TESORO CORPORATION

# DENTAL PLAN SUMMARY PLAN DESCRIPTION

*As of January 1, 2016*

## ABOUT THIS SPD

This Summary Plan Description (SPD) outlines the major features of the Tesoro Dental Plan. If you have questions regarding your coverage under the Tesoro Dental Plan, contact the Tesoro Benefits Center.

This SPD describes the benefits available under the Plan, as well as the Plan's various limitations and exclusions, as of January 1, 2016. This Plan is available to eligible Tesoro employees on the U.S. payroll as well as eligible LTD claimants and beneficiaries.

This information comprises the SPD for the Plan as required by the Employee Retirement Income Security Act of 1974 (ERISA). This description doesn't cover every provision of the dental options. Some complex concepts may have been simplified or omitted to provide a more understandable plan description. If this plan description is incomplete, or if there's any inconsistency between the information in this SPD and the official plan texts, the provisions of the official plan texts will prevail. You can receive a copy of the actual text from the Plan Administrator upon written request.

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# DENTAL PLAN HIGHLIGHTS

| | |
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| **Eligibility** | Regular full-time employees who meet the eligibility requirements are eligible under the Plan. |
| **Enrollment** | You may enroll yourself and your eligible dependents within 31 days of your employment date or the date you first become eligible, if later. You may also enroll during any subsequent open enrollment period. |
| **Effective Date** | If you enroll within 31 days of employment or eligibility date, coverage for you and your covered dependents begins on your hire date or the first date you became eligible, if later. If you enroll during the open enrollment period, coverage begins the following January 1. |
| **Cost** | Your monthly cost is based on the coverage option and level of coverage you choose. You and the Company share in the cost of your dental benefits and you generally pay for coverage with "pre-tax" dollars. The contribution amount for each coverage option and level of coverage is published annually. |
| **Dental Plan Options** | You have two Dental Plan options from which to choose, both administered by Aetna:<br>• **Tesoro PPO Dental Plan (Dental PPO); and**<br>• **Tesoro DMO Dental Plan (DMO). (Note: This option is not available in Alaska, North Dakota, Wyoming or other locations outside the DMO service area.)**<br>Under the Dental PPO, you can receive care from either an in-network Aetna Preferred Dental Network dentist or any out-of-network dentist — but you may pay less if you use a provider in Aetna's dental network.<br>The DMO is a managed dental plan, which means that you must receive all care from an in-network Aetna DMO Network dentist. You access care through your Primary Care Dentist (PCD) who provides your basic and routine dental services, coordinates all of your care and refers you to in-network specialty dentists as needed. Out-of-network benefits are not available under the DMO, except in the case of a dental emergency.<br>See **What Is Covered Under the Plan** on page 17 for a summary of coverage under the dental options. |

# WHO IS ELIGIBLE

## Employee Eligibility

You are eligible to participate in the Plan if you:

- are a regular full-time employee of Tesoro Corporation or one of its participating subsidiaries (scheduled to work at least 30 hours per week);
- are not covered under a collective bargaining agreement (unless your collective bargaining agreement provides for participation in the Plan); and
- are on a U.S. payroll.

You are **not** eligible to participate in the Plan if you:

- are not a regular full-time employee (e.g., are a part-time, temporary or seasonal employee);
- are covered by a collective bargaining agreement that does not provide for participation in the Plan;
- are not on a U.S. payroll;
- are a leased employee, non-employee director or independent contractor; or
- are employed by a related company or any subsidiary or affiliate which has not adopted the Plan.

## Dependent Eligibility

If you enroll for Plan coverage, you may also enroll your eligible dependents, as follows:

- your spouse (if you are not legally separated);
- your children under age 26. Dependent children include:
  - your biological children,
  - stepchildren, and
  - foster children or legally adopted children, including children placed with you for adoption for whom legal adoption proceedings have started even if not final;
  - children for which there is a court order establishing your legal guardianship or conservatorship, which has not been terminated by the parties or operation of law;
- your grandchildren or other children in your court-ordered custody agreement (applicable under the DMO only);
- your mentally or physically disabled dependent children of any age (*see the box on the following page*); and
- your domestic partner and your domestic partner's dependent children (*see the box on the following page*).

If you enroll in the DMO, your dependents must live with you or live in the DMO's service area (except in the case of a QMCSO). A dependent grandchild or other child for whom you are responsible under a court order must have the same legal residence as you to be eligible for DMO coverage.

## CONTINUING COVERAGE FOR A DISABLED CHILD

You must contact the Tesoro Benefits Center at least 31 days before the child's 26th birthday. Proof of a child's disability is required, and proof of continuing disability and dependency may be required periodically.

## DOMESTIC PARTNER COVERAGE

Domestic partner coverage includes a domestic partner meeting the eligibility criteria listed on Tesoro's Affidavit of Domestic Partnership. To qualify for benefits, you must register your domestic partnership with Tesoro by submitting a signed affidavit. This form is available through the Tesoro Benefits Center (see **Contacts** on page 61) or may be downloaded from HR Connect.

You must enroll your domestic partner and his or her dependent children within the first 31 days of the date they meet the eligibility requirements (upon hire or completion of six months of the domestic partner relationship). If you don't enroll within the 31-day period, you must wait until the next open enrollment period.

Note, however, that dependent coverage for eligible domestic partners generally requires that the value of that coverage be included as taxable income to the participant.

Proof of dependent status satisfactory to the Plan Administrator may be required when you enroll your dependents in the Plan. The Plan Administrator may also request proof for already enrolled dependents.

You must enroll a newly eligible dependent within the first 31 days after the life event (birth, adoption or marriage, etc.) leading to the eligibility. If you don't enroll within the 31-day period, you must wait until the next open enrollment period to enroll the dependent.

### Ineligible Dependents

The following persons are **not** eligible for dependent coverage under the Plan

- your legally separated spouse;
- a child who is employed by Tesoro or an affiliate,
- a child who no longer qualifies as a dependent because of age,
- a child who no longer qualifies as a dependent due to disability, or
- an individual who no longer qualifies as a child for whom you are the legal guardian or conservator.

# ENROLLING IN THE PLAN

To enroll in the Dental Plan, you'll need to:

- choose from the Plan options available to you; and
- decide which of your eligible dependents you wish to cover, if any.

Generally, the coverage levels available under the Plan are:

- Employee Only;
- Employee + Child(ren);
- Employee + Spouse;
- Employee + Family; or
- Waive Coverage.

The coverage levels available to cover Domestic Partner and Domestic Partner Children under the Plan are:

- Employee + Spouse/Domestic Partner;
- Employee + Family (including Domestic Partner plus Child(ren) &/or Domestic Partner Child(ren).

## IF YOUR SPOUSE IS ALSO AN ELIGIBLE EMPLOYEE

If both you and your spouse are eligible to enroll in the Plan, you may elect Plan coverage under the Dental PPO as an employee and as a dependent spouse (this is not allowed under the DMO). You may **not** enroll in coverage as both an employee and dependent child.

## Enrollment

You must enroll ***yourself and your eligible dependents*** in the Plan within 31 days of your employment date, or within 31 days of the date you first become eligible for the Plan (if later). **If you enroll within 31 days of your employment or eligibility date, your coverage is effective as of your eligibility date.**

If you do not enroll within 31 days of your employment date or the date you first became eligible, you will be automatically enrolled in default coverage plans at the Employee Only coverage level.

If you decline (waive) coverage, you must wait until the next open enrollment period to change your elections, unless you become eligible to make an election change under the Plan as a result of an eligible status change.

You may enroll by completing your Online Benefits Enrollment through the Tesoro Benefit Center at www.tsocorp.com/benefits or by calling (866) 787-6314. Coverage for your dependents will not be completed until you submit required documentation verifying eligibility.

After you have completed your enrollment, you should print a Confirmation Form verifying your elections. It is important for you to keep a copy of your enrollment elections to show proof of your elections should an issue later arise.

Your dental coverage will begin as of your eligibility date and any payroll deductions covering your elections will be made retroactively.

## Default Enrollment

If you do not enroll within 31 days of your becoming eligible for benefits, you will be enrolled in the PPO Dental Plan at the Employee Only coverage level.

## Annual Open Enrollment Period

During an annual open enrollment period designated by the Company (normally in October of each year for coverage beginning the following January 1), you must make an election to enroll, re-enroll or decline (waive) participation for the coming year. You may change Dental Plan options or coverage levels and add or drop dependents from your coverage. If you do not make an election during this period, you will receive the default employee-only coverage unless you have currently waived coverage. You will not be allowed to change that election before the next open enrollment period, unless you experience an eligible status change during the year.

Coverage elections (and deemed default elections) made during open enrollment become effective on January 1 of the immediately following year.

## Special Enrollment

Certain family status changes (see **Changes in Family Status** on page 9) may allow for mid-year enrollment as a Special Enrollee. If you are applying for coverage as a Special Enrollee, you must do so within 31 days of the change.

A Special Enrollee is a person (including yourself) for whom you did not elect dental coverage within 31 days of the date the person first became eligible or during an open enrollment period, but for whom you later elect coverage. Unless the need for dental services is as a result of accidental injury, dental benefits for a Special Enrollee will be limited as follows:

- For the first 12 months of coverage, dental benefits are limited to Type A – diagnostic and preventive care. Most basic and major services will not be covered during the first 12 months of coverage.
- For the first 24 months of coverage, orthodontic services will generally not be covered (this may be limited to only 12 months in certain locations under the DMO).

A person will be considered to be a Special Enrollee if ***all*** of the following apply:

- you did not elect dental coverage for that person within 31 days of the date the person first became eligible (or during an open enrollment period), because at the time you refused the coverage you indicated in writing that the reason for the refusal was because the person had dental coverage from another source; **and**
- the person loses such coverage because:
  - of termination of employment resulting in loss of coverage,
  - of reduction in hours of employment resulting in loss of coverage,
  - your spouse dies,
  - you and your spouse divorce or are legally separated
  - the dental coverage was COBRA continuation and the continuation is exhausted, or
  - the other plan terminates due to the employer's failure to pay the premium or any other reason; **and**
- you elect coverage within 31 days of the date the person loses coverage for one of the above reasons.

In addition, you will be a Special Enrollee if you obtain a new dependent through birth, adoption or marriage, and you elect coverage for that person within 31 days of the date you obtain the new dependent.

## WHEN COVERAGE BEGINS

| If you enroll ... | Coverage for you and your enrolled dependents begins ... |
|---|---|
| Within 31 days of employment | On your eligibility date |
| Within 31 days of your initial eligibility date | On your eligibility date |
| During the open enrollment period | On January 1 of the following year |
| Within 31 days of an eligible status change (see **Changing Your Coverage** on page 8) | On the effective date of the status change (unless otherwise prohibited by the Patient Protection and Affordable Care Act) |

## CHANGING YOUR COVERAGE

After your initial enrollment, you can make changes to your coverage only during the open enrollment period or as the result of an eligible status change, which includes a change in:

- your family status; or
- your or your spouse's employment status.

**You must request any changes to your coverage within 31 days of the eligible status change. You may make coverage changes online or by phone by contacting the Tesoro Benefits Center at (866) 787-6314 within 31 days of the change.**

An eligible status change allows you to:

- change your level of coverage (for example, from "Employee Only" to "Employee + Spouse" coverage);
- elect coverage if you previously waived coverage;
- terminate coverage; or
- change your benefit option (for example, from the Dental PPO to the DMO), provided the election change is consistent with the status change.

**Changes in your Plan coverage must be consistent with the status change.** For example, you may change your benefit option if your status change is relocation to a different network service area that your current benefit option does not cover.

Changes to your coverage and any change in your required contributions will take effect as of the date of the event (unless otherwise prohibited by the Patient Protection and Affordable Care Act).

### Changes in Family Status

An eligible change in family status includes:

- marriage;
- divorce or legal separation from your spouse;
- completion of six months in a domestic partnership;
- termination of a domestic partnership;
- birth, adoption or placement for adoption of a dependent child;
- death of a spouse or a dependent child;
- loss of dependent eligibility; or
- acquiring a dependent who was not eligible for coverage during the previous open enrollment period and later becomes eligible during a plan year.

### QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOs)

The Plan will provide coverage for your eligible child pursuant to the terms of a Qualified Medical Child Support Order (QMCSO), regardless of any enrollment season restrictions that might otherwise apply, even if:

- **you do not have legal custody of the child; or**
- **the child is not dependent on you for support.**

A QMCSO is an order from a state court or other state agency, usually issued as a part of a settlement agreement or divorce decree that provides for health care coverage for the child of a Plan participant. A QMCSO must meet certain legal requirements to be considered "qualified."

You are required to be enrolled in the Plan in order to enroll your eligible child. If the Plan receives a valid QMCSO and you do not enroll the dependent child, the custodial parent or state agency may enroll the affected child. Tesoro may withhold the contributions required for the child's coverage from your pay.

A copy of the Plan's QMCSO procedures is available, free of charge, upon request to the Tesoro Benefit Center.

### Changes in Employment Status

An eligible change in employment status includes the following for you, your spouse, your domestic partner or your dependent child if the change affects the person's eligibility for coverage under the Plan:

- a Company-authorized transfer or relocation requiring a change in work location and relocation of your residence;
- employment or unemployment (i.e., new job or loss of a job); or
- a change in work schedule (i.e., a reduction or increase in hours, a switch between part-time and full-time, strike or lockout or a commencement or return from an unpaid leave of absence).

## COST OF COVERAGE

You and the Company share the cost of dental coverage for you and your eligible dependents. Your cost is based on the coverage option and level of coverage you choose. You generally pay for coverage on a pre-tax basis through automatic payroll deductions. The contribution amount for each coverage option and level of coverage is subject to change and is announced in advance as part of open enrollment.

## HOW THE DENTAL PLAN WORKS

Tesoro Corporation offers two dental options, both administered by Aetna:

- Tesoro PPO Dental Plan; and
- Tesoro DMO Dental Plan. (Note: The DMO is not available in Alaska, North Dakota, Wyoming or other locations outside of the DMO service area.)

**When you select a Dental Plan option, that option applies to you and all of your covered dependents, even if your covered dependents live outside of the network area.**

Both Dental Plan options cover similar dental services, but the way they work is different.

The Tesoro PPO Dental Plan (Dental PPO) is a self-insured plan, which means that the Company and the employees (not third party providers) pay the total cost of dental expenses.

- There is no insurance contract and benefits are paid from the Company's general assets as claims are incurred.
- The Company has an "administrative services only" agreement with Aetna to administer the benefits and process claims under the Dental PPO.
- You may choose to receive care from either an in-network Aetna Preferred Dental Network dentist or any out-of-network dentist — but you may pay less if you use a provider in Aetna's dental network.

The Tesoro DMO Dental Plan (DMO) is a fully insured plan. This means the Company and employees pay the insurance company, Aetna, for benefits under this option.

- Tesoro has an insurance contract with Aetna and benefits are paid by Aetna.
- The DMO is a managed dental plan, so you must receive all care from an in-network Aetna DMO Network dentist.
- When you enroll in the DMO, you select a Primary Care Dentist (PCD) who will provide your basic and routine dental services, coordinate all of your care and refer you to specialty dentists as needed.
- Benefits are not available out-of-network under the DMO, except in the case of a dental emergency.

**Please note: Depending on where you live, and as required by state law, additional benefits may be available under the DMO that are not included in this Summary Plan Description. Call Aetna if you have any questions about DMO covered dental expenses in your location.**

### FINDING AN AETNA DENTAL NETWORK PROVIDER

The Dental PPO uses the Aetna Preferred Dental Network. The DMO uses the Aetna DMO Network. In-network dentists have agreed to provide dental services or supplies at a negotiated charge.

