your Express Scripts ID card to the pharmacist at a participating pharmacy. No claim forms are required.

The names of participating pharmacies in your area, or throughout the country (when you travel) are available by calling Express Scripts Customer Service at 1-800-841-3423, or from Express Scripts' website, www.express-scripts.com.

D. Exceptions

In certain situations, there are exceptions to these provisions. Each of the four following situations require the submission of a claim form (see "Situations Requiring a Claim Form" for claim filing information) when outpatient prescription drugs (including covered diabetic supplies) are purchased as indicated. The four exception situations are as follows:

1. Outpatient Prescription Drugs purchased outside the United States by covered individuals who reside in the United States, but who are temporarily out of the country due to business or leisure and where a medical need arises, are covered by the Plan at 85% of the purchase price for generic or brand-name drugs that are considered preventive or after the Health Plan deductible has been met for non-preventive drugs. None of the following provisions apply in this situation: Generic Election Provision, Incentive Mail-Order Provision and Incentive Formulary Provision.
2. If the covered individual receives Outpatient Prescription Drugs in the following situations and is billed by a non-participating pharmacy, coverage is 85% of the purchase price of the preventive prescription drug (whether the drug is generic or a brand name drug, on the formulary or not on the formulary) or after the Health Plan deductible has been met for non-preventive prescription drugs. In addition, the Incentive Mail-Order Provision does not apply in this situation.

a. Covered individual lives in and receives Outpatient Prescription Drugs through a rest home, nursing home, sub-acute care facility (or other extended care facility or skilled nursing facility), convalescent hospital, or similar institution; or

b. Covered individual receives Outpatient Prescription Drugs from a hospice or home health agency.

3. If the covered individual purchases Outpatient Prescription Drugs at a participating retail pharmacy but the claim is not filed electronically by the pharmacist for reasons listed below, coverage will be as indicated above in "Prescription Drug Benefit Levels" after the Health Plan deductible is met. In both situations the Generic Election Provision, Incentive Mail-Order Provision and the Incentive Formulary Provision apply.

   a. For a new covered individual (within the first 30 days of coverage) not included in the Express Scripts system, coverage is based on the purchase price of the prescription drug.

   b. If the covered individual did not have his or her Express Scripts ID card, or for any other reason the claim was not filed electronically coverage is based on the negotiated network price of the prescription drug.

4. If the covered individual resides in the United States and does not have access to (beyond ten miles) a participating Network pharmacy, coverage will be as indicated above in "Prescription Drug Benefit Levels" after the Health Plan deductible is met. In this situation the Generic Election Provision, Incentive Mail-Order Provision and the Incentive Formulary Provision all apply.

E. Using the Mail-Order Pharmacy Component

If you have an ongoing condition that requires you to take an Outpatient Prescription Drug over a long period of time (such as 60 days or more), you can order up to a 90-day supply of your Outpatient Prescription Drug mailed directly to your home.

It is more cost effective for you and the Plan to purchase your Outpatient Prescription Drugs under the Mail-Order component. The cost of Outpatient Prescription Drugs is less when purchased through the Mail-Order component than when purchased through a participating retail pharmacy because the Outpatient Prescription Drug discounts at mail-order are greater than the discounts at retail. This means your share of the cost of the drug is less when using the Mail-Order component.

F. Out-of-Pocket Maximum

To protect those who have illnesses requiring significant prescription drugs, an individual or family out-of-pocket maximum applies to this option of the Prescription Program. The individual out-of-pocket maximum is $2,600 per year. The family maximum out-of-pocket maximum is $5,200.

When the coinsurances a covered individual has paid total the amount of the individual or family out-of-pocket maximum in a calendar year, covered charges for that covered individual or family under the Prescription Program are paid at 100% for the rest of the calendar year.

G. Clinical Programs Administered by Express Scripts

The Plan has authorized Express Scripts to implement a number of clinical programs that assure that the drugs are clinically appropriate and consistent with the Plan's intent. These programs are subject to change as Express Scripts continues to develop and enhance existing programs. As the pharmaceutical industry changes rapidly, the Plan will actively pursue administrative opportunities to assure patient safety and optimize Health Plan effectiveness for Plan participants. At any time a current list of clinical programs administered by Express Scripts can be requested and will be provided to the covered individual on a timely basis. The major clinical programs are as follows:

- **Drug Utilization Review** — Concurrent and Retrospective to assure safety and appropriate use.
- **Specialty Pharmacy** — To provide enhanced pharmacy services for some conditions such as anemia, hepatitis C, multiple sclerosis, asthma, growth hormone deficiency, and rheumatoid arthritis that are treated with specialty medications. The Plan requires certain specialty drugs to be dispensed only through the Specialty Pharmacy.
- **Coverage Management Programs** — These programs help ensure the appropriateness of coverage for specific drugs and specific amounts of drugs. The following programs are included under Coverage Management — Traditional Prior Authorization, SMART Prior Authorization, Dose Duration, Quantity Duration, Dispensing Quantity, and Dose Optimization.

