Execution Version

MARATHON OIL COMPANY
RETIREE HEALTH AND WELFARE PLAN
WRAP DOCUMENT

Amended and Restated Effective January 1, 2019

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ARTICLE I
ESTABLISHMENT AND INTERPRETATION OF THE PLAN

1.1 The Plan. The Company has sponsored (a) the Health Plan of Marathon Oil Company (Amendment and Restatement Effective January 1, 2017) (Plan Number 504), which includes medical and prescription drug coverage for eligible pre-65 retirees (the "Pre-65 Retiree Health Coverage") and medical and prescription drug coverage and a wellness program for eligible employees and an employee assistance program for eligible employees and certain eligible former employees (the "Employee Health Coverage"), (b) the Dental Assistance Plan of Marathon Oil Company (Plan Number 509) (the "Dental Plan"), which includes coverage under a component entitled the Marathon Oil Company Dental Assistance Plan A effective January 1, 2014 for eligible pre-65 retirees (the "Pre-65 Retiree Dental Coverage") and coverage under a component entitled the Marathon Oil Company Dental Plan (Amended and Restated Effective as of January 1, 2017) for eligible employees (the "Employee Dental Coverage"), (c) the Vision Assistance Plan of Marathon Oil Company (Plan Number 530) (the "Vision Plan"), which includes coverage under a component entitled the Marathon Oil Company Pre-65 Retiree Vision Plan (Amended and Restated Effective as of January 1, 2017) for eligible pre-65 retirees (the "Pre-65 Retiree Vision Coverage") and coverage under a component entitled the Vision Plan of Marathon Oil Company (Effective January 1, 2017) for eligible employees (the "Employee Vision Coverage"), (d) the Marathon Oil Company Long Term Disability Plan (Amended and Restated as of January 1, 2015) (Plan Number 503) (the "LTD Plan"), which includes long-term disability coverage for eligible former employees (the "Former Employee LTD Coverage") and long-term disability coverage for eligible employees (the "Employee LTD Coverage"), (e) the Marathon Oil Company Level Premium Life Insurance Plan (Amended and Restated as of January 1, 2012) (Plan Number 502) (the "Level Premium Life Insurance Plan"), which includes life insurance coverage for eligible retirees (the "Retiree Level Premium Life Insurance Coverage") and life insurance coverage for certain eligible employees (the "Employee Level Premium Life Insurance Coverage"), and (f) the Marathon Oil Company Medicare Supplement Plan (Amended and Restated Effective January 1, 2017) (Plan Number 531) (the "Supplement Plan").

Effective as of January 1, 2019, the Company has spun-off the Pre-65 Retiree Health Coverage under the Health Plan from the Health Plan, the Pre-65 Retiree Dental Coverage under the Dental Plan from the Dental Plan, the Pre-65 Retiree Vision Coverage under the Vision Plan from the Vision Plan, the Former Employee LTD Coverage under the LTD Plan from the LTD Plan, and the Employee Level Premium Life Insurance Coverage under the Level Premium Life Insurance Plan from the Level Premium Life Insurance Plan. Further, effective as of January 1, 2019, the spun-off Pre-65 Retiree Health Coverage, Pre-65 Retiree Dental Coverage, Pre-65 Retiree Vision Coverage, and the Former Employee LTD Coverage, along with the Supplement Plan, are hereby merged into the Level Premium Life Insurance Plan (without the Employee Level Premium Life Insurance Coverage), and this newly combined plan amended and restated and renamed as the Marathon Oil Company Retiree Health and Welfare Plan (Amended and Restated Effective January 1, 2019) with a Plan Number of 503.

The terms and conditions of the Marathon Oil Company Retiree Health and Welfare Plan are set forth in this document (the "Wrap Document") and in the Welfare Program Documents. This Wrap Document and the Welfare Program Documents together constitute the plan document for the Marathon Oil Company Retiree Health and Welfare Plan and the written instrument under which the Plan is maintained for purposes of section 402(a) of ERISA.

1.2 Purpose and Intent. The purpose of the Plan is to provide Participants and Beneficiaries certain welfare benefits described herein. All of the Welfare Programs incorporated herein shall be treated as a single welfare plan for purposes of ERISA. This Plan is intended to meet all applicable requirements of the Code and ERISA, as well as rulings and regulations issued or promulgated thereunder. Nothing in this Plan shall be construed as requiring compliance with Code or ERISA provisions to the extent not otherwise applicable.

1.3 Definitions. When used herein, the following words shall have the meanings set forth below unless the context clearly indicates otherwise:

(a) **"Beneficiary"** means a beneficiary of a Participant as designated or determined under a Welfare Program.

(b) **"Code"** means the Internal Revenue Code of 1986, as amended from time-to-time, and any subsequent Internal Revenue Code. References to any section of the Code shall be deemed to include similar sections of the Code as renumbered or amended.

(c) **"Company"** means Marathon Oil Company or any successor entity by merger, consolidation, purchase or otherwise, unless such successor entity elects not to adopt the Plan.

(d) **"Controlled Group"** means the Company and any other entity or organization required to be aggregated with the Company pursuant to Section 414(b), (c), (m), (n) or (o) of the Code.

(e) **"Controlled Group Entity"** means an entity or organization that is part of the Controlled Group.

(f) **"Dependent"** means a covered dependent of a Retired Employee, as determined under a Welfare Program.