- **Under the Dental PPO, you do not have to use an in-network dentist, but any out-of-network benefits will be subject to reasonable and customary charge limits. You are responsible for any charges that exceed those limits.**
- **Under the DMO, you must receive all of your care from an in-network dentist, except in the case of a dental emergency.**

You can find participating in-network providers through:

- **Aetna Member Services at (877) 238-6200; or**
- **the DocFind search function on Aetna Navigator at www.aetna.com. Under "Select a Plan" choose:**
  - For the Dental PPO, select "Dental PPO/PDN."
  - For the DMO, select "Dental Maintenance Organization (DMO℠)."

## Dental Plan Summary Chart

The following chart highlights some of the dental services and supplies that are covered under the Dental Plan. Frequency and age limitations may apply to these services.

This is a summary only. It is not intended to be all-inclusive. See also **What Is Covered Under the Plan** beginning on page 17 for details of covered dental expenses.

| Feature | Dental PPO<br>*In-network and out-of-Network*[1] | DMO In-network only |
|---|---|---|
| **Annual deductible**[2] | $50 per person | $0 |
| **Annual maximum benefit**[2] | $2,000 per person | N/A |
| **Separate orthodontia deductible** | N/A | N/A |
| **Separate orthodontia copay** | N/A | $2,300 per person |
| **Separate TMJ deductible** | $50 per person (one time) | N/A |
| **Lifetime orthodontia maximum** | $2,000 per person | N/A |
| **Lifetime TMJ maximum** | $1,000 per person | N/A |
| **Covered services** | **Plan pays** | |
| **Preventive and diagnostic care** *(includes routine oral exams, cleanings, fluoride treatments, x-rays, sealants and space maintainers)* | 100% (no deductible) | 100% |
| **Basic services** *(includes fillings, root canal therapy, general anesthesia and stainless steel crowns)* | 80% after deductible | 90% |
| **Major services** *(includes inlays, onlays, crowns, dentures and pontics)* | 50% after deductible | 60% |
| **Orthodontia** | • Applies to covered dependent children only; appliance must be placed prior to age 20<br>• Lifetime maximum benefit of $2,000 | $2,300 copay (per adult or child) covers 24 months of comprehensive orthodontic treatment plus 24 months of retention. See **What Is Covered Under the Plan** for a breakdown of how the copay is paid in some locations. |
| **Dental implants** | 50% after deductible | Not covered |
| **TMJ** | • 50% after separate TMJ deductible<br>• Lifetime maximum benefit of $1,000 | Not covered |

1 Out-of-network benefits are subject to reasonable and customary charge limits.
2 Applies to basic services, major services and dental implants only.

## Dental PPO Plan Provisions

The Dental PPO includes certain annual and lifetime deductibles and maximums, as described below. In addition, any services received out-of-network will be subject to reasonable and customary charge limits.

### *Deductibles*

The Dental PPO includes the following deductibles:

- $50 per person per year for basic services, major services and dental implants. This annual deductible applies to each calendar year and starts over each January 1.
- $50 per person for TMJ expenses. This is a one-time deductible, which is payable only once per lifetime.

The deductible is the initial amount of eligible dental expenses you must pay before the Dental PPO pays benefits. The deductible does not include:

- preventive care services covered at 100%;
- monthly premium contributions;
- out-of-network amounts exceeding reasonable and customary charge limits (see Reasonable and Customary Charges at right);
- charges that exceed the annual maximum benefit or lifetime maximums under the Plan;
- charges that exceed plan limits for certain services (for example, services that are only covered two times per year); or
- expenses for services not covered under the Dental Plan.

When the applicable deductible is met, the Dental PPO will pay benefits at the coinsurance amounts listed under the **Dental Plan Summary Chart** on page 11.

### *Annual Maximum Benefit*

The Dental PPO will pay for covered dental expenses (not including preventive care, TMJ and orthodontic expenses) up to the annual maximum benefit of $2,000 per person per calendar year. The annual maximum benefit applies to each covered person and applies even if there is a break in coverage during the calendar year.

### *Lifetime Maximums*

The Dental PPO includes the following lifetime maximums:

- lifetime orthodontia maximum of $2,000 per eligible child; and
- lifetime TMJ maximum of $1,000 per person.

Covered orthodontic expenses are paid at 50% (up to the lifetime maximum) and covered non-surgical TMJ expenses are paid at 50% after the one-time $50 TMJ deductible (up to the lifetime maximum). When the lifetime maximums are met, the Dental PPO will not pay any additional orthodontia or TMJ expenses (as applicable) for the covered person. Lifetime maximums apply even if there is a break in coverage.

### *Reasonable and Customary Charges*

Under the Dental PPO, you may choose to receive care from either a dentist in Aetna's Preferred Dental Network or an out-of-network dentist. If you choose an out-of-network dentist, the Dental PPO will reimburse a portion of covered expenses (see the **Dental Plan Summary Chart** on page 11 for the coinsurance amounts), up to the lesser of the amount billed or the reasonable and customary charge.

The reasonable and customary charge for a service or supply is the lowest of:

- the provider's usual charge for furnishing it; and
- the charge Aetna determines to be appropriate, based on factors such as:
  - the cost of providing the same or a similar service or supply and the manner in which the charges are made, billed or coded; or
  - the prevailing charge for the service or supply in the geographic area where it is furnished.

To determine the reasonable and customary charge for a service or supply that is unusual or not often provided in the area or provided by only a small number of providers in the area, Aetna takes into account the:

- complexity of the service;
- degree of skill needed;
- type or specialty of the provider;
- range of services or supplies provided by a facility; and
- prevailing charge in other areas.

**If you incur a covered expense that is above the reasonable and customary charge limit, you are responsible for paying the excess amount above the limit. You have the right to have Aetna review your claim if you or your dentist believes that there are special circumstances that justify the charge over the reasonable and customary charge limit.**

### *Advance Claim Review*

An advance claim review is a voluntary review of a dentist's proposed course of treatment and charges that can help you and your dentist make informed decisions about the care you are considering. A course of treatment is a planned program of one or more services or supplies to treat a dental condition that was diagnosed as the result of an oral exam. **You should request an advance claim review when the dentist's charges are expected to be $350 or more.**

You or your dentist can file an advance claim review with Aetna. Aetna will then review the proposed course of treatment and estimate benefits under the Dental Plan.

### *Alternate Services*

If you receive dental care for a specific condition that is not included in the list of **What Is Covered Under the Plan** beginning on page 17 — but the list does include one or more services that, under standard dental practices, are suitable for the dental care of that same condition — the Plan will pay a benefit based on a covered expense that Aetna determines would have produced a professionally acceptable result.

## DMO Plan Provisions

The DMO does not include deductibles or maximums, but there are copays required for orthodontia as well as specific orthodontia exclusions, as detailed below. In addition, this section includes information about your primary care dentist, other network providers and what to do in the case of a dental emergency.

### *DMO Orthodontia Limits*

Under the DMO, each covered person (adult or child) must pay copays that add up to $2,300* for:

- orthodontic screening exam ($30);
- orthodontic diagnostic records ($150);
- comprehensive orthodontic treatment ($1,845); and
- orthodontic retention ($275).

* This may be required to be paid as a lump-sum $2,300 copay in certain locations.

After the copay(s), covered orthodontic expenses will be paid at 100% for 24 months of comprehensive (active, usual and customary) treatment on permanent dentition plus 24 months of post-treatment retention.

Coverage for services and supplies are not provided under the DMO for any of the following orthodontic services:

- replacement of broken appliances;
- re-treatment of orthodontic cases;
- changes in treatment necessitated by an accident;
- maxillofacial surgery;
- myofunctional therapy;
- treatment of cleft palate;
- treatment of micrognathia;
- treatment of macroglossia;
- treatment of primary dentition;
- treatment of transitional dentition; or
- lingually placed direct bonded appliances and arch wires (i.e., “invisible braces”).

Coverage is also not provided for an orthodontic procedure if an active appliance for that orthodontic procedure was installed before you became covered under the DMO.

### *Primary Care Dentist (PCD)*

This DMO is a managed dental plan, which means you access care through the primary care dentist (PCD) you select when you enroll. Each covered family member may select a different PCD. Your PCD provides basic and routine dental services and supplies, and will refer you to other dental providers in the network. Your PCD coordinates all of your dental care, and you must have a referral from your PCD in order for any services from a specialty dentist to be covered.

You can select a PCD in the Aetna DMO Network through:

- the DocFind search function on Aetna Navigator at www.aetna.com; or
- Aetna Member Services at (877) 238-6200.

If you do not choose a PCD, Aetna may select one for you. You may change your PCD for yourself or your covered family members at any time. The change will be effective as follows:

- If Aetna receives a request on or before the 15th day of the month, the change will be effective on the first day of the next month.
- If Aetna receives a request after the 15th day of the month, the change will be effective on the first day of the month following the next month.

## AVAILABILITY OF PROVIDERS

Aetna cannot guarantee the availability or continued participation of a particular provider. Either Aetna or any network provider may terminate the provider contract or limit the number of patients accepted in a practice. If the PCD initially selected cannot accept additional patients, you will be notified and given an opportunity to make another selection. If the agreement between Aetna and your selected PCD is terminated, Aetna will notify you of the termination and request that you select another PCD.

### *Network Referrals*

There may be times when you need services and supplies that only a dental specialist can provide. In these cases, your PCD will make a referral to a specialty dentist. A PCD referral is not required for any covered orthodontic services.

When your PCD determines that your treatment should be provided by a specialty dentist, you’ll receive a written or electronic referral. The referral will be good for 30 days, as long as you remain covered under the Plan on the date covered services and supplies are provided. When you visit the specialty dentist, bring the referral (or check in advance to verify that they have received the electronic referral). Without it, charges for the services provided by the specialty dentist will not be covered dental expenses. You cannot request a referral from your PCD after you have received services from a specialty dentist.

If a service you need isn't available from a network provider, your PCD may refer you to an out-of-network provider. Your PCD must get precertification from Aetna and issue a special out-of-network referral for services from out-of-network providers to be covered.

You do not need a PCD referral for:

- Emergency dental care. Please refer to If You Have a Dental Emergency at right.
- Covered orthodontic services and supplies.

### *Termination of a Provider Contract*

If a network provider's contract with Aetna is terminated without cause or for breach, the network provider (either PCD or specialty dentist) is still obligated to provide you with covered services:

- for any active treatment at the time of termination until the course of treatment is complete or until you transition to another network provider;
- upon your request and an approval by Aetna, until the anniversary date of your coverage or for one calendar year, whichever is less; and/or
- if, as of the effective date of termination, you are under treatment by the network provider for a disability, acute condition or life-threatening illness, where your treating dentist reasonably believes that discontinuing care by the provider could cause you harm.

### *If You Have a Dental Emergency*

In the case of a dental emergency, whenever possible, you should call your PCD to arrange an emergency appointment. If that is not possible or you cannot see your PCD, you should contact the nearest dental provider.

When you receive emergency dental care from a network provider, you will pay the coinsurance amount as outlined in the **Dental Plan Summary Chart** on page 11 and **What Is Covered Under the Plan** beginning on page 17.

When you receive emergency dental care from an out-of-network provider, the DMO will pay based on the "reasonable and customary charge" for such care. The reasonable and customary charge for a service or supply is the lowest of:

- the provider's usual charge for furnishing it; and
- the charge Aetna determines to be appropriate, based on factors such as:
  - the cost of providing the same or a similar service or supply and the manner in which the charges are made, billed or coded; or
  - the prevailing charge for the service or supply in the geographic area where it is furnished.

To determine the reasonable and customary charge for a service or supply that is unusual or not often provided in the area or provided by only a small number of providers in the area, Aetna takes into account the:

- complexity of the service;
- degree of skill needed;
- type or specialty of the provider;
- range of services or supplies provided by a facility; and
- prevailing charge in other areas.

The DMO will only cover the emergency out-of-network care if all of the following rules are met:

- the care given is for the temporary relief of an emergency condition until you can be seen by your PCD;
- an itemized bill describing the care involved is submitted to Aetna. Depending on whether or not benefits are assigned to the provider, the bill may be submitted by you or by the provider; and
- the dental service provided is listed under **What Is Covered Under the Plan** beginning on page 17.

### *Out-of-Network Services*

*If your PCD is part of a practice group or association of dental providers and covered services or supplies are not available within your PCD's limited provider network, you have the right to a referral to a network dentist outside of your PCD's limited provider network.*

If covered services or supplies are not available from any network dental providers in your area, Aetna will allow a referral to an out-of-network provider. Contact Aetna for information on out-of-network provider authorizations. The following will apply:

- you or a network dentist must make the request;
- you or your PCD must provide any reasonably requested documentation to Aetna;
- before Aetna denies a referral, a review will be conducted by a specialist of the same or similar specialty as the type of dental provider to whom a referral is requested;
- the referral will be provided within an appropriate time, not to exceed five business days, based on the circumstances and your condition;
- you shall not be required to change your PCD or specialty dentist to receive covered services and supplies that are not available from any network providers in your area; and
- Aetna will reimburse the out-of-network provider at the usual and customary or an agreed upon rate, less your required coinsurance.

## Alternate Treatment Rule

**The Alternate Treatment Rule applies under both the Dental PPO and DMO options.**

If more than one service can be used to treat your dental condition, Aetna may decide to authorize coverage only for a less costly covered service provided that all of the following terms are met:

- the service must be specifically listed as covered under the Plan;
- the service selected must be deemed by the dental profession to be an appropriate method of treatment; and
- the service selected must meet broadly accepted national standards of dental practice.

If the treatment is being given by a network dentist and you ask for the more costly service even though Aetna authorized the less expensive service, you will pay:

- your applicable coinsurance for the approved less costly service; plus
- the difference in cost between the approved less costly service and the more costly covered service.

## What Is Covered Under the Plan

The following conditions must be met in order for dental services and supplies to be covered by the Plan:

- the services and supplies must be medically necessary; and
- you must be covered by the Plan when you incur the expense.