These clinical programs will work with the prescribing physician, dispensing pharmacist and the covered individual to ensure that any conflicts that may arise are resolved in a prompt and safe manner.

H. Special Preventive Coverage

Your physician may prescribe a preventive vaccine that is available in oral form. Your physician may also write a prescription for you to purchase an injectable vaccine at the pharmacy, prior to administration in the physician's office. In such cases, the Prescription Program will cover the vaccine at 100% not subject to the Health Plan deductible if purchased under the Retail Pharmacy component or the Mail-Order component. Services to administer the vaccine would still be covered by the Medical/Surgical portion of the Plan.

II. Expenses Not Covered Under the Prescription Program

The Plan does not cover certain types of services and supplies, as well as services for certain conditions. Your out-of-pocket expenses for such services do not count toward the Health Plan deductible or out-of-pocket maximum.

Limitations and Exclusions

No benefits are payable under the Plan for, and the term "Covered Charges" will not include, charges for:

- Expenses resulting from experimental or investigational procedures including experimental drugs.
- Expenses for over-the-counter drugs, remedies, vitamins, dietary supplements and supplies, except as approved by the Prescription Program.
- Expenses for weight reduction drugs except as approved by the Prescription Program.

Prescription Program Claims

In general, when you purchase a prescription through the Retail Pharmacy component or the Mail-Order component of the Prescription Program, no claim forms are needed. There is no coverage for prescriptions for Outpatient Prescription Drugs that are not filled through a participating retail pharmacy under the Retail Pharmacy component or through the Mail-Order component.

However, the four situations described in Section D, "Exceptions" above do require you to file a claim form.

Claim forms and mail-order forms can be obtained online at www.express-scripts.com or by calling Express Scripts at 1-800-841-3423. Submit claim forms to:

Express Scripts
P.O. Box 14711
Lexington, KY 40512

III. If a Claim is Denied

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

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

Appeals to the Plan Administrator must contain all of the required information in order to be regarded as an appeal under the Plan. If required information is missing the request may not be regarded by the Plan as an appeal and, if it is not regarded as an appeal, it will be returned to the covered individual, or their designated representative, with no determination made. The covered individual, or their duly authorized representative, should contact the claim payer denying the claim (Express Scripts) prior to filing the appeal in order to clarify any questions they may have on the reason for the denial by the claim payer. All appeals to the Plan Administrator must contain the following information:

- A statement that a formal appeal under the Plan is being made and the type of appeal (Urgent Pre-Service Claim Appeal, Non-Urgent Pre-Service Claim Appeal or Post-Service Claim Appeal).
- The name of the individual for whom the claim was denied.
- The Social Security number of the employee or retiree covered individual, and, if the individual for whom the claim was denied is not the employee or retiree covered individual, the name of the employee or retiree covered individual.
- Name of Plan the individual is covered under. (For example, Health Plan of Marathon Oil Company, Prescription Program, Health Investment Plan option.)
- Identify the claim denied for which the appeal is being made. Include the date of service, name of the provider and/or facility.
- Any and all information necessary for a complete and thorough review of the claim appeal. Provide the complete name and phone number of any medical professionals to contact for additional information supporting the approval of the appeal.
- Address and telephone number of the individual, or duly authorized representative, making the appeal.
- Authorization for release of personal health information if appropriate and necessary.

How an appeal is made and the time frames for requesting an appeal vary depending on the type of health service claim denied. The following explains the three types of appeals for the three types of claims and the procedures for making an appeal for each of the three types of appeals: Urgent Pre-Service Claim Appeal, Non-Urgent Pre-Service Claim Appeal, and Post-Service Claim Appeal.

For those claim appeal procedures that require that the appeal be sent in writing to the Plan Administrator, the address for the Plan Administrator of the Marathon Oil Company Health Plan is as follows. A form for you to use to submit the appeal can be found at www.MRObenefits.com in the Forms section. The form can also be obtained by requesting a copy from the Marathon Health and Welfare Department at 1-855-652-3067.