(g) **"Employee"** means each individual employed by the Employer as reported on the Employer's payroll records, including such an employee who is on a Leave of Absence. "Employee" does not include:

(1) any individual who performs services for an Employer pursuant to a leasing agreement between an Employer and a third-party, regardless of whether such individual is later determined by a court or any governmental or administrative agency to be, or to have been, a common law employee of an Employer; and

(2) any individual who performs services for an Employer and is working in a classification described as independent contractor, is paid directly or indirectly through an Employer's accounts payable systems, or performs such services

pursuant to a contract or agreement which provides that the individual is an independent contractor or consultant, regardless of whether any such individual is later determined by a court or any governmental or administrative agency to be, or to have been, a common law employee of an Employer.

(h) **"Employer"** means the Company and any other related corporation, trade or business from time-to-time listed on Appendix A which has adopted the Plan pursuant to Section 6.2.

(i) **"ERISA"** means the Employee Retirement Income Security Act of 1974, as amended from time-to-time. References to any section of ERISA shall be deemed to include similar sections of ERISA as renumbered or amended.

(j) **"HIPAA"** means the Health Insurance Portability and Accountability Act of 1996, as amended.

(k) **"Leave of Absence"** means a personal leave, medical leave or military leave of an Employee, as approved by the Employer employing the Employee.

(l) **"Participant"** means:

(1) any Retired Employee who satisfies the requirements of Article II, is covered by one or more of the Welfare Programs under the Plan, and whose participation has not terminated in accordance with Section 2.3.

(2) for purposes of receiving long term disability benefits under the Plan only, any disabled individual whose employment has terminated with an Employer, who satisfies the requirements of Article II, and whose participation has not terminated in accordance with Section 2.3; and

(3) any former Dependent who is entitled to elect, and so elects, any continuation coverage on his or her own behalf.

(m) **"Participant Contributions"** means any after-tax contributions required to be paid by a Participant for coverage under any Welfare Program.

(n) **"Plan"** means the Marathon Oil Company Retiree Health and Welfare Plan, as set forth in this Wrap Document and the Welfare Program Documents, as amended from time to time.

(o) **"Plan Administrator"** as defined in section 3(16)(A) of ERISA means the Benefits Administrative Committee or "BAC."

(p) **"Plan Year"** means the 12-consecutive month period beginning each January 1 and ending on December 31.

(q) **"Protected Health Information"** means individually identifiable health information (within the meaning of 45 CFR § 160.103) that is transmitted by electronic

media, maintained in electronic media, or transmitted or maintained in any other form or medium, subject to the exclusions listed in 45 CFR § 160.103.

(r) **"Retired Employee"** means an Employee who retired from employment with an Employer or any other employee who was eligible upon retirement for retiree health and welfare coverage sponsored by a corporation, trade, or business formerly related to Marathon Oil Company, its affiliates, or its predecessors, for whom Marathon Oil Company assumed responsibility for coverage.

(s) **"Third Party Administrator"** means any insurer, third party administrator or other entity selected by the Plan Administrator for the administration of the Plan, including, but not limited to, initial and/or appeals claims determinations under a self-insured Welfare Program.

(t) **"Welfare Program"** means the welfare benefits offered as part of this Plan, identified in Appendix B, and described in the Welfare Program Documents.

(u) **"Welfare Program Documents"** means (i) all provisions of any summary plan description for the Plan that set forth terms and conditions of the Welfare Programs; (ii) any and all insurance policies and certificates of insurance and other documents that set forth the terms and conditions of an insured Welfare Program; and (iii) any and all benefits books or other formal documents provided by Third Party Administrators of any self-insured Welfare Programs. Any amendment to a Welfare Program Document will constitute automatically an amendment to the Plan.

1.4 Incorporation. The terms and conditions, including any limitations or restrictions, of each Welfare Program as set forth in the applicable Welfare Program Documents are incorporated by reference in this Wrap Document and constitute a part of the Plan.

1.5 Interpretation. If there is a conflict between a specific provision under this Wrap Document and the Welfare Program Documents, this Wrap Document controls. If this Wrap Document is silent, then the applicable Welfare Program Document controls. Notwithstanding the foregoing, however, with respect to insured benefits, the terms of the certificate of insurance coverage control over the Wrap Document and any other Welfare Program Document when describing specific benefits that are covered or insurance-related terms.

1.6 Effective Date. The effective date of this Wrap Document (which is an amendment and restatement of the Level Premium Life Insurance Plan that has been renamed as described further above) is January 1, 2019.

ARTICLE II
ELIGIBILITY AND PARTICIPATION

2.1 Participation. Eligibility to participate in a Welfare Program shall be determined by the provisions of the applicable Welfare Program Documents.

A Retired Employee may be required to provide legal documentation to prove the eligibility of his/her Dependent(s). The Plan reserves the right to require Retired Employees to provide written documentation of proof of Dependent eligibility. It is the Retired Employee's responsibility to provide the written documentation as requested by the Plan. If necessary documentation is not provided in the time frame requested, the Plan has the right to cancel Dependent coverage. It is the Retired Employee's responsibility to notify the Plan of any changes in the eligibility of his/her Dependent(s).