### *Dental PPO Covered Services*

Covered dental expenses are charges for the services, supplies and treatment that are listed in the following chart. Under the Dental PPO, out-of-network covered charges are reimbursable up to the lesser of the amount billed or the reasonable and customary charge (see **Reasonable and Customary Charges** on page 12).

| DENTAL PPO PLAN | |
|---|---|
| **Covered service** | **Limitation** |
| **Type A: Preventive and Diagnostic Care<br>Covered at 100%, no deductible required** | |
| **Visits and X-rays** | |
| Office visit during regular office hours, for oral examination | |
| Routine comprehensive or recall examination | Two visits per year |
| Problem-focused examination | Two visits per year |
| Prophylaxis (cleaning) | Two treatments per year |
| Topical application of fluoride | Two per year and only for children under age 19 |
| Sealants, per tooth | One application every three rolling years for permanent molars only and only for children under age 16 |
| Bitewing X-rays | Two sets per year, up to eight films per year |
| Periapical X-rays | Up to 13 single films |
| Complete X-ray series, including bitewing (if necessary) or panoramic film | One set every three rolling years |
| Vertical bitewing X-rays | One set every three rolling years |
| **Space maintainers** | |
| Fixed (unilateral or bilateral) | Includes all adjustments within six months of installation |
| Removable (unilateral or bilateral) | Includes all adjustments within six months of installation |
| **Type B: Basic Restorative Care<br>Covered at 80% after deductible** | |
| **Visits** | |
| Professional visit after hours | Payment based on the basis of services rendered or visit, whichever is greater |
| Emergency palliative treatment, per visit | |

| DENTAL PPO PLAN | |
|---|---|
| **Covered service** | **Limitation** |
| **X-Ray and Pathology** | |
| Intra-oral, occlusal view, maxillary or mandibular | |
| Upper or lower jaw, extra-oral | |
| Biopsy and histopathologic examination of oral tissue | |
| **Oral Surgery and Anesthesia** | |
| Uncomplicated extractions | |
| Surgical removal of erupted tooth/root tip | |
| Removal of impacted teeth | Soft tissue, partially bony or completely bony |
| Odontogenic cysts and neoplasms | |
| Incision and drainage of abscess | |
| Removal of odontogenic cyst or tumor | |
| General anesthesia and intravenous sedation | Only when provided in conjunction with a covered surgical procedure |
| **Other Surgical Procedures** | |
| Alveoplasty, in conjunction or not in conjunction with extractions | Per quadrant |
| Sialolithotomy: removal of salivary calculus | |
| Closure of salivary fistula | |
| Excision of hyperplastic tissue | |
| Removal of exostosis | |
| Transplantation of tooth or tooth bud | |
| Closure of oral fistula of maxillary sinus | |
| Sequestrectomy | |
| Crown exposure to aid eruption | |
| Removal of foreign body from soft tissue | |
| Frenectomy | |
| Suture of soft tissue injury | |

| DENTAL PPO PLAN | |
|---|---|
| **Covered service** | **Limitation** |
| **Periodontics** | |
| Occlusal adjustment (other than with an appliance or by restoration) | |
| Subgingival curettage or root planing and scaling, per quadrant | Four separate quadrants every two rolling years |
| Gingivectomy | One quadrant every three rolling years |
| Gingivectomy, treatment per tooth, one to three teeth per quadrant | One per site every three years |
| Gingival flap procedure | One quadrant every three years |
| Periodontal maintenance procedures | Two per year |
| Full Mouth Debridement | One per lifetime |
| Periodontics — crown lengthening | |
| **Endodontics** | |
| Pulp capping | |
| Pulpotomy | |
| Apexification/recalcification | |
| Apicoectomy | |
| Root canal therapy, including necessary X-rays | Anterior, bicuspid or molar |
| **Restorative Dentistry**<br>Excludes inlays, crowns (other than as indicated below) and bridges. Multiple restorations in one surface will be considered as a single restoration. | |
| Amalgam restorations | |
| Resin restorations | Other than for molars |
| Sedative fillings | |
| Pins | |
| Pin retention, per tooth | In addition to amalgam or resin restoration |
| Crowns — prefabricated stainless steel or prefabricated resin crown (excluding temporary crowns) | When tooth cannot |
| Recementation of inlay, crown or bridge | |

| DENTAL PPO PLAN | |
|---|---|
| **Covered service** | **Limitation** |
| **Type C: Major Restorative Care**<br>**Covered at 50% after deductible** | |
| **Restorative**<br>Covered only as treatment for decay or acute traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge. | |
| Inlays/onlays — metallic or porcelain/ceramic | • Inlay on one or more surfaces<br>• Onlay on two or more surfaces |
| Inlays/onlays — resin | • Inlay on one or more surfaces<br>• Onlay on two or more surfaces |
| Labial veneers | • Laminate — chair side<br>• Resin laminate |
| Crowns — resin, resin with noble metal, resin with base metal, porcelain, porcelain with noble metal, porcelain with base metal, base metal (full cast), noble metal (full cast) or metallic (3/4 cast) | |
| Post and core | |
| Crown buildup | |
| **Prosthodontics** | |
| Bridge abutments | |
| Pontics — base metal (full cast), noble metal (full cast), porcelain with noble metal, porcelain with base metal, resin with noble metal or resin with base metal | • Inlay on one or more surfaces<br>• Onlay on two or more surfaces |
| Removable bridge (unilateral) | One piece casting, chrome cobalt alloy clasp attachment (all types) per unit, including pontics |
| Dentures — complete upper denture or complete lower denture | • Fees for dentures and partial dentures include relines, rebases and adjustments within six months after installation<br>• Specialized techniques and characterizations are not covered |
| Partial upper or lower — resin base or cast metal base with resin saddles, including any conventional clasps, rests and teeth | |
| Office reline, laboratory reline | Fees for relines and rebases include adjustments within six months after installation |
| Rebase, per denture | |
| Stress breakers | |

| DENTAL PPO PLAN | |
|---|---|
| **Covered service** | **Limitation** |
| Interim partial denture (stayplate) | Anterior only |
| Special tissue conditioning, per denture | |
| Adjustment to denture more than six months after installation | |
| Full and partial denture repairs | Includes broken dentures (no teeth involved), repairing cast framework or replacing missing or broken teeth |
| Adding teeth to existing partial denture — each tooth and each clasp covered | |
| Repairs to crowns or bridges | |
| Occlusal guard | For bruxism only, one every three rolling years |
| Implants | |
| **Type D: TMJ Care**<br>**Covered at 50% after separate TMJ deductible** | |
| Non-surgical services for treatment of Temporomandibular Joint dysfunction | Covered up to the $1,000 TMJ lifetime maximum benefit per person. |
| **Orthodontia***<br>**Covered at 50%** | |
| Comprehensive orthodontic treatment | • Orthodontia is only covered for children who are under age 20 on the date treatment begins<br>• Lifetime maximum benefit of $2,000 per person |
| Interceptive orthodontic treatment | |
| Limited orthodontic treatment | |
| Post-treatment stabilization | |
| Removable appliance therapy to control harmful habits | |
| Fixed appliance therapy to control harmful habits | |

* No benefits will be paid for an orthodontic procedure if an active appliance for that orthodontic procedure was installed before the effective date of your coverage. In the case of Special Enrollees, no benefits will be paid for an orthodontic procedure for which an active appliance was installed within the first 24 months starting with the effective date of coverage.

### *DMO Covered Services*

Covered dental expenses are charges for the services, supplies and treatment that are listed in the following chart. Depending on where you live, and as required by state law, additional benefits may be available under the DMO.

| DMO DENTAL PLAN | |
|---|---|
| **Covered service** | **Limitation** |
| **Type A: Preventive and Diagnostic Care<br>Covered at 100%** | |
| **Visits and X-rays and Pathology** | |
| Office visit for oral examination | Four visits per year* |
| Emergency palliative treatment | |
| Prophylaxis (cleaning) | Two treatments per year* |
| Topical application of fluoride | One per year and only for children under age 16* |
| Oral hygiene instruction | |
| Sealants, per tooth | One application every three years for permanent molars only and only for children under age 16* |
| Pulp vitality test | |
| Bitewing X-rays | One set per year* |
| Entire X-ray series, including bitewings or panoramic film | One set every three years* |
| Vertical bitewing X-rays | One set every three years* |
| Periapical X-rays | |
| Intra-oral, occlusal view, maxillary or mandibular | |
| Extra-oral upper or lower jaw | |
| Biopsy and histopathologic examination of oral tissue | |
| **Space maintainers** | |
| Fixed, band type | Includes all adjustments within six months of installation |
| Removable acrylic with round wire clasp | Includes all adjustments within six months of installation |

* Limit will not apply if needed more frequently due to medical necessity as determined by your Primary Care Dentist

| DMO DENTAL PLAN | |
|---|---|
| **Covered service** | **Limitation** |
| **Type B: Basic Restorative Care**<br>**Covered at 90%** | |
| **Oral Surgery (includes local anesthetics and routine post-operative care)** | |
| Uncomplicated extractions | |
| Surgical removal of erupted tooth | |
| Surgical removal of impacted tooth (soft tissue) | |
| Excision of hyperplastic tissue | |
| Excision of pericoronal gingiva | |
| Incision and drainage of abscess | |
| Crown exposure to aid eruption | |
| Removal of foreign body from soft tissue | |
| Suture of soft tissue injury | |
| **Other Surgical Procedures**<br>**(Specialty Dentist Services — includes local anesthetics and routine post-operative care)** | |
| Removal of residual root | |
| Removal of odontogenic cyst | |
| Closure of oral fistula | |
| Removal of foreign body from bone | |
| Sequestrectomy | |
| Frenectomy | |
| Transplantation of tooth or tooth bud | |
| Alveoplasty, in conjunction or not in conjunction with extractions | Per quadrant |
| Removal of exostosis | |
| Sialolithotomy: removal of salivary calculus | |
| Closure of salivary fistula | |

| DMO DENTAL PLAN | |
|---|---|
| **Covered service** | **Limitation** |
| **Periodontics** | |
| Emergency treatment (abscess, acute periodontitis, etc.) | |
| Subgingival curettage | Four separate quadrants every two years |
| Scaling and root planing | Four separate quadrants every two years |
| Periodontal maintenance procedures following surgical therapy | Two per year |
| **Periodontics (Specialty Dentist Services)** | |
| Gingivectomy or gingivoplasty, per quadrant | One quadrant every three years |
| Gingivectomy or gingivoplasty, per tooth | One per site every three years |
| Gingival flap procedure, per quadrant | |
| Occlusal adjustment (other than with an appliance or by restoration) | |
| **Endodontics** | |
| Pulp capping | |
| Pulpotomy | |
| Surgical exposure for rubber dam isolation | |
| Root canal therapy, including necessary X-rays | Anterior or bicuspid |
| **Endodontics (Specialty Dentist Services — includes local anesthetics when necessary)** | |
| Apexification/recalcification | |
| Apicoectomy, per tooth | |
| Retrograde filling | |
| Root amputation | |
| Hemisection | |
| **Restorations and Repairs** | |
| Amalgam restorations | One or more surfaces |
| Resin restorations (other than for molars) | One or more surfaces or incisal angle |
| Retention pins | |
| Sedative fillings | |
| Stainless steel crowns | |
| Prefabricated resin crowns (excluding temporary crowns) | |

| DMO DENTAL PLAN | |
|---|---|
| **Covered service** | **Limitation** |
| Recementation of inlay, crown, bridge or space maintainer | |
| Tissue conditioning for dentures | |
| **Type C: Major Restorative Care<br>Covered at 60%** | |
| General anesthesia and intravenous sedation | |
| **Restorations** | |
| Inlays | One or more surfaces |
| Onlays | One or more surfaces |
| Crowns — resin, resin with noble metal, resin with base metal, porcelain, porcelain with noble metal, porcelain with base metal, base metal (full cast), noble metal (full cast) or metallic (3/4 cast); post and core | Including build-ups when necessary |
| Pontics — base metal (full cast), noble metal (full cast), porcelain with noble metal, porcelain with base metal, resin with noble metal or resin with base metal | |
| Dentures and partials — full (upper and lower), partial, stress breakers (per unit) and stayplates | Fees for dentures and partial dentures include relines, rebases and adjustments within six months after installation |
| Repairs to crowns or bridges | |
| Full and partial denture repairs | |
| Adding teeth to existing denture | |
| Occusal guard | For bruxism only, one every three years |
| **Periodontics** | |
| Full mouth debridement | Once per lifetime |
| **Periodontics (Specialty Dentist Services)** | |
| Occeous surgery, including flap entry and closure, per quadrant | One per quadrant, every three years |
| Clinical crown lengthening — hard tissue | |
| **Endondontics (Specialty Dentist Services — includes local anesthetics when necessary)** | |
| Molar root canal therapy | Includes necessary X-rays |
| **Oral surgery (Specialty Dentist Services — includes local anesthetics when necessary and post-operative care)** | |
| Surgical removal of impacted teeth | Partially bony, completely bony or completely bony with unusual surgical implications |

| DMO DENTAL PLAN | |
|---|---|
| **Covered service** | **Limitation** |
| **Orthodontia*<br>Covered at 100% after copays as listed under "Limitation**"** | |
| Orthodontic screening exam | $30 copay |
| Orthodontic diagnostic records | $150 copay |
| Comprehensive orthodontic treatment of adolescent or adult dentition | $1,845 copay |
| Orthodontic retention | $275 copay |

* See **DMO Orthodontia Limits** on page 13 for exclusions. In the case of Special Enrollees, benefits will generally not be paid for an orthodontic procedure for which an active appliance was installed within the first 24 months starting with the effective date of coverage (this may be limited to only 12 months in certain locations).
** This may be required to be paid as a lump-sum $2,300 copay in certain locations.

In addition to the services in the chart above, further dental services are covered for a person who is pregnant or has coronary artery disease/cardiovascular disease or diabetes. For covered participants with those conditions, the following services are covered at 100% of the negotiated charge and are subject only to the limitations shown below:

- one additional prophylaxis (cleaning) per year (in addition to the two per year shown in the chart above — benefit is payable the same as any other prophylaxis under the DMO);
- scaling and root planing (4 or more teeth), per quadrant;
- scaling and root planing (limited to 1 – 3 teeth), per quadrant;
- full mouth debridement;
- periodontal maintenance (one additional treatment per year in addition to the two per year shown in the chart above); and
- localized delivery of antimicrobial agents.

## WHAT IS NOT COVERED UNDER THE PLAN

Not every service or supply is covered by the Plan, even if prescribed, recommended or approved by your dentist or if it is the only available treatment for your condition. The Plan covers only those services and supplies that are medically necessary and included under **What Is Covered Under the Plan** beginning on page 17. Charges made for the following are not covered except to the extent listed.

The Plan will not pay benefits for any of the services, treatments, items or supplies described in this section as determined by the Claims Administrator in its sole discretion. This list of benefit exclusions is not all-inclusive. If you have a question on a specific expense, contact the Claims Administrator.

- Acupuncture therapy is generally excluded, except where specifically provided for under the Plan. Not excluded is acupuncture performed by a physician as a form of anesthesia in connection with a covered surgery when a medical provider indicates that other sedation methods would be adverse to the patient.
- Any charges in excess of the benefit limits as stated under **What Is Covered Under the Plan** beginning on page 17 or in excess of any applicable annual or lifetime maximums under the Plan.
- Any dental services and supplies which are covered wholly or partially under any other group benefits plan provided by Tesoro Corporation.
- Any of the following services:
  - an appliance, or modification of one, if an impression for it was made before you became covered under the Plan;
  - a crown, bridge, or cast or processed restoration, if a tooth was prepared for it before you became covered under the Plan;
  - root canal therapy, if the pulp chamber for it was opened before you became covered under the Plan.
- Charges that:
  - are for a service or supply furnished by a network provider in excess of the provider's negotiated charge for that service or supply. This exclusion will not apply to any service or supply for which a benefit is provided under Medicare before benefits under the Plan are paid;
  - are for a service or supply furnished by an out-of-network provider in excess of the reasonable and customary charge (applies to the Dental PPO only — does not apply to the DMO since out-of-network benefits are not payable under that option);
  - are for services not rendered, or that are rendered to a person not eligible for coverage under the Plan;
  - are made only because you have dental coverage (to the extent this exclusion is permitted by law);
  - are in excess of reasonable and customary charges, as determined by Aetna; or
  - you are not legally obliged to pay.
- Crowns, pontics, cast or processed restorations made with high noble metals, except as specifically provided for under the Plan. Generally, crowns and cast and processed restorations are excluded unless:
  - they are treatment for decay or traumatic injury and teeth cannot be restored with a filling material; or
  - the tooth is an abutment to a covered partial denture or fixed bridge.
- Dentures, crowns, inlays, onlays, bridgework or other appliances or services used for the purpose of splinting (stabilization or immobilization of periodontally involved teeth), to alter vertical dimension (the degree of jaw separation when the teeth are in contact), to restore occlusion (the contact relationship of the teeth in the upper and lower jaw), or correcting attrition, abrasion or erosion (grinding or wearing away of teeth by mechanical or chemical means).
- Experimental or investigational services or supplies are generally excluded, as determined by Aetna. A drug, device, procedure or treatment will be considered experimental or investigational if:
  - there are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or if required by the FDA, approval has not been granted for marketing; or a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; or

  - the written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental, investigational, or for research purposes.