Health Plan of Marathon Oil Company Appeals
The Plan Administrator, Health Plan of Marathon Oil Company
5555 San Felipe Street, Room 2687
Houston, TX 77056

Telephone: 1-855-652-3067

For claim appeal procedures that require the appeal to be sent in writing to the claims payer, the address for the claim payers are as follows:

Express Scripts
Attn: Administrative Reviews
8111 Royal Ridge Parkway
Irving, TX 75063

Telephone: 1-800-841-3423

Pre-Service Claim Appeal

If a request for health care was denied before the health care is rendered (for example, as a result of a prior authorization, precertification or preapproval) by a claim payer under the Plan, the claim is a Pre-Service Claim and you may appeal following the Pre-Service Claim Appeal procedures. The Pre-Service Claim Appeal procedures depend on whether the claim is an urgent or a non-urgent claim.

An urgent claim appeal is a medical service claim that requires immediate action if a delay in treatment could significantly increase the risk to health or the ability to regain maximum function, or cause severe pain, or jeopardize the life or health of patient or a patient's unborn child.

Urgent Pre-Service Claim Appeal

You, or your designated representative, may appeal a denial decision of an Urgent Pre-Service Claim by phone or in writing (by mail or fax). The appeal must be received by the Plan Administrator within 180 days of the initial claim denial.

- If you make your appeal by telephone or fax, contact Marathon Oil Appeals Administration at 1-855-652-3067. Information for filing an appeal by phone or fax will be provided.
- If you make your appeal by mail, send it to Marathon Oil Appeals Administration at the address listed above.

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

Urgent vs. Non-Urgent Claims

A Pre-Service Claim that is "urgent" when it is initially filed will cease to be an "Urgent" Pre-Service Claim and will become a Non-Urgent Pre-Service Claim if, between the date of the claim denial and the date the appeal is made, the health care services are actually rendered and the only decision to be made is who will pay for the services.

Non-Urgent Pre-Service Claim Appeal

You, or your designated representative, are encouraged first to call the appropriate claim payer (Express Scripts) at the telephone number stated above and ask that your claim be reviewed, but this is not required. If, after the claim has been reviewed in response to your telephone call, you continue to disagree with the handling and disposition of the claim, you are entitled to submit a written appeal to Express Scripts at the address stated above. You may also submit a written appeal to Express Scripts without first attempting to resolve the claim by telephone call.

- Send a copy of your written appeal to the Plan Administrator at the address also stated above.
- That written appeal will be reviewed in accordance with Express Scripts' internal appeal procedures. The written appeal must be received by Express Scripts within 180 days of the initial denial.

- Express Scripts must respond to your written appeal within 15 days for a Non-Urgent Pre-Service Claim.

If, after receiving the response to a written appeal from Express Scripts, you continue to disagree with the handling and disposition of the claim, you are entitled to submit a written appeal to the Plan Administrator.

- You, or your designated representative, may appeal a denial decision of a Non-Urgent Pre-Service Claim Appeal in writing to the Plan Administrator at the address stated above.
- Appeal to the Plan Administrator must be in writing. Non-Urgent Pre-Service Claim Appeals cannot be submitted by telephone, fax or e-mail.
- The appeal to the Plan Administrator must be received by the Plan Administrator within 30 days of the date of the denial of the first appeal by the claim payer.

A determination by the Plan Administrator, or others delegated authority by the Plan Administrator to hear final appeals, will be made within 15 days of the Plan Administrator receiving the appeal request. The appeal determination will be sent to the individual making the appeal at the address provided in the appeal.

Post-Service Claim Appeal

If you disagree with the handling and disposition of the claim, you are entitled to submit a written appeal to Express Scripts at the address stated above.

- Send a copy of your written appeal to the Plan Administrator at the address also stated above.
- That written appeal will be reviewed in accordance with the Express Scripts' internal appeal procedures. The written appeal must be received by Express Scripts within 180 days of the initial denial.
- Express Scripts must respond to your written appeal within 30 days for a Post-Service Claim Appeal.

If, after receiving the response to a written appeal from Express Scripts, you continue to disagree with the handling and disposition of the claim, you are entitled to submit a written appeal to the Plan Administrator.

- You, or your designated representative, may appeal a denial decision of a Post-Service Claim in writing by sending the appeal to the Plan Administrator at the address stated above.
- Appeal to the Plan Administrator must be in writing and cannot be submitted by telephone, fax or e-mail.
- The appeal to the Plan Administrator must be received by the Plan Administrator within 30 days of the date of the denial of the first appeal by the claim payer.

A determination by the Plan Administrator, or others delegated authority by the Plan Administrator to hear final appeals, will be made within 30 days of the Plan Administrator receiving the appeal request. The appeal determination will be sent to the individual making the appeal at the address provided in the appeal.

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

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Morris R. Clark
Vice President and Treasurer
Marathon Oil Company

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Date