With respect to pre-65 retiree medical, prescription drug, dental and vision benefits under the Plan ("Pre-65 Benefits"):

(a) If a Retired Employee and any of the Retired Employee's eligible Dependents were eligible for such Pre-65 Benefits on and/or before December 31, 2018 but were not enrolled in such benefits (*e.g.*, because such individuals never enrolled in Pre-65 Benefits or enrolled but subsequently unenrolled in such Pre-65 Benefits), such Retired Employee and such eligible Dependents must enroll no later than December 31, 2018 to be eligible for coverage effective January 1, 2019; if any such individuals are not enrolled in any of the Pre-65 Benefits before January 1, 2019 for coverage effective January 1, 2019, they will no longer be eligible to enroll in such Pre-65 Benefits. Further, if such a Retired Employee has any Dependents who are not eligible for Pre-65 Benefits as of January 1, 2019 or acquires any new Dependents on or after January 1, 2019, such Dependents are not eligible to enroll in Pre-65 Benefits; and

(b) If an Employee retires from the Company or another participating Employer and is eligible to enroll in the Pre-65 Benefits in connection with such retirement, the Retired Employee must enroll him or herself and any eligible Dependents in the Pre-65 Benefits within 31 days of such retirement; if any such individuals are not enrolled in any of the Pre-65 Benefits within 31 days of such retirement, they will no longer be eligible to enroll in such Pre-65 Benefits. Further, if such an Employee has any Dependents who are not eligible for Pre-65 Benefits as of such Employee's retirement date or acquires any new Dependents on or after such retirement date, such Dependents are not eligible to enroll in Pre-65 Benefits.

2.2 Enrollment Procedures. The Plan Administrator may establish procedures for the enrollment of Participants in a Welfare Program. The Plan Administrator may prescribe enrollment forms, which may include electronic equivalencies that must be completed by a prescribed deadline prior to commencement or continuation of coverage under a Welfare Program.

2.3 Termination of Participation. A Participant will cease being a Participant in a Welfare Program and coverage under such Welfare Program for the Participant and his Dependents and Beneficiaries shall terminate in accordance with the provisions of the applicable Welfare Program Document.

2.4 Continuation of Coverage. A Participant may continue coverage for benefits under the Plan, to the extent permitted by and as described in the applicable Welfare Program Documents.

ARTICLE III
CONTRIBUTIONS, BENEFITS AND CLAIMS

3.1 Employer Contributions. Each Employer may make contributions for the payment of benefits under the Plan in such amounts and at such times as the Company shall from time-to-time direct. Such contributions may be paid directly to each insurance company issuing a policy or contract in connection with an insured Welfare Program, or may be used to pay benefits directly (including through a Third Party Administrator) in the case of benefits under a self-insured Welfare Program. Nothing herein shall require an Employer to make payments or contribute to any Welfare Program.

3.2 Participant Contributions. Participation in the Plan and the receipt of Plan benefits shall be conditioned on a Participant contributing to the Plan such amounts as the Company shall establish from time-to-time. The Company may establish different contribution rates for different classes of Retired Employees, Participants, Dependents or Beneficiaries for any Welfare Program and reserves the right to change the required contribution amounts for such individuals at any time in its sole discretion.

3.3 Funding. Nothing herein shall require the deposit of any Employer payments or contributions or Participant Contributions to a trust. No Retired Employee, Participant, Dependent or Beneficiary shall have any right to, or interest in, the assets of the Company or any Employer or any affiliate thereof, the assets of any trust or any other funding vehicle of the Plan.

3.4 Insurance. The Plan Administrator may, but shall not be required to, insure any of the benefits provided by a Welfare Program. To the extent the Plan Administrator elects to purchase insurance, any such insured benefits shall be the sole responsibility of the insurer, and neither the Company, any Employer, nor their affiliates, nor the Plan shall have responsibility for the payment of such benefits. In the event that any insurer pays dividends, rebates, demutualization proceeds or similar payments, such amounts shall be paid to the Company or Employer to the extent permitted by law unless the Company or Employer elects to contribute such amounts to the Plan.

3.5 Benefits. Benefits under each Welfare Program (including limitations and restrictions) will be determined by the Plan Administrator or the delegate thereof, Third Party Administrator or insurer, as applicable, in its discretion pursuant to the terms of the applicable Welfare Program Documents.

3.6 Claims Procedures. Each claim for benefits under a Welfare Program must be filed in accordance with the procedures set forth in the applicable Welfare Program Documents. All claims for benefits must be duly filed no later than the deadline for such Welfare Program set forth in the applicable Welfare Program Documents. All claims for benefits will be processed and may be appealed in accordance with the procedures for such Welfare Program set forth in the applicable Welfare Program Documents.

3.7 Limitations on Actions. Participants must follow the claims procedures, including exhausting their rights to appeal, before taking action in any other forum regarding a claim for benefits under a Welfare Program. Except as otherwise provided in an insurance policy, any suit or legal action initiated by a participant for benefits under a Welfare Program must be brought by

the Participant no later than three years following a final decision on the appeal of the claim for benefits by the person or entity described in the applicable Welfare Program Documents with the discretionary authority to determine appeals with respect to such claim. In no case may a suit or legal action be brought if the claim for benefits was not made within the time period prescribed in the claims procedures of the applicable Welfare Program Documents. This limitation on suits for benefits applies in any forum where a Participant initiates a suit or legal action. Any such legal action must be brought in the U.S. District Court for the Southern District of Texas, where the Plan is administered.

3.8 Right to Request HealthRecords. The Plan has the right to request group health plan records for any Participant, Beneficiary or Dependent, to the extent permitted by 45 CFR section 164.502(a).