- **For the DMO only**: Services and supplies provided by an out-of-network provider, except if provided as emergency dental care or if previously approved by Aetna because covered services or supplies are not available from any network dental providers in your area.
- General anesthesia and intravenous sedation, unless given in conjunction with another necessary covered service.
- More than two quadrants of scaling or root planing in a single office visit, unless necessary due to the need for pre-medication, significant travel distance or patient management difficulty (applies to the DMO only).
- Orthodontic treatment, except as specifically provided for under the Plan.
- Plastic surgery, reconstructive surgery, cosmetic surgery or other services and supplies which improve, alter or enhance appearance, whether or not for psychological or emotional reasons, except to the extent needed to repair an injury or for dental services and supplies provided in connection to a congenital defect. If needed to repair an injury, surgery must be performed in the calendar year of the accident which causes the injury, or in the next calendar year. **Note that facings on molar crowns and pontics are always considered cosmetic and are not covered.**
- Replacement of a lost, missing or stolen appliance, and replacement of appliances that have been damaged due to abuse, misuse or neglect.
- Replacement of a prosthetic that is dependent on severely compromised abutment teeth (applies to the DMO only).
- Services given to a person age five or older if that person becomes covered under the Plan other than:
  - during the first 31 days he or she is eligible for coverage; or
  - due to an exception as described in the **Special Enrollment** section on page 6; or
  - during the annual open enrollment period.

  This does not apply to charges incurred:
  - after the end of the twelve-month period starting on the date the person became covered under the Plan; or
  - as a result of accidental injuries sustained while the person was covered under the Plan; or
  - for Type A – Diagnostic and preventive care services.
- Services intended for treatment of any jaw joint disorder, except as specifically provided for under the Plan.
- Services or supplies:
  - for care or treatment that is not prescribed, recommended or approved by your attending dentist (or your PCD under the DMO);
  - for treatment where there is no evidence of pathology, dysfunction or disease (including routine dental exams) other than covered preventive services and supplies that are specifically listed as covered under the Plan;
  - furnished, paid for or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government (to the extent allowed by law);
  - furnished, paid for or for which benefits are provided or required under any law of a government — to the extent allowed by law. (This exclusion will not apply to “no fault” auto insurance if it is required by law, provided on other than a group basis, or to a plan established by government for its own employees or their dependents or to Medicaid.);
  - needed solely in connection with non-covered services;
  - not listed as specifically covered under this SPD;
  - not medically necessary, as determined by Aetna, for the diagnosis, care, or treatment of the disease or injury involved. This applies even if they are prescribed, recommended or approved by your attending physician or dentist (or PCD under the DMO);
  - provided in connection with treatment or care that is not covered under the Plan;

- that will inadequately treat your condition or where diagnostic information does not support the proposed treatment; or
- to diagnose or treat an occupational illness or occupational injury or any disease or injury related to employment or self-employment.

- Space maintainers, except when needed to preserve space resulting from the premature loss of deciduous teeth.
- Surgical removal of impacted wisdom teeth only for orthodontic reasons, except as specifically provided for under the Plan.
- Treatment by a resident physician or intern rendered in that capacity.
- Treatment by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be done by a licensed dental hygienist. In this case, the treatment must be given under the supervision and guidance of a dentist.

## Replacement Rule

The replacement of, addition to or modification of existing dentures, crowns, cast or processed restorations, removable bridges or fixed bridgework is covered only if one of the following is met:

- The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed. In addition, you must have been covered under the Plan when the extraction took place.
- The existing denture, crown, cast or processed restoration, removable bridge or bridgework cannot be made serviceable, and was installed at least **eight years** before its replacement under the Dental PPO or at least **five years** before its replacement under the DMO.
- The existing denture is an immediate temporary one to replace one or more natural teeth that were extracted while you were covered under the Plan, and cannot be made permanent. Replacement by a permanent denture is required and must take place within 12 months from the date of initial installation of the immediate temporary denture.

The extraction of a third molar does not qualify. Any such appliance or fixed bridge must include replacement of an extracted tooth or teeth.

### *Tooth Missing But Not Replaced Rule*

**Note: This rule applies under the Dental PPO and may apply under the DMO in some locations.**

For teeth other than congenitally missing teeth, coverage for the first installation of removable dentures, fixed bridgework and other prosthetic services must:

- be needed to replace one or more natural teeth that were removed while you were covered under the Plan; and
- not be abutments to a partial denture, removable bridge or fixed bridge installed during the prior eight years.

For congenitally missing teeth, only the second requirement above applies.

## Benefits for Treatment in Progress After Termination of Coverage

Dental services provided after termination of coverage are not paid by the Plan. However, if your Plan coverage terminates and you are not “totally disabled” as defined by the Plan, then any ordered inlays, onlays, crowns, removable bridges, cast or processed restorations, dentures, fixed bridgework and root canals will be covered if the work was started prior to — and completed within 30 days after — your Plan coverage terminates.

“Ordered” means that, prior to the date that Plan coverage ends:

- In the case of a denture, impressions have been taken from which the denture will be prepared.
- In the case of a root canal, the pulp chamber was opened.
- In the case of any other item listed above, the teeth which will serve as retainers or support, or which are being restored, have been fully prepared to receive the item, and impressions have been taken from which the item will be prepared.

# HOW TO FILE A CLAIM FOR BENEFITS

**Dental claim forms are available from the Tesoro Benefits Center (see Contacts on page 61) or through HR Connect.**

## Dental PPO Claims

| | |
|---|---|
| **If You Use a Network Provider**<br>Your provider files the claim on your behalf. | When you receive services from a network provider, the provider will file claims on your behalf and will be paid directly by the Plan for your covered dental expenses. However, you are responsible for paying the network provider:<br>• **any amount still required to meet your annual deductible(s), if applicable; and/or**<br>• **your coinsurance.**<br>The network provider may require you to pay the amount you owe at the time of service, or you may be billed for services. Contact Aetna if you receive a bill for any amount in excess of your annual deductible (if this has been met) and/or coinsurance amounts. |
| **If You Use an Out-of-Network Provider**<br>Your provider MAY file the claim. However, you are responsible for making sure this happens. | When you receive dental services from an out-of-network provider, you are usually responsible for filing a claim with the Claims Administrator.<br>If you provide written authorization for direct payment to an out-of-network provider, all or a portion of any eligible expenses may be paid directly to the provider instead of being paid to you.<br>**Even if an out-of-network provider submits a claim on your behalf, it is still your responsibility to ensure that the claim is submitted in a timely fashion.** |

**You should submit a claim within 90 days after the date of service. If you are unable to meet this deadline through no fault of your own, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims will not be accepted if they are filed more than 12 months after the expiration of the 90-day deadline.**

## Filing Your Dental PPO Claim

Be sure to read the instructions on the claim form carefully and complete all information completely and accurately. If you submit an incomplete or inaccurate form, processing of the claim will be delayed while the necessary information is obtained. You must sign any release form required in order for benefits to be paid.

When submitting a dental claim form, attach all itemized bills for dental expenses. Keep complete records of your expenses, specifically:

- the name of the provider who furnished the services;
- dates expenses are incurred; and
- copies of all bills and receipts.

If your claim is denied in whole or in part, you will receive a written notice of the denial from Aetna. The notice will explain the reasons for the denial and the appeal procedures.

## Where to Send Dental PPO Claims

Claims for Dental PPO benefits should be sent to:

**Aetna Dental**
**P.O. Box 14094**
**Lexington, KY 40512-4094**

## Payment of Claims

**You can review your benefit claims by logging onto www.aetna.com. If you have any questions about your claims for dental benefits, call Aetna Member Services at (877) 238-6200.**

Regardless of who receives the benefits under the Plan (you or your dependents), payment of the claim will be made directly to you — the employee — except under these circumstances:

- payment will be made directly to the provider for network services;
- payment may be made to an out-of-network provider if the provider notifies the Claims Administrator that your signature is on file assigning benefits directly to that provider; or
- payment for a Plan benefit of up to $1,000 may be made to any of your relatives whom the Plan believes is fairly entitled to the payment. For example, if the benefit is payable to you and you are a minor or are not able to give a valid release — or if a benefit is payable to your estate.

After your claim has been processed, you will receive an Explanation of Benefits (EOB) statement. The EOB includes the following information:

- all charges that were submitted;
- what benefits were covered under the Plan;
- the amount paid to the provider and to you;
- an explanation of how the benefit amounts were determined; and
- the amount you are responsible for paying.

## ASSIGNMENT OF BENEFITS

Benefits payable under the Dental Plan may not be assigned, other than to a service provider or to the Company, without the written consent of Aetna.

### *Types of Claims and Timeframes*

You may file claims for Plan benefits and appeal adverse claim decisions, either yourself or through an "authorized representative." An authorized representative is a person you authorize, in writing, to act on your behalf, which could include a court order giving a person authority to submit claims on your behalf. Depending on the type of claim, different rules may apply. The following are types of claims under the Plan:

- post-service claims;
- pre-service claims; and
- urgent care claims.

**Post-Service Claims**

Post-service claims are claims filed for payment of benefits after dental care has been received. Most claims are post-service claims. Within 30 days following receipt of a post-service claim, the Claims Administrator will either:

- pay all benefits payable;
- deny the claim in whole or in part; or
- request additional information.

If additional information is needed to process the claim, the Claims Administrator will notify you within 30 days of receipt, and you will have no less than 45 days to provide the requested information. You will be notified of a determination no later than 15 days after the earlier of:

- the Claims Administrator's receipt of the requested information, or
- the end of the 45-day period within which you were to provide the additional information, if the information is not received within that time.

**Pre-Service Claims**

Pre-service claims are claims that require advance approval of a service, supply or procedure before a benefit will be payable. You will be notified of the decision by the Claims Administrator within 15 days of receipt of the claim.

If additional information is needed to process the claim, the Claims Administrator will notify you within 15 days of receipt, and you will have no less than 45 days to provide the requested information. You will be notified of a determination no later than 15 days after the earlier of:

- the Claims Administrator's receipt of the requested information, or
- the end of the 45-day period within which you were to provide the additional information, if the information is not received within that time.

**Urgent Care Claims**

Urgent care claims are claims for dental care or treatment, where a delay in treatment could:

- jeopardize your life;
- jeopardize your ability to regain maximum function; or
- cause you to suffer severe pain that cannot be adequately managed without the care.

**For an urgent care claim, a health care professional with knowledge of your condition may always act as your authorized representative. In the case of an urgent care claim, you or your dentist should call the Claims Administrator as soon as possible. The claim does not need to be submitted in writing.**

You will be notified of the decision, whether adverse or not, as soon as possible but no more than 72 hours after an urgent care claim is received by the Claims Administrator.

If additional information is needed to process the claim, the Claims Administrator will notify you within 24 hours of receipt, and you will have no less than 48 hours to provide the requested information. You will be notified of a determination no later than 48 hours after the earlier of:

- the Claims Administrator's receipt of the requested information; or
- the end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

## Ongoing Course of Treatment

If you had been previously approved for an ongoing course of treatment, and the Claims Administrator decides to reduce or terminate that treatment, you will be notified in enough time for you to appeal that decision before the termination or reduction takes effect.

## If a Claim for Benefits Is Denied

### *Appealing a Denied Claim*

Whenever a claim is denied, you, your beneficiary(ies) or an authorized representative have the right to appeal the decision. If you have a question or concern about a benefit determination, you should call Aetna Member Services before requesting a formal appeal. If you still wish to submit a formal appeal, you can submit a written appeal to the Claims Administrator (see **Additional Information** on page 54 for the phone number and address of the Claims Administrator).

### *Filing an Appeal*

There are two levels of appeal. The first level appeal and second level appeal are both submitted to the Claims Administrator.

If the appeal relates to a claim for payment, your written first level appeal to the Claims Administrator should include:

- the group name (employer name);
- your name (and the patient's name if not you);
- the date(s) of service(s);
- the provider's name;
- a copy of the adverse benefit determination;
- the reason you believe the claim should be paid; and
- any documentation or other written information to support your request for claim payment.

Upon request and free of charge, you have the right to reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits.

**Your first level of appeal must be submitted to the Claims Administrator within 180 days after you receive the claim denial. If an appeal is not made within the 180-day period, the denial will be considered final, conclusive and binding.**

### IMMEDIATE ACTION — URGENT CARE CLAIM APPEALS

Your initial claim for benefits may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

- **the appeal does not need to be submitted in writing;**
- **you or your dentist should call the Claims Administrator as soon as possible; and**
- **the Claims Administrator will provide you with a determination within 36 hours after receipt of your appeal.**

You or your authorized representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your authorized representative and the Plan by telephone, fax or other similar method.

To make a determination on your appeal, the Claims Administrator:

- will appoint a qualified individual to resolve or recommend the resolution of the appeal. This individual will not have been involved in the decision being appealed;
- may consult with a health care professional who was not involved in the initial determination with appropriate expertise in the field (if the appeal is related to clinical matters); and
- may consult with, or seek the participation of, dental experts as part of the appeal resolution process.

By requesting an appeal, you consent to this referral and the sharing of pertinent dental claim information.

**Determinations for Appeals**

For appeals of pre-service claims, post-service claims and urgent care claims, the Claims Administrator will conduct the first level of appeal and provide you written or electronic notification of the decision:

- within 15 days from receipt of a request for appeal of a denied pre-service claim;
- within 30 days from receipt of a request for appeal of a denied post-service claim; and
- within 36 hours after receipt of your appeal of a denied urgent care claim.

**Second Level Appeals**

If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from the Claims Administrator.

**Your second level appeal request must be submitted to the Claims Administrator within 60 days from receipt of the first level appeal decision. If you do not appeal the denial within the 60-day period, the denial will be considered final, conclusive and binding.**

The written request to the Claims Administrator must state the reasons why you believe the claim was improperly denied and submit any written comments, documents, records or other information you deem appropriate.

The Claims Administrator will provide written notification of the decision:

- within 15 days from receipt of your second and final written appeal for a pre-service claim;
- within 30 days from receipt of your second and final appeal of a post-service claim; and
- within 36 hours after receipt of your second and final appeal of a denied urgent care claim.

**Exhaustion of Appeals Process**

You must exhaust the first level and second level appeals process before you pursue other action. If you receive a final denial of your second level appeal from the Claims Administrator, you may:

- contact the Department of Insurance to request an investigation of a complaint or appeal;
- file a complaint or appeal with the Department of Insurance; or
- pursue litigation, arbitration or administrative proceedings.

You may not pursue your claim in state or federal court until you have first exhausted the claims and appeals procedures to the Claims Administrator. No legal action may be brought after three years from the date participation in the Plan ends or the date the claim is denied following exhaustion of the appeals procedures outlined above.

**DMO Plan Claims**

When you receive services from a network provider, the provider will file claims on your behalf and the provider will be paid directly by Aetna for your covered dental expenses. However, you are responsible for paying the network provider any applicable coinsurance or copays.

The network provider may require you to pay the amount you owe at the time of service, or you may be billed for services. Contact Aetna if you receive a bill for any amount in excess of your coinsurance amounts.

If you receive care from an out-of-network provider in a dental emergency, you must submit a claim for reimbursement. Be sure to read the instructions on the claim form carefully and complete all information completely and accurately. When submitting a dental claim form, attach all itemized bills for dental expenses. Keep complete records of your expenses, specifically:

- the name of the provider who furnished the services;
- dates expenses are incurred; and
- copies of all bills and receipts.

**The deadline for filing a claim is 90 days after the date of service**. If you are unable to meet this deadline through no fault of your own, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims will not be accepted if they are filed more than one year after the expiration of the 90-day deadline.

You may not assign benefits without the written consent of Aetna. All benefits are payable to you. However, Aetna has the right to pay any benefits directly to the provider providing services unless you specify otherwise before or when you file a claim. When you make a claim for out-of-network emergency care, within 15 days after receipt of the claim, Aetna will:

- acknowledge receipt of the claim;
- begin investigation of the claim; and
- request any additional information from you or the provider that Aetna deems necessary.

No later than 15 business days after Aetna receives all necessary information, Aetna will:

- notify you of acceptance or rejection of the claim; or
- notify you if additional time is needed.