3.9 Right to Audit. The Plan has the right to audit Participant, Beneficiary and Dependent claims, including claims of medical and other health care providers. The Plan may reduce or deny benefits for otherwise covered services for all current and/or future claims with the provider made on behalf of any Participant, Beneficiary, or Dependent in the Plan, or a participant in any other health and welfare plan administered by the Third Party Administrator based on the results of an audit. The Plan may also reduce or deny benefits for otherwise covered services for all current and/or future claims of a Participant, Beneficiary, or Dependent based on the results of an audit.

3.10 Right to Recover Overpayment. Payments are made in accordance with the provisions of the applicable Welfare Program Documents. If it is determined that payment was made for an ineligible charge or that other insurance was considered primary, the Plan has the right to recover the overpayment. The Plan (or any Third Party Administrator) will attempt to collect the overpayment from the party to whom the payment was made. However, the Plan reserves the right to seek overpayment from any Participant, Beneficiary or Dependent. Failure to comply with this request will entitle the Plan to withhold benefits due a Participant, Beneficiary or Dependent. In addition, the Plan has the right to engage an outside collection agency to recover overpayments on the Plan's behalf if the Plan's collection effort is not successful.

If the overpayment is made to a provider, the Plan (or any Third Party Administrator) may offset, reduce or deny benefits, in the amount of the overpayment, for otherwise covered services for current and/or future claims with the provider on behalf of any Participant, Beneficiary, or Dependent in the Plan. The Plan and further reserves the right to effectuate such offset by means of a Third Party Administrator's offset procedures.

In addition, if some or all expenses are required to be paid by or on behalf of a Participant, Beneficiary, or Dependent in the Plan in the form of a deductible or co-payment, and such expenses are not required to be paid or were waived by a provider, the Plan may seek a refund of amounts paid on behalf of a Participant, Beneficiary, or Dependent in the Plan.

3.11 Participant's Right to Recover Overpayments. If a Participant overpays contributions or premiums for coverage under the Plan, the Plan will refund excess contributions or premiums upon request of the Participant to the extent administratively feasible.

3.12 Subrogation and Reimbursement.

The Plan has a right to subrogation and reimbursement, as defined in this Section 3.12. To the extent a Welfare Program Document governing a Welfare Benefit that is fully insured contains a subrogation and reimbursement section that conflicts with this Section 3.12, the subrogation and reimbursement section in the Welfare Program Document will govern.

(a) **In General.** The Plan has the right to reduce or deny medical or dental benefits for pre-65 Retired Employees otherwise paid by the Plan, and recover or subrogate 100% of the medical or dental benefits for pre-65 Retired Employees paid by the Plan for a Participant, Beneficiary or Dependent, to the extent any and all of the following occurs: (i) any judgment, settlement, or payment made or to be made because of an accident or malpractice, including but not limited to other insurance, (ii) any automobile or recreational vehicle insurance coverage or benefits, including but not limited to uninsured or underinsured motorist coverage, (iii) any business medical and/or liability insurance coverage or payments, (iv) any attorney's fees, (v) any payment made by a person or entity alleged to have caused the Participant, Beneficiary, or Dependent to suffer a sickness, injury or damages, or who is legally responsible for the sickness, injury or damages; (vi) any coverage or benefits from an insurer or other indemnifier of any person or entity alleged to have caused or who caused the sickness, injury or damages; (vii) any amounts due from Marathon Oil Company in workers' compensation cases, or (viii) payments or benefits provided by any person or entity who is or may be obligated to provide the Participant, Beneficiary, or Dependent with benefits or payments under: medical provisions of no-fault or traditional insurance (auto, homeowners or otherwise); workers' compensation coverage; or; any other insurance carrier or third party administrator. The Plan's right to reimbursement applies when the Plan pays benefits, and a judgment, payment, or settlement is made on behalf of the Participant, Beneficiary or Dependent for whom the benefits were paid. Reimbursement to the Plan of 100% of these charges shall be made at the time any such payment is received by a Participant, Beneficiary, Dependent or their representative or any other entity. The Plan's right to reduction, reimbursement and subrogation is based on the terms of the Plan in effect at the time of judgment, payment or settlement.

(b) **Right to Subrogation.** The right to subrogation means the Plan is substituted to and shall succeed to any and all legal claims that a Participant, Beneficiary, or Dependent may be entitled to pursue against any third party for benefits that the Plan has paid that are related to the sickness or injury for which a third party is considered responsible. Subrogation applies when the Plan has paid on behalf of a Participant, Beneficiary, or Dependent benefits for a sickness or injury for which a third party is considered responsible, e.g., an insurance carrier if the individual is involved in an auto accident. The Plan shall be subrogated to, and shall succeed to, all rights of recovery from any or all third parties, under any legal theory of any type, for 100 percent of any services and benefits the Plan has paid on behalf of a Participant, Beneficiary, or Dependent relating to any sickness or injury caused by any third party.

(c) **Right to Reimbursement.** The right to reimbursement means that if a third party causes a sickness or injury for which a Participant, Beneficiary, or Dependent receives a settlement, judgment, or other recovery from any third party, the Participant,

Beneficiary, or Dependent must use those proceeds to fully return to the Plan 100% of any benefits the Participant, Beneficiary, or Dependent received for that sickness or injury.

(d) **First Priority Right.** The Plan has first priority with respect to its right to reduction, reimbursement, and subrogation. The Plan has the right to recover interest on the amount paid by the Plan. The Plan has the right to 100% reimbursement in a lump sum. The Plan is not subject to any state laws or equitable doctrines, including, but not limited to, the common fund doctrine, which could otherwise require the Plan to reduce its recovery by any portion of a Participant, Beneficiary or Dependent's attorney's fees or costs. The Plan is not responsible for the Participant, Beneficiary or Dependent's attorney's fees, expenses, or costs. The Plan's right applies regardless of whether any payments to a Participant, Beneficiary or Dependent are designated as payment for, but not limited to, (i) pain and suffering, or (ii) medical benefits. This applies regardless of whether a Participant, Beneficiary or Dependent has been fully compensated for injuries. The Plan's right to reduction, reimbursement, and subrogation applies to any funds recovered from another party, by or on behalf of the estate of any Participant, Beneficiary or Dependent. The Plan's first priority right shall not be reduced due to the negligence of the Participant, Beneficiary or Dependent.

(e) **Cooperation.** The Plan requires a Participant, Beneficiary, Dependent, and their representatives to timely cooperate in efforts to obtain reimbursement to the Plan from third parties. To aid the Plan in its enforcement of its right of reduction, recovery, reimbursement, and subrogation, Participants, Beneficiaries, Dependents and their representatives must, at the Plan's request and at its discretion (i) take any action, (ii) give information, and (iii) sign documents as required by the Plan. Failure to aid the Plan and to comply with such requests may result in the Plan's withholding or recovering benefits, services, payments, or credits due or paid under the Plan to a Participant, Beneficiary or Dependent under the Plan. A Participant, Beneficiary or Dependent and/or their representatives may not do anything to hinder reimbursement of overpayment to the Plan after benefits have been accepted by a Participant, Beneficiary, Dependent or their representatives.

(f) **Attorneys' Fees and Costs.** If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by the Participant, Beneficiary, Dependent, or his or her representative, the Plan has the right to recover those fees and costs from the Participant, Beneficiary, or Dependent.

3.13 Coordination of Benefits. All covered charges payable under this Plan are subject to coordination of benefits provisions. In the event that benefits under this Plan are provided under an applicable insurance policy, the coordination of benefits provisions in the insurance policy documents will govern. In the event that the benefits provided under the Plan are self-insured by the Employer, the coordination of benefits provisions in the summary plan description will govern.

ARTICLE IV
ADMINISTRATION AND FIDUCIARY PROVISIONS

4.1 Administrator. The Plan Administrator shall be the "named fiduciary" of the Plan, as defined in ERISA Section 402(a)(2). The general administration of the Plan shall be vested in a committee, referred to as the Benefits Administrative Committee. For purposes of ERISA, the Benefits Administrative Committee or "BAC" will serve as the Plan Administrator and named fiduciary for the Plan.

4.2 Appointment of the Committee.

(a) **BAC Membership.** The BAC will consist of the Company's (1) Senior Vice President ("SVP"), HR, Communications and Administrative Services, (2) Director of Compensation and Benefits, and (3) Benefits and Payroll Manager.

(b) **Quorum.** A quorum of the BAC shall consist of two members.

(c) **Committee Action.** Action of the BAC shall be by vote of a majority of the members present at a meeting, or in writing without a meeting and evidenced by the signature of the SVP, HR, Communications and Administrative Services or of any member who is so authorized by such committee.

The Company's SVP, HR, Communications and Administrative Services will serve as the "Appointing Fiduciary" for purposes of the membership of the BAC and will have the authority to remove a member with or without cause and to fill any vacancy that may result therefrom or for any other reason. If there is no SVP, HR, Communications and Administrative Services of the Company, then the senior most human resources officer of the Company (or, if such role is vacant, the equivalent position at Marathon Oil Corporation) will serve as the Appointing Fiduciary. Each member of the BAC will serve until he resigns, dies, or is removed by the Appointing Fiduciary. Any member of the BAC who is an Employee will automatically cease to be a member of such committee as of the date he or she ceases to be employed by Company and all Controlled Group Entities.

4.3 Duties and Powers of the BAC. The BAC will supervise the general administration and enforcement of the Plan according to the terms and provisions hereof and shall have the powers necessary to accomplish these purposes. The BAC's authority shall include (not by way of limitation) the authority to construe, in its discretion, all terms, provisions, conditions, and limitations of the Plan.

The Plan Administrator shall be deemed to have delegated its responsibilities for determining benefits and eligibility for benefits to a Third Party Administrator, insurer or other fiduciary where such person has been appointed to make such determinations. In such case, such other person shall have the duties and powers as the Plan Administrator as set forth above, including the complete discretion to interpret and construe the provisions of the Plan.

4.4 Allocation and Delegation of Duties. The BAC may appoint subcommittees, individuals, assistant plan administrators or other agents or third party service providers as it deems advisable and may delegate, with such delegation conferring fiduciary status upon the delegate, to such appointees any or all of the powers and duties of such committee. Such appointment and delegation must specify in writing the powers or duties being delegated (such as in a written agreement) and must be accepted in writing by the delegate. Upon such appointment, delegation and acceptance, the BAC shall have no liability for the acts or omissions of any such delegate as long as the BAC does not itself violate any fiduciary responsibility in making or continuing such delegation. To the extent that the BAC has so delegated any of its duties, powers or responsibilities pursuant to this Section, references in the Plan to the BAC or the "Plan Administrator" shall be deemed reference to such delegate with respect to such delegated duties, powers or responsibilities.