**If your claim for benefits is accepted, Aetna will make the payment within five days after you receive notice of its acceptance. In no case will Aetna take longer than 45 days (after it receives all necessary documentation) to either pay or reject the claim.**

***Submitting Complaints***

**You are encouraged to contact Aetna Member Services if you have any questions or concerns related to your DMO benefits. Many issues can be resolved by phone before submitting a written complaint.**

A complaint is any dissatisfaction, expressed by you orally or in writing, to Aetna about any aspect of the DMO Plan's operation, including:

- plan administration;
- appeal of an adverse benefit determination;
- denial, reduction or termination of a service;
- the way a service is provided; or
- disenrollment decisions.

A complaint is not a misunderstanding or misinformation that is resolved promptly to your satisfaction.

**Initial Oral/Written Complaint**

All initial oral or written complaints will receive an acknowledgment letter within five business days of receipt of the complaint which includes an acknowledgement of the date of receipt of the complaint and a description of Aetna's complaint procedures and timeframes. If the complaint is received orally, Aetna shall also enclose a one-page complaint form. **The one-page complaint form does prominently and clearly state that the complaint form must be returned to Aetna for prompt resolution of the complaint**.

Aetna will investigate each oral and written complaint received in accordance with its policies and in compliance with state mandates. The total time for acknowledgment, investigation and resolution of the complaint by Aetna will not exceed 30 calendar days after the date that Aetna receives the written complaint or one-page complaint form.

**Resolution and Response Obligation**
All response letters from Aetna will include:

- date of receipt of an oral or written request for appeal;
- a statement of the specific medical/dental and contractual reasons for the resolution;
- the specialization of any dentist or other provider consulted;
- a full description of the process for appeal, including the timeframes for the appeals process and the timeframes for the final decision on the appeal;
- Texas Department of Insurance complaint address:

  **Texas Department of Insurance**

  **P.O. Box 149091**

  **Austin, TX 78714-9091**; and
- Texas Department of Insurance toll-free telephone number: (800) 252-3439.

**Non-Expedited Appeals Process**
If the complaint is not resolved to your satisfaction, Aetna will provide for either an expedited or non-expedited appeals process.

Under the non-expedited appeals process, you have the right either to appear in person before an Aetna complaint appeal panel where you normally receive dental care services (unless another site is agreed to by you) or to address a written appeal to the complaint appeal panel. All appeals will receive an acknowledgment letter within five business days of receipt of the appeal. Aetna shall complete the non-expedited appeals process no later than the 30th calendar day after the date of the receipt of the request for appeal.

You or your designated representative (if you are a minor or disabled) are entitled to:

- appear in person before the complaint appeal panel;
- present alternative expert testimony; and
- request the presence of, and question, any person responsible for making the prior determination that resulted in the appeal.

Aetna shall appoint members to the complaint appeal panel, which will advise Aetna on the resolution of the dispute. The complaint appeal panel will be composed of equal numbers of Aetna staff, dentists or other providers, and enrollees. In addition:

- a member of the complaint appeal panel may not have been previously involved in the disputed decision;
- the dentists or other providers must have experience in the area of care that is in dispute;
- if specialty care is involved in the complaint, the appeal panel must include an additional person who is a specialist in the field of care to which the appeal relates; and
- the enrollees may not be employees of Aetna Dental Inc.

No later than the fifth business day before the scheduled meeting of the panel, unless you agree otherwise, Aetna will provide to you or your designated representative:

- any documentation to be presented to the panel by Aetna staff;
- the specialization of any dentists or providers consulted during the investigation; and
- the name and affiliation of all Aetna representatives on the panel.

You may respond to the documentation in person or in writing. The response must be considered in panel deliberations if received prior to or during the hearing. A record of the proceeding will be kept for three years. You will be given a copy within 30 days of your request.

The final response letter from the appeal panel will include:

- date of receipt of the oral or written request for appeal;
- the contractual criteria used to reach a final resolution;
- the specialization of any dentist or other provider consulted;
- Texas Department of Insurance complaint address:

  **Texas Department of Insurance**

  **P.O. Box 149091**

  **Austin, TX 78714-9091**; and
- Texas Department of Insurance toll-free telephone number: (800) 252-3439.

**Expedited Appeals Process**
Under the expedited appeals process, investigation and resolution of appeals relating to ongoing emergencies will be concluded in accordance with the medical/dental immediacy of the case — but in no event later than one business day after your request for appeal. Due to the ongoing emergency, and at your request, Aetna will provide — in lieu of a complaint appeal panel — a review by a dental provider who has not previously reviewed the case. The dental provider will be of the same or similar specialty as typically manages the dental condition, procedure or treatment under discussion for review of the appeal.

The dental provider reviewing the appeal may interview the patient or the patient's designated representative and shall render a decision on the appeal. Initial notice of the decision may be delivered orally, followed by written notice of the determination within three days. Investigation and resolution of appeals after emergency care has already been provided shall be conducted in accordance with the process established under this section, including the right to a review by an appeal panel.

**The appeal procedures described above do not prohibit you from pursuing other appropriate remedies available under law, if you believe that the requirement of completing the appeal and review process places your health or your dependent's health in serious jeopardy.**

**Record Retention**
Aetna will maintain a record of each complaint, any complaint proceedings and any actions taken on a complaint for three years from the date of the receipt of the complaint. You are entitled to a copy of the record of your complaints and proceedings.

## COORDINATION OF BENEFITS (COB)

Coordination of benefits (COB) applies when you or your covered dependents have health care coverage under more than one benefit plan. In these situations, it's necessary to determine which plan has primary responsibility for the payment of benefits.

### When COB Is Applicable

The COB provision applies to this Plan when you or your covered dependent has health coverage under more than one plan. If you or a covered dependent are covered under more than one plan and you incur an expense that is covered — partially or in full — under this Plan and at least one other plan:

- benefits related to that expense will be paid under the Primary and Secondary Plans as determined under the COB provisions; and
- under no circumstances will the sum of the benefits paid from each plan exceed the actual expense incurred.

**Some plans may provide benefits in the form of services rather than cash payments. If this is the case, the cash value will be used to determine payment of benefits under the Plan.**

## How COB Works

The order of benefit determination rules determine which plan will pay as the Primary Plan. When an individual is covered under more than one group health plan:

- one plan is determined to be the Primary Plan and the others are considered Secondary Plans;
- the Primary Plan pays or provides its benefits first as if the Secondary Plan(s) did not exist;
- when this Plan is secondary, it pays after the Primary Plan and may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense. A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan; and
- when this Plan is secondary, it will credit to its Plan deductible any amounts that would have been credited in the absence of other coverage. In determining the amount to be paid when this Plan is secondary, this Plan will calculate the benefits that it would have paid on the claim in the absence of other health plan(s) and apply that amount to any allowable expense under this Plan that was unpaid by the Primary Plan.

This Plan will not pay more than it would have paid without the COB provision. In order to pay claims, the Claims Administrator must determine the Primary Plan and the Secondary Plan(s).

### *Determination of Primary and Secondary Plans*

The first of the following rules that describes which plan pays its benefits first will be the rule that applies:

1. A plan that does not contain a coordination of benefits provision that is consistent with this provision is always the Primary Plan.
2. **Non-Dependent or Dependent.** The plan that covers the person other than as a dependent — for example as an employee, member or subscriber — is primary, and the plan that covers the person as a dependent is secondary.
   - However, if the person is a Medicare beneficiary, and by federal law Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person other than as a dependent, then the order of benefits is reversed, so that the plan covering the person as an employee, member or subscriber is secondary and the other plan is primary
3. **Child Covered Under More than One Plan.** The order of benefits is:

   A. The Primary Plan is the plan of the parent whose birthday (month and day of birth) is earlier in the year, and the Secondary Plan is the plan of the parent whose birthday is later in the year. If both parents have the same birthday, the plan that has covered a parent longer is primary.

   B. If the other plan does not have the “birthday rule” but instead has a rule based on the gender of the parent so the plans do not agree on the order of benefits, the gender rule of the other plan will apply.

   C. If the parents are divorced or separated and the terms of a court order state that the parents shall share joint custody of a child, without stating that one of the parents is responsible for health care coverage, the order of benefits is determined based on the birthday rule or gender rule above.

   C. If the parents are divorced or separated and the terms of a court order state that one parent is responsible for health care coverage, the plan which covers the child as a dependent of that parent will be primary and any other plan that covers the child will be secondary. If the parent with responsibility has no health care coverage for the dependent but that parent’s spouse does, the plan of the parent’s spouse is primary.

   E. If the parents are divorced or separated and there is no court order assigning responsibility for health care coverage, the order of benefits is:
      i. The plan of the custodial parent;
      ii. The plan of the spouse of the custodial parent;
      iii. The plan of the noncustodial parent; and then
      iv. The plan of the spouse of the noncustodial parent.

   Note: For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits should be determined as shown above as if the individuals were the parents.

4. **Active Employee or Retired or Laid Off Employee.** The plan that covers a person as an active employee (neither laid off nor retired) or as a dependent of an active employee is the Primary Plan. The plan covering the same person as a retired or laid off employee or as a dependent of a retired or laid off employee is the Secondary Plan. If the other plan does not have this rule, so the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the "Non-Dependent or Dependent rules" above determine the order of benefits.

5. **Continuation Coverage**. If a person whose coverage is based on continuation rights under federal or state law is also covered under another plan, the plan covering the person as an employee, member or subscriber (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, so the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the "Non-Dependent or Dependent rules" above determine the order of benefits.

6. **Longer or Shorter Length of Coverage**. The plan that has covered the person as an employee, member or subscriber longer is primary.

7. If the preceding rules do not determine the Primary Plan, allowable expenses (necessary and reasonable expenses covered at least in part by any of the plans covering the person) will be shared equally between the plans. However, this Plan will not pay more than it would have paid had it been primary.

**If your spouse is covered under the Plan but is also covered under another group plan, your spouse's group plan will always be the Primary Plan for your spouse.**

**If a person is covered under the Dental PPO both as an employee and a dependent, or as a dependent of two employees, each instance of coverage will be treated as a separate plan for purposes of calculating benefits under the multiple coverages.**

In order to avoid delays in claims processing, your claims should be submitted to the Primary Plan as soon as possible. When you file a claim, you will have to give information about any other plans under which you are covered.

- To facilitate COB processing when you or your dependents have other insurance, you should notify member services by phone or provide this information on Aetna Navigator under "Coverage & Benefits," then "Your Other Health Plans."
- If this Plan is the Secondary Plan, you or your provider should submit a copy of the Explanation of Benefits (EOB) from the Primary Plan, along with an itemized statement of expenses and a claim form, if necessary, for benefits consideration.
- For non-Medicare claims, this Plan will consider benefit payments you receive from the Primary Plan. The Plan makes up the difference up to the maximum amount the Plan would have paid if there were no other dental coverage.

The Claims Administrator has the right to release or obtain any information and make or recover any payment it considers necessary in order to administer the COB provisions. When COB reduces the total amount of benefits otherwise payable under this Plan during a calendar year, each benefit that would be payable in the absence of COB will be reduced proportionately. Such reduced amount will be charged against any applicable benefit limit of the Plan.

A payment made under another program may include an amount for a benefit that should have been provided under the Plan. If it does, Aetna may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit provided under the Plan, and the Plan will have no further liability with respect to that amount. The term "payment made" includes providing benefits in the form of services. In that case, the payment made will be deemed to be the reasonable cash value of any benefits provided in the form of services.

## How DMO or HMO Coverage Works With COB Under the Dental PPO Plan

If you have chosen dental coverage under the DMO (or you have medical coverage under an HMO that includes dental benefits), you and your eligible dependents will be excluded from coverage under the Dental PPO on the date your coverage begins under the DMO or HMO. If you are covered under the DMO or an HMO providing dental coverage, you can choose to change to coverage for yourself and your eligible dependents under the Dental PPO, as follows:

- If you live in a DMO/HMO Plan enrollment area and choose to change dental coverage during an open enrollment period, coverage will take effect on the first day of the contract period which follows the open enrollment period. There will be no rules for waiting periods or preexisting conditions.
- If you live in a DMO/HMO Plan enrollment area and choose to change coverage other than during an open enrollment period, coverage will take effect only if and when Aetna and the Company give their written consent.
- If you move from a DMO/HMO Plan enrollment area or if the DMO/HMO discontinues and you choose to change coverage within 31 days of the move or the discontinuance, coverage under the Dental PPO will take effect on the date your DMO/HMO Plan coverage ended. There will be no restrictions for waiting periods or preexisting conditions. If you choose to change coverage after 31 days, coverage will take effect only if and when Aetna and the Company give their written consent.

No benefits under the Dental PPO will be paid for any charges for services rendered or supplies furnished under a DMO/HMO Plan.

## Rights of Recovery

### *Overpayment of Benefits*

If the Plan pays benefits, the Plan has the right to recover the overpayment if either of the following apply:

- all or some of the expenses were not paid by the covered person or did not legally have to be paid by the covered person; or
- all or some of the payment exceeded the benefits under the Plan.

The covered person, another person or the organization that received the overpayment must make a refund to the Plan

**If the covered person, or any other person or organization that was paid, does not promptly refund the full amount, the amount of any future benefit payments may be reduced.**

The refund equals the amount paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, the covered person agrees to help get the refund when requested.

### *Subrogation and Reimbursement*

Under certain circumstances, the Plan will be entitled to recover, through either or both of its rights to reimbursement or subrogation, the cost of certain benefits previously provided to a covered individual as a result of an illness, injury or condition for which a Third Party is or may be held legally responsible. This section (Subrogation and Reimbursement) explains the circumstances under which the Plan will have these rights to recovery and your obligations under such circumstances. Please note that your failure to comply with the requirements of this section may result in a loss of coverage under the Plan.

There are important terms used throughout this section, the definitions of which are provided below:
"Reimbursement" refers to the repayment by you of dental expenses previously paid by the Plan for an illness, injury or condition for which a Third Party is or may be held legally responsible.

- "Subrogation" refers to the substitution of you by the Plan with respect to a claim related to an illness, injury or condition of the covered individual for which a Third Party is or may be held legally responsible.
- "Third party" means any person other than the Plan, including, but not limited to, any one or more of the following: (i) the party or parties who caused the illness, injury, or condition, (ii) the insurer, guarantor, or other indemnifier of the party or parties who caused the illness, injury, or condition, (iii) the covered individual's own insurer (for example, uninsured, underinsured, and no fault coverage), (iv) a worker's compensation insurer, and/or (v) any other person, entity, policy, health care plan or insurer that is liable or legally responsible for the illness, injury, or condition.
- "You" or "your" refer to any individual covered under the Plan, as well as any person or entity (including but not limited to the estate or legal representative of a covered individual) that has or may recover a claim for benefits on behalf of a covered individual.

**General**: If you receive payment or reimbursement of dental expenses from the Plan, or you submit a claim to the Plan for payment or reimbursement of such expenses, which relate to the treatment of an illness, injury, or condition for which a Third Party is or may be held liable or legally responsible (for example, when the Plan pays claims for the treatment of an illness, injury or condition caused by an automobile accident or another person's negligence), the payment, reimbursement, or claim, as applicable, will be subject to the Plan's rights of reimbursement and subrogation as further described in this section.

**Notice to Plan**: You are required to notify the Plan of any payment, reimbursement or claim for dental expenses under the Plan that relates to the treatment of an illness, injury or condition for which a Third Party is or may be held liable or legally responsible. Such notice must be provided within 30 days of the date when notice is provided to you (or your representative, including your attorney or insurer) of an intent to pursue or investigate a claim against a Third Party to receive damages or obtain another recovery due to the injury, illness, or condition sustained by the covered individual. Such notice must be provided directly to the Plan Administrator (see **Additional Information** on page 54 for the Plan Administrator's address).