4.5 Indemnification.

(a) The Company shall indemnify and hold harmless to the fullest extent permitted by law any person who was or is (a) made or is threatened to be made a party or is involved in any proceeding whether civil, criminal, administrative or investigative or who incurs any other liability by reason of any act, or failure to act in relation to the Plan or the funds of the Plan, including without limitation, expenses reasonably incurred in the defense of any claim relating to the Plan or funds of the Plan, and amounts paid in compromise or settlement relating to the Plan or the funds of the Plan, (b) by reason of the fact that he or she, or a person for whom he or she is the legal representative, is or was a director, officer, employee or agent of the Company or another participating Employer serving or acting with respect to the Plan. Any such person shall be indemnified against all expenses, liability, and loss reasonably incurred or suffered by such person; provided, however, that the Company shall indemnify any person seeking indemnity in connection with a proceeding initiated by such person only if the proceeding was authorized by the Board of Directors of the Company.

(b) To the fullest extent authorized by law, and to the extent not first covered by insurance or the Company's indemnity set forth in Section 4.5(a), the Plan Administrator, officers and employees of the Company or another participating Employer or Employers who provide services to the Plan shall be fully indemnified by the Plan against any and all liabilities reasonably incurred or suffered by such person and arising by reason of any act, or failure to act, in relation to the Plan or the funds of the Plan, including without limitation, expenses reasonably incurred in the defense of any claim relating to the Plan or funds of the Plan, and amounts paid in compromise or settlement relating to the Plan or the funds of the Plan; provided, however, that the Plan shall indemnify any person seeking indemnity in connection with a proceeding initiated by such person only if the proceeding was authorized by the Board of Directors of the Company.

4.6 Bonding. The Plan Administrator shall serve without bond and without additional compensation for his or her services.

4.7 Plan Expenses. All fees and expenses incurred in connection with the operation and administration of the Plan, including, but not limited to, Plan Administrator, legal, accounting, actuarial, investment, management, and administrative fees and expenses may be paid out of Plan assets to the extent that it is legally permissible for these fees and expenses to be so paid. The

Company may, but is not required, to pay such fees and expenses directly. The Company may also advance amounts properly payable by the Plan and then obtain reimbursement from the Plan for these advances.

4.8 Information to be Supplied by Employer. Each Employer shall provide the Plan Administrator and any delegates thereof with such information as they shall from time-to-time need or reasonably request in the discharge of their duties. The Plan Administrator and any delegates thereof may rely conclusively on the information provided by an Employer.

4.9 HIPAA Compliance.

(a) **Disclosures to Company.** The Plan may disclose participant information to the Company, as permitted under the Standards for Privacy of Individuality Identifiable Health Information, 45 CFR Parts 160 and 164 ("HIPAA Privacy Regulations"). In addition, the Plan may disclose Protected Health Information to the Company as necessary to allow the Company to perform plan administration functions, within the meaning of the HIPAA Privacy Regulations.

(b) **Use of PHI.** The Plan will not use or disclose Protected Health Information that is genetic information for underwriting purposes.

(c) **Access to Health Information.** The following employees or individuals under the control of the Company shall have access to the Plan's Protected Health Information to be used solely for plan administration functions, within the meaning of the HIPAA Privacy Regulations:

(1) The Plan Administrator;

(2) Members of the benefits, legal, information system, and human resources departments of the Company to the extent they perform functions with respect to the Plan; and

(3) Such other individuals or classes of individuals identified by the Plan's Privacy Officer as necessary for the Plan's administration.

(d) **Company Agreement to Restrictions.** The Plan will not disclose Protected Health Information to the Company until the Company has certified to the Plan that it agrees to:

(1) Not use or disclose Protected Health Information other than as permitted or required by law or as specified above;

(2) Not use or disclose the Protected Health Information in any employment- related decisions or in connection with any other benefit or employee benefit plan of the Company;

(3) Report to the Plan any use or disclosure of Protected Health Information that is inconsistent with the uses and disclosures

permitted by law or specified above of which Company becomes aware;

(4) Make Protected Health Information accessible to the subject individual in accordance with the HIPAA Privacy Regulations;

(5) Allow the subject individuals to amend or correct their Protected Health Information and incorporate any amendments to Protected Health Information in accordance with the HIPAA Privacy Regulations;

(6) Make available the information to provide an accounting of its disclosures of Protected Health Information in accordance with the HIPAA Privacy Regulations;

(7) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services for determining compliance;

(8) Return or destroy the Protected Health Information received, if feasible, after it is no longer needed for the original purpose and retain no copies of such information or if not feasible, restrict access and uses to those that make the return or destruction of the information infeasible as required by the HIPAA Privacy Regulations;

(9) Ensure that any agents, including a subcontractor, of the Company to whom the Company provides Protected Health Information shall also agree to these same restrictions;

(10) Ensure that adequate separation between the Company and Plan is established as required under the HIPAA Privacy Regulations and restrict access to Protected Health Information to those classes of employees or individuals identified in Section 4.9(c); and

(11) Restrict the use of Protected Health Information by those employees identified in Section 4.9(c) for plan administration functions within the meaning of the HIPAA Privacy Regulations.

(e) **Permitted Disclosure to Company.** Notwithstanding the foregoing, the Plan (or a health insurance issuer with respect to the Plan) may disclose to the Company the following types of information:

(1) Summary health information may be disclosed to the Company if the Company requests the summary health information for the purpose of (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan, or (2) modifying, amending, or terminating the Plan.

(2) Information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer offered by the Plan.

(3) Information provided pursuant to an authorization within the meaning of Section 164.508 of the HIPAA Privacy Regulations.

(4) De-identified information, as defined under the HIPAA Privacy Regulations.