**Conditional Benefit Payments**: The payment by or on behalf of the Plan of any claim for dental benefits for which a Third Party is or may be held liable or legally responsible is conditioned and contingent upon actual repayment to the Plan in the event of a recovery from a Third Party.

**Lien**: The Plan will have a first priority lien against, and will be entitled to recovery of, the first dollars paid or payable to you or on your behalf by a Third Party. It is important to note that the Plan's lien applies regardless of how the claims, awards, recoveries or amounts paid or payable by or on behalf of a Third Party are classified or characterized by the parties, the courts or any other person or entity, including, for example, amounts paid to or for the benefit of the covered individual for general damages, and regardless of whether the covered individual is made whole for his or her losses and claim(s) for benefits following the Plan's recovery, and regardless of whether the Third Party is at fault or has had made an admission of fault, and regardless of whether such amounts are paid pursuant to settlement, judgment or otherwise. The lien may be enforced against any person who possesses funds or proceeds representing the amount of benefits paid by the Plan.

The amount of the Plan's lien will equal the lesser of the following amounts:

A. the amount of benefits paid or payable by the Plan for the illness, injury, or condition, plus
   I. the amount of all future benefits which may become payable under the Plan due to the illness, injury or condition,
   II. the costs and expenses incurred by the Plan in collecting such recovery from you and/or a Third Party, and
   III. to the extent described below, interest on such amounts, or
B. the amount recovered from the Third Party or parties.

Accordingly, the Plan will not seek recovery from you in excess of the amount payable to or on behalf of the covered individual from (i) any policy or contract from any insurance company or carrier (including, without limitation, the covered individual's insurer) and/or (ii) any Third Party, plan or fund.

**Constructive Trust**: All payments received by you from a Third Party with respect to which the Plan has subrogation or reimbursement rights hereunder are subject to a constructive trust for the benefit of the Plan.

**Reimbursement of Paid Expenses**: Upon recovery of any amounts from a Third Party, you are required to reimburse the Plan first from such recovery for the amount of benefits paid by the Plan, if any, for the illness, injury, or condition to which the recovery relates, plus the costs and expenses incurred by the Plan in collecting such recovery from you or the Third Party. If you fail to reimburse the Plan within 30 days of receipt of such recovery, the Plan may charge you interest on the amount you are required to reimburse the Plan in accordance with this provision. The rate of interest that may be recovered by the Plan will equal one and one-half percent (1½%) per month or the maximum amount permitted by applicable law, whichever is less, commencing on the date you recovered any such funds from a Third Party and ending on the date of reimbursement. All interest charged pursuant to this section will be added to the amount of the Plan's lien, as described above.

**Payment of Future Expenses**: Upon recovery of any amounts from a Third Party, future expenses incurred by the covered individual that relate to the same illness, injury or condition with respect to which you received such recovery will not thereafter be reimbursable from, or paid directly by, the Plan, unless otherwise provided in a separate written agreement signed by you and the Plan Administrator. Any funds paid or payable by a Third Party to or on behalf of the covered

individual for future dental claims relating to the same illness, injury or condition for which the Third Party is, or may be, held liable or legally responsible are required to be set aside in an escrow account for the benefit of the covered individual. All benefits paid by the Plan with respect to such illness, injury or condition will be added to the amount of the Plan's lien, as described above. As a result, the Plan will have the right to recover such amounts from the escrow account or directly from you.

**No Offset of Costs**: The Plan will not pay, offset any recovery, or in any way be responsible for any fees or costs associated with enforcing its reimbursement or subrogation rights under the Plan unless the Plan Administrator, in its sole and absolute discretion, agrees to do so in writing. All costs and fees incurred by the Plan to enforce its reimbursement and subrogation rights will be added to the amount of the Plan's lien, as described above.

**Subrogation of Rights Against Third Parties**: The Plan will be subrogated to and will succeed to all claims, demands, actions and rights of recovery (under all possible legal theories) that you may have against any Third Party with respect to any illness, injury, or condition for which such Third Party may be held liable or legally responsible. This means that the Plan may, at its option, take over your right to pursue or receive payments from a Third Party, provided that the Plan's recovery will not exceed the amount of the Plan's lien described above.

**Preservation of Rights**: The Plan Administrator may, in its sole and absolute discretion, take any action as it, in its sole and absolute discretion, determines necessary or appropriate to preserve the Plan's rights to reimbursement and/or subrogation (including but not limited to the right to bring suit for imposition of a constructive trust or an injunctive order, file suit directly against a Third Party, or intervene in an action against a Third Party).

**Cooperation and Assistance**: You are required to cooperate in protecting the Plan's rights to reimbursement and subrogation (including but not limited to providing notice of such claims to the Plan and holding recovered amounts in trust in satisfaction of the Plan's rights), and may not act (or fail to act) at any time or in any manner that prejudices the Plan's rights to reimbursement and/or subrogation (including but not limited to settling a claim with a Third Party without advance notice to and approval of the Plan Administrator). Accordingly, you are required to provide all information and sign and return all documents necessary for the Plan to exercise its rights to reimbursement and subrogation within five business days of a request by the Plan Administrator or its representative. The Plan is permitted to investigate the circumstances surrounding your injury, illness or condition and identify and notify any Third Party that is or may be responsible for such injury, illness or condition of the Plan's lien on amounts recovered by you.

**Written Agreements**: As a condition to the covered individual's continued participation under the Plan, you may be required to execute a written agreement acknowledging the Plan's rights of reimbursement and subrogation. Upon such request, and prior to the Plan's receipt of an executed agreement, any claim related to the illness, injury or condition that is the subject of the reimbursement or subrogation rights of the Plan will be pended and will not be processed or paid. Failure of the Plan Administrator to require the execution of a written agreement from you does not act as a waiver of the Plan's right to request a written agreement at any time or to pursue its rights to reimbursement and/or subrogation.

**Failure to Comply:** Your benefits under the Plan are conditioned on your compliance with the requirements related to the Plan's rights to reimbursement and subrogation. Accordingly, your failure to comply with your obligations under this section constitutes wrongdoing and results in the wrongful payment of benefits under the Plan to or on behalf of the covered individual. If you do not reimburse the Plan such amounts, the Plan may take any action the Plan Administrator deems appropriate, including but not limited to the following:

- reducing future dental benefits that would otherwise be payable for any illness, injury or condition of the covered individual, regardless of whether such illness, injury or condition is related to the Third Party claim with respect to which the Plan's reimbursement and subrogation rights relate, up to the amount of the Plan's lien, as described above;
- terminating dental coverage under the Plan for the covered individual and his or her family members; and/or
- instituting court proceedings against you to recover amounts up to the amount of the Plan's lien, as described above.

**Additional Information**: The Plan's rights to reimbursement and subrogation will not be reduced as a result of the covered individual's own negligence; or due to you not being made whole from the recovery from a Third Party; or as a result of attorney's fees and costs incurred in the recovery from you or the Third Party. Specifically, but without limitation, the "make whole" doctrine does not apply to the Plan and the Plan is not subject to any state law doctrines, including, but not

limited to, the common fund doctrine, which would purport to require the Plan to reduce its recovery by any portion of your attorney's fees and costs.

**Jurisdiction**: By accepting benefits under the Plan, you have agreed to allow the Plan to institute any court proceedings to enforce its subrogation and reimbursement rights in any court of competent jurisdiction selected by the Plan and waive any right to contest such jurisdiction, regardless of your present or future residence.

## IF YOU TAKE A LEAVE OF ABSENCE

Your Dental Plan coverage will continue, and contributions will be deducted from your paycheck, during any Company-approved absences with full or adequate partial pay.

Your coverage will also continue as long as you remain eligible for the Plan and you are on:

- Long-Term Disability — receiving benefits from a Company-sponsored Long-Term Disability program;
- Personal Leave of Absence — for up to six months for employer-certified leave;
- Family and Medical Leave under FMLA (Family and Medical Leave Act of 1993); or
- Military Leave under USERRA (Uniformed Services Employment and Reemployment Rights Act of 1994). See **Uniformed Services Employment and Reemployment Rights Act** on page 50 for more information.

Your coverage while on leave will be the same coverage that was in force on your last day of work as an active employee. However, any changes or reductions in benefits that apply to active employees after your leave begins will also apply to you.

**You are allowed to waive your coverage while on a USERRA leave of absence. If you wish to waive coverage, you must contact the Tesoro Benefits Center within 31 days of your leave start date**

**Payment of Contributions While on Leave**
If you are not receiving a paycheck, you must make the required contributions within a 30-day grace period in order to continue coverage. Contact the Tesoro Corporate Benefits Department to make payment arrangements.

If payments are not made within the 30-day grace period, coverage may be terminated once final written notice has been given with 15 work days to pay. If coverage is terminated during your leave due to non-payment of contributions:

- when you return to active employment, you will be eligible to enroll effective upon your return; and
- all previously owed contributions will be deducted from your paycheck.

If you do not return to work, reinstatement is not allowed.

In addition to terminating coverage due to non-payment of contributions, coverage may also be terminated:

- **the date you stop receiving a Long-Term Disability benefit;**
- **after six months on an employer-certified Personal Leave of Absence;**
- **the date you retire; or**
- **if you do not return to employment at the end of your FMLA or USERRA leave of absence.**

If you lose coverage under the Plan, you may be eligible for COBRA continuation coverage in certain situations (see **Continuation of Coverage Under COBRA** on page 46).

## WHEN COVERAGE ENDS

Unless you are eligible to continue coverage as explained under **Continuation of Coverage Under COBRA** on page 46, your coverage under the Plan will end if:

- you die;
- the Plan is discontinued;
- you waive coverage during the open enrollment period or due to a qualified status change;
- you no longer meet the eligibility requirements for coverage under the Plan (for example if you are a full-time employee and your regularly scheduled hours are reduced to less than 30 hours per week);
- you fail to make required contributions in a timely manner;
- you terminate employment or are laid off due to lack of work;
- your Company-sponsored Long-Term Disability benefits are discontinued; or
- you are on a Personal Leave of Absence and the leave extends beyond six months (you are only eligible for six months of continued dental coverage).

Unless your dependent is eligible to continue coverage as explained under **Continuation of Coverage Under COBRA** on page 46, coverage for your dependent(s) ends if:

- you fail to make required contributions for dependents' coverage;
- your own coverage ends for any of the reasons above; or
- your dependent no longer meets the eligibility requirements for coverage under the Plan.

If you are covering a domestic partner and/or your domestic partner's children under the Plan, they will no longer be considered eligible dependents and coverage will end on the earlier of:

- the date the Plan no longer provides for such coverage; or
- the date your domestic partnership ends. In that event, you must provide the Company with a signed Benefits Change Form.

Coverage for dependents may continue for a period after your death. In addition, coverage for handicapped dependents may continue after your dependent reaches the normal age limit for dependent children. For more information **see Other Coverage Continuation Options** on page 50.

### Special Termination Provision for DMO Coverage

In addition to the situations described above, your coverage under the DMO will end (after notice described below) if one of the following occurs:

- you or your dependent commits fraud in the use of services or facilities (coverage will be terminated after 31 days advance written notice);
- you or your dependent participates in misconduct detrimental to safe plan operations or delivery of services (no advance notice of termination is required); or
- you and your primary care dentist (PCD) — or your dependent and his/her PCD — are unable, after reasonable efforts, to establish and maintain a satisfactory patient-provider relationship, provided it is shown that:
  - Aetna has, in good faith, given you or your dependent the opportunity to select an alternative PCD; and
  - Aetna has given you 30 days advance written notice that it considers the provider-patient relationship unsatisfactory, Aetna has specified the changes necessary to avoid termination, and you or your dependent have failed to make those changes.

# CONTINUATION OF COVERAGE UNDER COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (known as "COBRA"), you and your eligible dependents that lose group health plan coverage may continue your coverage for a period of time. COBRA continuation rights are available if coverage is lost due to certain "qualifying events" (see **COBRA Qualifying Events** below). Your covered domestic partner and his or her covered children will be eligible for a continuation of benefit similar to COBRA if they lose coverage under the Plan due to a qualifying event.

COBRA continuation coverage with respect to the Plan is the same coverage that the Plan gives to other participants or dependents who are covered under the same option under the Plan and who are not receiving continuation coverage. Each person who elects COBRA continuation coverage will have the same rights under the Plan as other participants or dependents covered under the Plan, including special enrollment rights and the right to add or change coverage during the open enrollment period.

## COBRA Qualifying Events

### *Employees*

As an employee, you will be eligible for COBRA continuation coverage if you lose coverage due to:

- termination of employment, for reasons other than gross misconduct; or
- a reduction in hours of employment that results in loss of coverage.

### *Eligible Dependents*

Your covered dependents will be eligible for COBRA continuation coverage if they lose coverage due to:
your death;

- your termination of employment, for reasons other than gross misconduct;
- a reduction in your hours of employment that results in loss of coverage;
- your divorce or legal separation; or
- your dependent child no longer meeting the definition of a dependent child.

It is your or your covered dependent's responsibility to notify the Tesoro Benefits Center (see **Contacts** on page 61) within 60 days of a qualifying event if your covered spouse or dependent child(ren) lose coverage under this Plan due to:

- divorce or legal separation; or
- your dependent's loss of eligibility under the Plan.

**If you notify the Tesoro Benefits Center more than 60 days after the qualifying event, your covered dependents may not be entitled to elect COBRA continuation coverage. Please note that you must provide notification in writing within 31 days (not 60) to comply with the rules for changing your coverage level (see Changing Your Coverage on page 8).**

## Length of COBRA Coverage

COBRA is a temporary continuation of coverage. Depending on the qualifying event, coverage may be continued from the date coverage would otherwise end, as follows:

| COBRA Qualifying Event | Maximum Amount of Time Coverage May Continue Under COBRA | |
|---|---|---|
| | For You | For Your Covered Beneficiary |
| **You terminate employment (other than for gross misconduct)**<br>**OR**<br>**Your hours of employment are reduced, resulting in a loss of coverage** | 18 months (may be extended due to disability — see below) | 18 months (may be extended due to disability or for a second qualifying event — see below) |
| **You die** | N/A | 36 months |
| **You become entitled to Medicare** | N/A | 36 months (special rules apply) |
| **You divorce or legally separate** | N/A | 36 months |
| **Your child no longer meets the definition of a dependent child** | N/A | 36 months |

### *Extension of COBRA Coverage Due to Disability*

You and each of your covered dependents may be eligible to extend your 18-month COBRA period to a total of 29 months if you or your covered dependent(s) is determined to be disabled under Title II or Title XVI of the Social Security Act at any time during the first 60 days of continuation coverage.

- To receive the extension, you must provide notice of the disability determination to the Tesoro Benefits Center (see **Contacts** on page 61) within 60 days of the date of the Social Security Administration's determination and before the end of the initial 18-month continuation period.
- If you or your covered dependent(s) is later determined to not be disabled, you must notify the Tesoro Benefits Center within 30 days of the Social Security Administration's determination. If the date of the determination is after the original 18-month COBRA period, your COBRA benefits will cease effective the date of determination.

**If you and/or your covered dependent(s) are enrolled in COBRA continuation coverage and are determined to be disabled, contact the Tesoro Benefits Center to find out if you qualify for an extension of coverage.**

### *Extension of Continuation Coverage Due to a Second Qualifying Event*

If you are receiving COBRA continuation coverage as a result of your termination of employment or reduction in hours of employment, up to an 18-month extension of coverage may be available to your covered dependent(s) if a second qualifying event occurs during the first 18 months of COBRA coverage (or within the first 29 months in the case of a disability).

A second qualifying event includes:

- your death;
- your divorce or legal separation;
- your enrollment in Medicare; or
- your dependent child's eligibility for coverage ends.

**The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months from the date of the first qualifying event or, if applicable, the date on which you became entitled to Medicare.** You must provide written notification to the Tesoro Benefits Center within 60 days after the second qualifying event occurs (see **Contacts** on page 61).

## Enrolling in COBRA Coverage

Upon notification to the Company of a COBRA qualifying event, COBRA election notices are prepared and mailed to your home address. Your dental coverage is discontinued as of the date of the event until a completed COBRA enrollment form, along with your contribution payment, is received. You and/or your covered dependent(s) will have 60 days from the date coverage would be lost due to a qualifying event (or the date you are notified of your right to continue coverage, if later) to elect COBRA continuation coverage.

**You and each of your covered dependents may independently elect COBRA coverage.** You or your spouse, however, may elect COBRA coverage on behalf of all the covered children who are under age 18.

If you choose to waive coverage during the 60-day election period, you may revoke the waiver in writing at any time before the 60-day period ends, and you will be entitled to COBRA continuation coverage as long as you and/or your covered dependent(s) meet all of the other conditions for continuation of coverage and the required contributions are paid on a timely basis.

If you do not elect continuation coverage, your benefits will terminate in accordance with the terms of the Plan.

## Paying for COBRA Coverage

In order to continue your coverage under COBRA, you will be required to pay the **full** cost of coverage (your premium and the Company's contribution), plus a 2% COBRA administration fee. If you or your covered dependent(s) is receiving the additional 11 months of COBRA coverage because of disability (see **Extension of COBRA Coverage Due to Disability** at left), the cost for each of those additional 11 months is 150% of the full monthly cost.

- The first payment of premiums will be due within **45 days** of the date you elect to continue coverage.
- Premiums for coverage will be retroactive to the date you and/or your covered dependent(s) lost eligibility due to the qualifying event.
- Claims for reimbursement will not be processed and paid until you have elected COBRA continuation coverage and the first contribution payment has been timely paid and received.
- To continue COBRA coverage, you will need to make ongoing contribution payments. Each contribution payment is due on the first day of the month for which COBRA coverage is provided. If payment is not received by the 30th day following such due date, your COBRA coverage may be terminated.

**If you do not make the full payment for any coverage period, COBRA coverage will be terminated retroactively to the end of the month for which the last full payment was made, and you will lose all rights to further COBRA continuation coverage under the applicable COBRA plan. Once coverage is terminated, it cannot be reinstated.**

## Adding Dependents During a COBRA Continuation Period

If through birth, adoption, marriage or completion of six months in a new domestic partnership, you acquire a new dependent during the continuation period, your dependent can be added to your coverage for the remainder of the continuation period if:

- he or she meets the definition of an eligible dependent (see **Dependent Eligibility** on page 4);
- you notify the Tesoro Benefits Center of your new dependent within 31 days of eligibility (see **Contacts** on page 61); and
- you pay any additional contributions for continuation coverage on a timely basis.

**You must notify the Tesoro Benefits Center if, at any time during your continuation period, any of your covered dependents cease to meet the eligibility requirements for coverage.**

## Early Termination of COBRA Coverage

COBRA continuation coverage will end when the first of the following occurs:

- the Company no longer provides group dental coverage to its employees;
- you or your covered dependent(s) do not pay the premium on or before its due date;
- you and/or your covered dependents' maximum COBRA continuation period ends;
- you become entitled to Medicare following an election of COBRA coverage;
- you or your covered dependent(s) becomes covered under another group health plan following an election of COBRA coverage. However, if the other plan contains an exclusion or limitation with respect to any preexisting conditions, you or your covered dependent(s) to whom such an exclusion or limitation applies may continue COBRA coverage under the Plan; or
- in the case of extended coverage due to disability (see **Extension of COBRA Coverage Due to Disability** on page 48), the disabled individual is no longer determined to be disabled under the Social Security Act.

**You and/or your covered dependent(s) must notify the Tesoro Benefits Center within 31 days if, after electing COBRA, you become entitled to Medicare, become covered under other group health plan coverage or are determined by the Social Security Administration to no longer be disabled.**

## OTHER COVERAGE CONTINUATION OPTIONS

In addition to the option to continue benefits under the provisions of COBRA, certain continuation benefits are available if your handicapped child exceeds the normal dependent child age limit.

There is no option to convert coverage to an individual policy.

**Continuing Coverage for Handicapped Dependent Children**
Coverage for a fully handicapped dependent child may be continued past the normal maximum age for a dependent child.

Your child is considered fully handicapped if:

- he or she is unable to earn a living because of mental retardation or a physical handicap that started before the date he or she reaches the maximum age for dependent children under the Plan; and
- he or she depends chiefly on you for support and maintenance.

You must submit proof that your child is fully handicapped to the Tesoro Benefits Center no later than 31 days after he or she reaches the maximum age for dependent children under the Plan. Coverage will end on the first to occur of:

- ending of the handicap;
- failure to give proof that the handicap continues;
- failure to have any required exam; or
- termination of the dependent coverage for any reason other than reaching the maximum age under the Plan.

The Company has the right to:

- require proof of the continuation of the child's handicap; and
- examine your child, at its own expense, as often as needed, while the handicap continues. An exam will not be required more often than once each year, after two years from the date your child reached the maximum age under the Plan.

## UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

If you are absent from employment for more than 30 days by reason of service in the uniformed services, you may elect to continue Plan coverage for you and your dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended.

The terms "uniformed services" or "military service" mean service in:

- the Armed Forces;
- the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training or full-time National Guard duty;
- the commissioned corps of the Public Health Service; and
- any other category of persons designated by the president in time of war or national emergency.

If qualified under USERRA, you may elect to continue coverage under the Plan by notifying the Tesoro Benefits Center and providing payment of any required contribution for coverage. You may be required to pay the full cost of coverage (employee and Company portions) plus a 2% administration fee.

**If your military service is less than 31 days, you may not be required to pay more than your regular contribution amount, if any, for continuation of health coverage.**

You may continue Plan coverage under USERRA for up to the lesser of:

- the 24-month period beginning on the date of your absence from work; or
- the day after the date on which you fail to timely apply for, or return to, a position of employment.

For information regarding the applicable time period for reporting back to work or applying for reemployment, please contact the Plan Administrator. Regardless of whether you continue your coverage under the Plan during your military service, if you return to work within the time period prescribed by law, you and your eligible dependent's coverage will be reinstated under the Plan. No exclusions or waiting period may be imposed on you in connection with this reinstatement, unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

# OTHER INFORMATION YOU SHOULD KNOW

## Plan Administration

The Plan Administrator for the Plan is:

**Tesoro Employee Benefit Committee**
**Tesoro Corporation**
**19100 Ridgewood Parkway**
**San Antonio, TX 78259**

For the Dental PPO, the Company has entered into an Administrative Services Only (ASO) Agreement with the Claims Administrator, Aetna Life Insurance Company. For the DMO, Aetna Dental, Inc. is the insurer.

The Plan Administrator is responsible for the administration of the Plan and has final discretionary authority:

- to interpret the Plan's provisions;
- to resolve ambiguities in the Plan; and
- to determine all questions relating to the Plan, including eligibility for benefits.

**The decisions of the Plan Administrator will be final, conclusive and binding on all persons with respect to all issues and questions relating to the Plan.**

The Plan Administrator may delegate to other persons the responsibilities for performing ministerial duties in accordance with the terms of the Plan and may rely on information, data, statistics or analysis provided by these persons.

## Plan Funding

The funding for the two options under the Dental Plan is different. Below is a summary of how each of the options are funded.

### *Dental PPO*

The Dental PPO is a self-insured welfare benefit plan. This means that claims are not paid through insurance purchased from an insurance company. Contributions from the Company and Plan participants are used to pay participant claims and the operating expenses of the Dental PPO.

The Plan Administrator, on behalf of the Plan, has contracted with Aetna to act as the Claims Administrator to process claims under the Dental PPO and provide certain other administrative services. The Claims Administrator is paid a fee to provide these services.

**As the Claims Administrator, Aetna has no incentive to deny or delay claims — they are simply reimbursed for claims that are paid under the Plan.**

Each year, the Plan's financial experience is reviewed by looking at contributions paid into the Plan compared to claims paid plus Dental PPO operating expenses. Based on this actuarial analysis (including projections of future dental costs), the Company may adjust contribution rates. Normally, any change in contributions will become effective on January 1.

### *DMO Plan*

The Tesoro DMO Dental Plan (DMO) is a fully insured plan. This means the Company and Plan participants pay the insurance company, Aetna Dental Inc., for benefits under this option. The Company has an insurance contract with Aetna and claims are paid through the insurance contract.

## Plan Cost

### *Company Contributions*

The Company contributes an amount to the Dental PPO each month for all of the eligible Dental PPO participants. The Company also pays an amount to Aetna each month to insure DMO participants under the insurance contract for that dental option. The Company's contributions will be reviewed periodically, and any increase or decrease will be based on several factors, including the Company's ability to continue making contributions.

The Company's contributions are voluntary payments for participants. The Company reserves the right to withhold or discontinue these contributions at any time.

### *Participant Contributions*

All Plan participants are required to share in the cost of the Plan. Contribution rates are published annually during the open enrollment period.

**For active employees, your contributions will be equally divided and deducted on a pre-tax basis from your normal payroll checks.**

As an active employee, your contributions will be paid on a "pre-tax basis," which means:

- your contributions are deducted from your pay before taxes are withheld;
- you are not required to pay federal income tax and, in most cases, state and local taxes on the amount of this deduction; and
- you will pay less FICA Hospital Insurance taxes, and if you are earning less than the maximum taxable wage base for Old Age and Survivors Disability Insurance ("OASDI") Social Security, you will also pay less OASDI Social Security taxes.

If you are on a leave of absence without pay or otherwise not receiving payroll compensation from the Company, please see **If You Take a Leave of Absence** on page 44.

If you drop any dependent's coverage within 31 days of the dependent's loss of eligibility and this changes your level of coverage and monthly contribution amount, you may be entitled to a refund.

- If you fail to drop coverage for your dependent within 31 days of the loss of eligibility, you will not be entitled to a refund of contributions, and the premium will not be reduced until the following plan year.
- The Claims Administrator will require reimbursement for any expenses paid after the retroactive loss of coverage date (unless otherwise prohibited under the Patient Protection and Affordable Care Act).

## Future of the Plan

The Dental Plan is a voluntary plan. It is the Company's intention to continue to provide benefits to participants of the Plan. However, the Company reserves the right to amend, modify or terminate the Plan, in whole or in part, at any time and for any reason, including but not limited to, discontinuing Company contributions and/or retiree benefits. Such actions will be effective as of any date designated by the Company.

Changes to the Plan, if any, will be applied to all Plan participants as of the effective date of the change.

## General Provisions

### *Type of Coverage*

Coverage under the Plan is non-occupational — only non-occupational illnesses and non-occupational injuries are covered. Charges for services and supplies are covered only while the person is an eligible participant in the Plan.

### *Physical Examinations*

Aetna has the right to examine and evaluate any person who submits a claim at all reasonable times while a claim is pending or under review. There is no cost to you for any such examination.

### *Legal Action*

Legal action to pursue a benefit must be taken within three years from the date participation in the Plan ends or the date a claim is denied following exhaustion of the appeal procedures under the Plan.

### *Assignments*

Coverage may be assigned only with the written consent of Aetna. To the extent allowed by law, Aetna will not accept an assignment to an out-of-network provider or facility, including assignment of:

- benefits due under the Plan contract;
- right to receive payments due under the Plan contract; or
- any claim you make for damages resulting from a breach or alleged breach of the terms of the contract.

### *Misstatements*

If you misstate any fact relating to your enrollment or coverage, a fair adjustment in premiums may be made. If the misstatement affects the existence or amount of coverage, the true facts will be used to determine whether coverage is or remains in force and its amount.

All statements made by you or the Company shall be deemed representations and not warranties. Any written statement made by you may not be used by Aetna in a contest unless a copy of the statement is furnished to you or your beneficiary or the person making the claim.

Aetna's failure to implement or insist upon compliance with any provision of the Plan contract at a given time shall not be interpreted as a waiver of Aetna's right to implement or insist upon compliance with that provision at another time. This includes, but is not limited to, the payment of premiums and applies whether or not the circumstances are the same.

## ADDITIONAL INFORMATION

As a participant or beneficiary under this Plan, you have certain rights and protections as more fully described in **Your Rights Under ERISA** on page 55. Other important information about the Plan is provided below:

| | | |
|---|---|---|
| Plan Name | Tesoro Dental Plan (a constituent benefit program of the Tesoro Corporation Omnibus Group Welfare Benefits Plan) | |
| Type of Plan | Welfare benefit plan | |
| Plan Sponsor | Tesoro Corporation<br>19100 Ridgewood Parkway<br>San Antonio, TX 78259<br>(210) 828-8484 | |
| Plan Sponsor's Employer Identification Number | 95-0862768 | |
| Plan Administrator | Tesoro Employee Benefit Committee<br>Tesoro Corporation<br>19100 Ridgewood Parkway<br>San Antonio, TX 78259 | |
| Plan Number | 501 | |
| Plan Year | January 1 – December 31 | |
| Plan Funding | The Plan is funded by employee and employer contributions. | |
| Type of Administration | Dental PPO is under an Administrative Services Only (ASO) contract with Aetna Life Insurance Company.<br><br>DMO is under an insurance contract with Aetna Dental Inc. | |
| Plan Insurer | Dental PPO is self-insured.<br>DMO is insured through Aetna. | |
| Claims Administrator | Dental PPO:<br>Aetna Dental<br>P.O. Box 14094<br>Lexington, KY 40512-4094<br><br>Aetna Member Services<br>(877) 238-6200<br>www.aetna.com | DMO:<br>Aetna Dental<br>Three Sugar Creek Center<br>Sugar Land, TX 77478<br><br>Aetna Member Services<br>(877) 238-6200<br>www.aetna.com |
| Agent for Service of Legal Process | General Counsel<br>Tesoro Corporation<br>19100 Ridgewood Parkway<br>San Antonio, TX 78259<br><br>Service of legal process may also be made upon the Plan Administrator. | |

# YOUR RIGHTS UNDER ERISA

Under the Employee Retirement Income Security Act of 1974 (ERISA), as amended, the Company is required to provide you with the following statement of ERISA rights to fully inform you of your rights as a participant under those benefit plans subject to ERISA.

As a participant in the Plan, you are entitled to certain rights and protections under ERISA.

## Right to Receive Information About Your Plan and Benefits

ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500) and an updated Summary Plan Description. The Plan Administrator may charge a reasonable amount 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 health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your 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 employee benefit plans. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

## Enforce Your Rights

If your claim for a Plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report 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 Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court (providing you have first exhausted all claims and appeals procedures under the Plan). In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

## Assistance With Your Questions

If you have any questions about 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 in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (866) 444-3272.

If you have any questions about the information presented here, please contact the Corporate Benefits Department (see **Contacts** on page 61).

## Rights of States Where Eligible Employees or Dependents are Also Eligible for Medicaid Benefits

*Compliance by the Plan with Assignment of Rights*
Benefit payments with respect to a covered eligible employee or dependent who is also covered by a state plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a) (1) (A) of such Act (as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993) — referred to in this section as a state's Medicaid program — will be made in accordance with any assignment of rights made by or on behalf of the covered person as required by a state Medicaid program.

*Enrollment and Provision of Benefits Without Regard to Medicaid Eligibility*
With respect to enrollment in the Plan or the payment of benefits under the Plan, the Plan will not take into account the fact that a covered person is also eligible for or qualifies for medical assistance under a state Medicaid plan.

*Acquisition by States of Rights of Third Parties (State Subrogation Rights)*
The Plan will honor any subrogation rights that a state may have gained from a covered person eligible for Medicaid by virtue of the state's having paid Medicaid benefits for which the Plan has a legal liability for covering.

# HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

This section incorporates the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended, and the regulations issued thereunder as set forth in 45 C.F.R. Parts 160, 162 and 164, as amended (HIPAA Regulations).