(f) **Noncompliance.** In the event of noncompliance with the restrictions of Section 4.9(a) through (d) by a designated employee or other individual receiving Protected Health Information on behalf of the Company, the employee or other individual shall be subject to discipline in accordance with the Company's disciplinary procedures. Complaints or issues of noncompliance by such persons shall be filed with the Plan's Privacy Officer.

(g) **HIPAA Security Standards.**

(1) **Safeguards.** The Company shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Plan, as required under 45 CFR Part 160 and Subparts A and C of Part 164 (the "HIPAA Security Standards").

(2) **Agents.** The Company shall ensure that any agent, including a subcontractor, to whom it provides electronic Protected Health Information agrees to implement reasonable and appropriate safeguards to protect such information.

(3) **Security Incidents.** The Company shall report to the Plan any security incident under the HIPAA Security Standards of which it becomes aware.

(4) **Adequate Separation.** The Company shall establish reasonable and appropriate security measures to ensure adequate separation between the Plan and Company, in support of the requirements described in this Section 4.9.

(h) **Application.** The provisions of this Section 4.9 shall only apply with respect to any Plan health benefits subject to the HIPAA Privacy Regulations or HIPAA Security Standards.

ARTICLE V
AMENDMENT AND TERMINATION OF THE PLAN

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

The Company may exercise its reserved rights of amendment, modification and termination (i) by written resolution by the Board of Directors of the Company, (ii) by written resolution by the Compensation Committee of the Marathon Oil Corporation Board of Directors (the "Corporation Compensation Committee"), (iii) by written resolution or written actions exercised by the Executive Committee of Marathon Oil Corporation that is composed of the Chief Executive Officer of Marathon Oil Corporation ("CEO"), the direct reports of the CEO who are officers of Marathon Oil Corporation and such other employees of the Company or a Controlled Group Entity as the CEO may determine ("ExCom"), or (iv) by written actions exercised by any other entity or person to which or to whom the Board of Directors of the Company, the Corporation Compensation Committee, or the ExCom has specifically delegated rights of amendment, modification and/or termination.

The SVP, HR, Communications and Administrative Services of the Company (or, if there is no SVP, HR, Communications and Administrative Services of the Company, then the senior most human resources officer of the Company or, if such role is vacant, the equivalent position at Marathon Oil Corporation) also has the authority to amend and/or modify (but not to terminate) this Plan (including both this Wrap Document and the Welfare Program Documents). This authority shall be exercised in writing.

5.2 Effect of Amendment or Termination. In the event of an amendment to or termination of the Plan as provided under this Article, each Participant shall have no further rights hereunder, and neither the Company, nor any other Employer, shall have further obligations hereunder except as otherwise specifically provided under the terms of the Plan and each Welfare Program Document; provided, however, that no amendment or termination shall be made that would diminish any benefits arising from incurred but unpaid claims of Participants prior to the effective date of such modification, alteration, amendment, suspension, or termination.

ARTICLE VI
MISCELLANEOUS PROVISIONS

6.1 Action by the Company or an Employer. Any action to be taken by the Company or an Employer hereunder, to the extent not otherwise provided, may be taken by any authorized officer of the Company or Employer.

6.2 Adoption by Related Employers. Any employer, with the consent of the Company and under such terms and conditions as the Company may prescribe, may become an Employer hereunder, provided that such employer is a corporation, trade or business that, together with the Company, is a member of a controlled group of corporations as defined in Code section 414(b), under common control as defined in Code section 414(c), or a member of an affiliated service group as defined in Code sections 414(m) or (o) (collectively "controlled entities"). An Employer that ceases to be a controlled entity may remain an Employer hereunder for a limited transition time after ceasing to be a controlled entity, solely at the discretion of the Company and solely on such terms and conditions as the Company may prescribe. By its adoption of the Plan and participation therein, each Employer agrees to be bound by the terms of the Plan, as amended from time-to-time. Any Employer shall have the right at any time and under such terms and conditions as the Company may prescribe to withdraw from the Plan on sixty (60) days' written notice to the Company.

6.3 Exclusive Benefit. This Plan has been established for the exclusive benefit of Participants, Dependents and Beneficiaries and, except as otherwise provided herein, all contributions under the Plan may be used only for such purpose.

6.4 Nonalienation of Benefits. Except as otherwise provided in a Welfare Program Document for the life insurance benefit, no benefit, right or interest of any Participant, Dependent or Beneficiary under a Welfare Program may be assigned without the Plan Administrator's written consent on behalf of the Plan. When the Plan Administrator's written consent is not obtained, no benefit, right or interest of any Participant, Dependent or Beneficiary under a Welfare Program shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, including any liability for, or subject to, the debts, liabilities or other obligations of such person; and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge, garnish, execute or levy upon, or otherwise dispose of any right to benefits payable hereunder or legal causes of action, shall be void. Notwithstanding the foregoing, even when the Plan's Administrator's written consent has not been obtained, the Plan may choose to remit payments directly to health care providers with respect to covered services, if authorized by Participants or Beneficiaries, but only as a convenience to Participants. Such direct payment shall not operate as a waiver of the Plan Administrator's right on behalf of the Plan to withhold consent to an assignment. Health care providers are not, and shall not be construed as, either "participants" or "beneficiaries" under this Plan and have no rights to receive benefits from the Plan or to pursue legal causes of action on behalf of (or in place of) Participants, Dependents and Beneficiaries under any circumstances.

6.5 Limitation of Rights. Nothing contained herein shall operate or be construed to give any person any legal or equitable right against the Company or any Employer, except as expressly provided herein or required by law, or to create a contract of employment between an Employer and any Retired Employee.