## Definitions

For purposes of this section, words and phrases not otherwise defined herein which are defined in the HIPAA Regulations shall have the meanings assigned therein when used herein. In the event of a conflict between the meaning of a word or phrase used herein with the definition given elsewhere in the Plan, the meaning given in this section shall control.

## The Use and Disclosure of Protected Health Information

Effective April 14, 2003, the Plan will use and disclose protected health information without an authorization from the individual only to the extent of and in accordance with the uses and disclosures permitted by HIPAA and the HIPAA Regulations, including the following uses and disclosures:

- **Health care payment**: For this purpose, health care payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of benefits under the Plan or to obtain or to provide reimbursement for the provisions of health care that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:
  - determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of benefit claims;
  - risk adjusting amounts due based on enrollee health status and demographic characteristics;
  - billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss coverage), and related health care data processing;
  - review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;
  - utilization review activities, including pre-certification and preauthorization of services, concurrent and retrospective review of services; and
  - disclosures to consumer reporting agencies of any of the following protected health information relating to collection or premiums or reimbursement: name and address, date of birth, social security number, payment history, account number, and name and address of health care provider and/or health plan.
- **Health care operations**: For this purpose, health care operations include, but are not limited to, the following activities:
  - conducting quality assessment and improvement activities, including outcomes and evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities;
  - conducting population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions that do not include treatment;
  - reviewing the competence or qualifications of health care professionals, evaluation practitioner and provider performance, health plan performance, conducting training programs which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-healthcare professionals, accreditation, certification, licensing, or credentialing activities;
  - underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance) provided certain requirements are met if applicable;
  - conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance review programs;

- business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies; and
- business management and general administrative activities of the Plan, including, but not limited to:
- management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements;
- customer service, including the provision of data analyses for policyholders, plan sponsors or other customers, provided the protected health information is not disclosed to such policy holder, plan sponsor, or customer;
- resolution of internal grievances;
- the sale, transfer, merger or consolidation of all or part of the Plan with another Plan, or an entity that following such activity will become a covered entity and due diligence related to such activity; and/or transfer of assets to a potential successor in interest; and
- consistent with the applicable requirements of 45 C.F.R. § 164.514, creating de-identified health information or a limited data set, and fundraising for the benefit of the Plan.

- Treatment: For this purpose, treatment means
  - the provision, coordination or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party
  - consultation between health care providers relating to a patient; or
  - the referral of a patient for health care from one health care provider to another.

## Disclosure to the Plan Sponsor

The Plan will disclose protected health information to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the requirements listed under the headings **Additional Agreements of Plan Sponsor** and **Adequate Separation Between the Plan and the Plan Sponsor** below. The Plan has received this certification from the Plan Sponsor.

However, the Plan may disclose summary health information to the Plan Sponsor if the Plan Sponsor requests the summary health information for the purpose of obtaining premium bids from health plans for providing health insurance coverage under the Plan or modifying, amending or terminating the Plan. In addition, the Plan may disclose to the Plan Sponsor information on whether the individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

The Plan participates in an organized health care arrangement with the following plan sponsored by the Plan Sponsor: The Tesoro Corporation Omnibus Group Welfare Benefits Plan.

Accordingly, the Plan and such plan may exchange protected health information for treatment, payment and health care operations purposes of such organized health care arrangement.

## Additional Agreements of Plan Sponsor

With respect to protected health information, the Plan Sponsor further agrees to:

- not use or further disclose the information other than as permitted or required by the plan document or as required by law;
- ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides protected health information received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
- not use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;
- report to the Plan any protected health information use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;

- make available protected health information to an individual in accordance with HIPAA's access requirements and 45 C.F.R. § 164.524;
- make available protected health information for amendment and incorporate any amendments to protected health information in accordance with HIPAA and 45 C.F.R. § 164.526;
- make available the information required to provide an accounting of disclosures in accordance with HIPAA and 45 C.F.R. § 164.528;
- make its internal practices, books and records relating to the use and disclosure of protected health information received from Plan available to the Secretary of the Department of Health and Human Services for the purposes of determining the Plan's compliance with HIPAA;
- if feasible, return or destroy all protected health information received from the Plan that the plan sponsor 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, limit further uses and disclosures to those purposes that make the return or destruction not feasible;
- ensure that adequate separation between the Plan and Plan Sponsor (as described below) is established;
- effective April 20, 2005, implement administrative, physical and technological 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 (except with respect to enrollment and disenrollment information, summary health information and protected health information disclosed pursuant to an authorization under 45 C.F.R. § 164.508) and shall ensure that any agents (including subcontractors) to whom it provides such electronic protected health information agree to implement reasonable and appropriate security measures to protect such information; and
- effective April 20, 2005, report to the Plan any security incident of which it becomes aware.

## Adequate Separation Between the Plan and the Plan Sponsor

In accordance with HIPAA and the HIPAA Regulations, only the following employees or classes of employees or other persons may be given access to protected health information to be disclosed:

- the Plan Administrator;
- Human Resources employees within the Corporate Benefits Department;
- Human Resources employees with responsibility for investigating appeals and recommending decisions to the Plan Administrator;
- Human Resources employees with access to the data which is stored electronically;
- employees within the Information Technology ("IT") Group that maintain the servers on which some protected health information may be stored;
- employees in the Controller's Department who handle benefits accounting or payroll;
- employees in the Internal Audit Department; and
- in-house legal counsel.

The persons identified in this sub-section may only have access to and use and disclose protected health information for Plan administration functions that the Plan Sponsor performs for the Plan. If the persons identified in this section do not comply with the restrictions set forth in this Plan document and otherwise under HIPAA and the HIPAA Regulations, the Plan Sponsor shall respond to such noncompliance in accordance with the requirements of applicable law and the Plan Sponsor's policies, including as appropriate, the imposition of disciplinary sanctions. The Plan Sponsor will ensure that the provisions of this section are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic protected health information.

## Consistency With HIPAA and HIPAA Regulations

In the event any amendment to HIPAA or the HIPAA Regulations is adopted which renders any provision of this section inconsistent therewith, this section shall be deemed amended to be consistent therewith.

## Other Uses and Disclosures of Health Information

In addition to the above uses and disclosures, the Plan Sponsor may use and disclose protected health information to the fullest extent permitted under HIPAA or the HIPAA Regulations.

## Notice of Privacy Practices

The HIPAA Regulations require the Plan to provide you with a notice describing the Plan's privacy practices and other information regarding your privacy rights with respect to protected health information. This notice is provided at the time of enrollment to new Plan enrollees. In addition, an updated notice will be provided to all Plan participants within 60 days of any material revision of the notice. Copies of the notice are available at all times through the Corporate Benefits Department.

## CONTACTS

The following contacts are available to answer questions and provide information about the Plan.

**Tesoro Benefits Center**
Tesoro Benefits Center
P.O. Box 572535
Houston, TX 77257-2535
(866) 787-6314
www.tsocorp.com/benefits

**Corporate Benefits Department**
Corporate Benefits Department
Tesoro Corporation
19100 Ridgewood Parkway
San Antonio, TX 78259
(866) 688-5465

**Claims Administrators**
***Dental PPO***
Aetna Dental
P.O. Box 14094
Lexington, KY 40512-4094
Member Services: (877) 238-6200
www.aetna.com

***DMO***
Aetna Dental
Three Sugar Creek Center
Sugar Land, TX 77478
Member Services: (877) 238-6200
www.aetna.com

## GLOSSARY

**Accident** — A sudden, unexpected and unforeseen identifiable occurrence or event producing, at the time, objective symptoms of a bodily injury. The accident must occur while the person is covered under this Plan. The occurrence or event must be definite as to time and place. It must not be due to, or contributed to by, an illness or disease of any kind.

**Annual Maximum Benefit** — Under the Dental PPO, the annual maximum benefit is the most the Plan will pay for covered dental expenses (not including preventive care, TMJ and orthodontic expenses) in a calendar year. The annual maximum benefit applies separately to each covered person. The maximum applies even if there is a break in coverage during the calendar year.

**COBRA** — The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

**Coinsurance** — The coinsurance is both the percentage of covered expenses that the Plan pays and the percentage of covered expenses that you pay. The percentage that the Plan pays is referred to as the "plan coinsurance" and varies by the type of expense. Please refer to the **Dental Plan Summary Chart** on page 11 and **What Is Covered Under the Plan** beginning on page 17 for specific information on coinsurance amounts.

**Copay** — Under the DMO, a fixed dollar amount required to be paid by you for orthodontic services. After the copay, covered orthodontic expenses will be paid at 100% for 24 months of comprehensive (active, usual and customary) treatment on permanent dentition plus 24 months of post-treatment retention.

**Cosmetic** — Services or supplies that alter, improve or enhance appearance.

**Covered Dental Expenses** — Dental services and supplies shown as covered under this SPD. The services and supplies are subject to the limitations set forth in the SPD.

**Deductible** — Under the Dental PPO, the amount of covered dental expenses you pay before certain benefits are payable by the Plan. There is a one-time TMJ deductible for TMJ expenses and annual (calendar year) deductible for covered basic services, major services and dental implants. Each covered person must meet separate deductibles. There are no deductibles under the DMO.

**Dental Provider** — Any dentist, group, organization, dental facility or other institution or person legally qualified to furnish dental services or supplies.

**Dentist** — A legally qualified dentist, or a physician licensed to do the dental work he or she performs.

**Directory** — A listing of in-network providers under the Plan. Copies of the directory may be obtained free of charge by calling Aetna Member Services or by using Aetna's online DocFind directory at www.aetna.com.

**Emergency Care** — Dental services administered in a dentist's office, dental clinic or other comparable facility to evaluate and stabilize dental conditions of a recent onset and severity accompanied by excessive bleeding, severe pain or acute infection that would lead a prudent layperson, possessing average knowledge of dentistry, to believe that immediate care is needed.

**FMLA** — The Family and Medical Leave Act of 1993, as amended.

**HIPAA** — The Health Insurance Portability and Accountability Act of 1996, as amended.

**Hospital** — An institution that:

- is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services;
- is supervised by a staff of physicians;
- provides 24-hour-a-day R.N. service;
- charges patients for its services; and
- is operating in accordance with the laws of the jurisdiction in which it is located; or
- does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a hospital and is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations.

In no event does a hospital include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, skilled nursing facility, hospice, rehabilitative hospital or facility primarily for rehabilitative or custodial services.

**Injury** — An accidental bodily injury that is the sole and direct result of:

- an unexpected or reasonably unforeseen occurrence or event; or
- the reasonable unforeseeable consequences of a voluntary act by the person.

The act or event must be definite as to time and place.

**Jaw Joint Disorder** — Any of the following:

- a Temporomandibular Joint (TMJ) dysfunction or any similar disorder of the jaw joint;
- a Myofacial Pain Dysfunction (MPD); or
- any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

**Lifetime Maximum Benefit** — Under the Dental PPO, the lifetime maximum benefit is the most the Plan will pay for covered orthodontic expenses and covered non-surgical TMJ expenses in a covered person's lifetime. There is a separate orthodontic lifetime maximum and TMJ lifetime maximum for each covered person. The maximums apply even if there is a break in coverage during the person's lifetime.

**Necessary** — A service or supply furnished by a particular provider is necessary if Aetna determines that it is appropriate for the diagnosis, care or treatment of the disease or injury involved. To be appropriate, the service or supply must:

- be care or treatment as likely to produce a significant positive outcome as — and no more likely to produce a negative outcome than — any alternative service or supply, both as to the disease or injury involved and your overall health condition;
- be a diagnostic procedure, indicated by your health status and be as likely to result in information that could affect the course of treatment as — and no more likely to produce a negative outcome than — any alternative service or supply, both as to the disease or injury involved and your overall health condition; and
- as to diagnosis, care and treatment, be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration:

- information provided on your health status;
- reports in peer reviewed medical literature;
- reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment;
- the opinion of health professionals in the generally recognized health specialty involved; and
- any other relevant information brought to Aetna's attention.

In no event will the following services or supplies be considered necessary:

- those that do not require the technical skills of a medical, mental health or dental professional;
- those furnished mainly for your personal comfort or convenience, any person who cares for you, any person who is part of your family, any health care provider or health care facility;
- those furnished solely because you are an inpatient on any day on which your disease or injury could safely and adequately be diagnosed or treated while not confined; or
- those furnished solely because of the setting, if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.

**Negotiated Charge** — The maximum charge an in-network provider has agreed to make as to any service or supply for the purpose of the benefits under this Plan.

**Network Provider or In-Network Provider** — A dental provider who has contracted to furnish services or supplies for a negotiated charge, but only if the provider is, with Aetna's consent, included in the directory as a network provider for the service or supply involved and for the class of employees to which you belong.

**Non-Occupational Illness** — An illness that does not arise out of (or in the course of) any work for pay or profit, or result in any way from an illness that does. An illness will be deemed to be non-occupational regardless of cause if proof is furnished that the person is covered under any type of workers' compensation law and is not covered for that illness under such law.

**Non-Occupational Injury** — An accidental bodily injury that does not arise out of (or in the course of) any work for pay or profit, or result in any way from an injury that does.

**Occupational Illness or Occupational Injury** — An illness or injury that arises out of (or in the course of) any activity in connection with employment or self-employment, whether or not on a full-time basis, or results in any way from an injury or illness that does.

**Orthodontic Treatment** — Any medical or dental service or supply furnished to prevent, diagnose or correct a misalignment of the teeth, bite, jaws or jaw joint relationship, whether or not for the purpose of relieving pain. Not included is the installation of a space maintainer or a surgical procedure to correct malocclusion.

**Other Plan** — Any plan that provides health care coverage under:

- group insurance;
- any other type of coverage for persons of a group (including plans that are insured and those that are not); or
- no-fault auto insurance required by law and provided on other than a group basis.

**Out-of-Network Provider** — A dentist or other health care provider who has not contracted with Aetna to furnish services or supplies at a negotiated charge.

**Physician** — A legally qualified physician.

**Primary Care Dentist (PCD)** (does not apply to Dental PPO) — Under the DMO, a primary care dentist (PCD) is the in-network dentist who:

- is selected by a person from the list of primary care dentists in the directory;
- supervises and provides basic and routine dental services to a person;
- may initiate referrals to specialty dentists and coordinates all of a patient's care; and
- is shown on Aetna's records as the person's PCD.

You and your covered dependents may each choose a different PCD. You may change your PCD by notifying Aetna by telephone or in writing. See **Primary Care Dentist (PCD)** on page 14 for more information.

**QMCSO** — A Qualified Medical Child Support Order.

**Reasonable and Customary Charge** — The reasonable and customary charge for a service or supply is the lowest of:

- the provider's usual charge for furnishing it; and
- the charge Aetna determines to be appropriate, based on factors such as:
  - the cost of providing the same or a similar service or supply and the manner in which the charges are made, billed or coded; or
  - the prevailing charge for the service or supply in the geographic area where it is furnished.

To determine the reasonable and customary charge for a service or supply that is unusual or not often provided in the area or provided by only a small number of providers in the area, Aetna takes into account the:

- complexity of the service;
- degree of skill needed;
- type or specialty of the provider;
- range of services or supplies provided by a facility; and
- prevailing charge in other areas.

If you receive services from an out-of-network dentist (only in a dental emergency under the DMO), the Plan will reimburse a portion of covered expenses, up to the lesser of the amount billed or the reasonable and customary charge. You are responsible for paying the amount above the reasonable and customary charge.

**Referral** — Under the DMO, a referral is when your primary care dentist (PCD) recommends a particular specialty dentist for certain services. You must have a referral from your PCD in order to receive coverage for any services from a specialty dentist (except orthodontia).

**Specialty Dentist** — Any dental provider who, by virtue of advanced training, is board eligible or certified by a specialty board as being qualified to practice in a special field of dentistry.

**USERRA** — The Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.