6.6 Gender and Number. Except when the context indicates to the contrary, when used herein, masculine terms shall be deemed to include the feminine and neuter, and terms in the singular shall be deemed to include the plural, and the plural the singular.

6.7 Headings. The headings of Articles and Sections are included solely for convenience of reference and, if there is any conflict between such headings and the text of this Plan, the text shall control.

6.8 Severability. If any provision of this Plan shall be held invalid or, unenforceable, such invalidity or unenforceability shall not affect any other provisions hereof and the Plan shall be construed and enforced as if such provisions had not been included herein.

6.9 Governing Law. The Plan shall be construed and enforced according to the laws of the State of Texas other than its laws respecting choice of law, to the extent not preempted by federal law.

6.10 Participant's Responsibilities.

(a) **Missing Participants.** Each Participant shall be responsible for providing the Plan Administrator and/or the Employer with the Participant's and each Dependent's or Beneficiary's current address. In the event that a Participant, Dependent, or Beneficiary becomes entitled to a payment under this Plan and such payment is delayed or cannot be made:

(1) because the current address according to the Employer's records is incorrect;

(2) because the Participant, Dependent or Beneficiary fails to respond to the notice sent to the current address according to the Employer's records;

(3) because of conflicting claims to such payments; or

(4) because of any other reason;

the amount of such payment, if and when made, shall be that determined under the provisions of this Plan without payment of any interest or earnings. If, after reasonable efforts, the Plan Administrator is unable to locate any Participant, Dependent or Beneficiary whose benefits under the Plan have become distributable, such benefits may be forfeited. If the Participant subsequently applies for benefits, the amount so forfeited will be paid to the Participant. Notwithstanding the forgoing, with respect to any benefit or arrangement that is underwritten by insurance, the terms of the insurance policy shall control to the extent such terms are inconsistent with this Section 6.10.

(b) **Uncashed Checks.** If a check to a Participant, Dependent or Beneficiary for benefits under the Plan remains uncashed beyond the "void" date, if any, listed on the check, or if no void date, 180 days after issue, amounts attributable to such check shall be forfeited to the Plan. In such event, the Plan shall reissue such check upon

request of the Participant, Dependent or Beneficiary if made within three years after date of issue.

6.11 Payments to Minors and Incompetents. Upon proof satisfactory to the Plan Administrator, or the appropriate insurer or Third Party Administrator (if applicable), that an individual entitled to receive a payment under the Plan is legally incompetent, including by reason of being a minor, the Plan Administrator may direct that benefit payments be made in any one or more of the following ways:

(a) to the individual's spouse, child, parent, or dependent whom such individual has the duty to support;

(b) to the individual's legal guardian or conservator; or

(c) to any other person, including a recognized charity or governmental institution, to be held and used for the individual's benefit.

The decision of the Plan Administrator is final and binding upon all parties. The Plan Administrator is not obliged to see to the proper application or expenditure of any payments so made.

6.12 Withholding Taxes. The Plan Administrator, or the appropriate insurer or Third Party Administrator (if applicable), may make any appropriate arrangements to deduct from all amounts paid under the Plan any taxes required to be withheld under applicable law. The Participants and Beneficiaries, as applicable, are responsible for all taxes due on amounts paid under the Plan to the extent that such taxes are not withheld, irrespective of whether withholding is required.

6.13 Clerical Errors or Omissions. Clerical errors or omissions in information provided to a Participant, Dependent, or Beneficiary do not deprive a Participant, Dependent, or Beneficiary of his or her right to receive a benefit, and do not affect the amount of his or her benefit. Conversely, clerical errors or omissions do not cause a Participant, Dependent, or Beneficiary to have the right to receive a benefit to which he or she is not entitled, and a Participant, Dependent, or Beneficiary receiving an overpayment by mistake must repay the overpayment, if requested to do so. The Plan Administrator reserves the right to correct any mistake in any reasonable manner, including but not limited to, adjusting the amount of future benefit payments, repaying to the Plan any overpayment, or making catch-up payments to a Participant, Dependent, or Beneficiary for an underpayment. The failure to enforce any provision of the Plan does not affect the Plan's right thereafter to enforce this provision, nor does such failure affect its right to enforce any other Plan provision.

6.14 No Vested Right to Benefits. No Participant or person claiming through such Participant shall have any right to, or interest in, any benefits provided under the Plan or any Welfare Program upon termination of his or her employment, retirement, termination of Plan participation, or otherwise, except as specifically provided under the Plan or a Welfare Program Document.

IN WITNESS WHEREOF, this instrument has been executed by an authorized officer of Marathon Oil Company on the ___th day of December 2018.

PLAN SPONSOR

_____

Deanna L. Jones
Senior Vice President, HR, Communications & Administrative Services

APPENDIX A

The following entities have adopted the Plan:

Marathon Oil Corporation

Marathon Service Company

APPENDIX B

The terms and conditions of the Welfare Programs (including limitations and restrictions) are set forth in the Welfare Program Documents. The following benefits constitute the Welfare Programs offered by Employers under the Plan:

- Pre-65 Retirees
    - Medical benefits
    - Prescription drug benefits
    - Dental benefits
    - Vision benefits
- Post-65 Retirees
    - Health reimbursement arrangement (HRA) related benefits
- Certain disabled individuals
    - Long-term disability benefits
- Optional contributory level premium life insurance (closed to new participants June 1, 1994)