TESORO CORPORATION GROUP UNIVERSAL LIFE INSURANCE PLAN

SUMMARY PLAN DESCRIPTION

As of January 1, 2017

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This summary plan description (SPD) outlines the major features of the Tesoro Group Universal Life Insurance Plan. If you have questions regarding your coverage under the Group Universal Life Insurance Plan, contact the Tesoro Benefits Center at (866) 787-6314.

This document describes the Tesoro Group Universal Life Insurance Plan as of January 1, 2017. This Plan is available to eligible Tesoro employees on the U.S. payroll. This information comprises the SPD of this Plan as required by the Employee Retirement Income Security Act of 1974 (ERISA). This description doesn't cover every provision of the Plan. Some complex concepts may have been simplified or omitted in order to present a more understandable plan description. If this plan description is incomplete, or if there's any inconsistency between the information provided here and the official plan texts, the provisions of the official plan texts will prevail.

The Tesoro Group Universal Life Insurance Plan offers supplemental life insurance that you may purchase for yourself, your spouse, and/or your dependent children. The Plan provides financial protection for you and/or your survivors to help meet financial obligations in the event of death.

PARTICIPATION

You are eligible to participate in the Group Universal Life Insurance (GUL) Plan upon hire if you're a regular full-time employee of one of Tesoro Corporation's participating subsidiary companies. You will be considered a full-time employee if you are regularly scheduled to work at least thirty (30) hours each week.

If you are in a job covered by a collective bargaining agreement, you are not eligible for participation in this GUL Plan unless the provisions are included or incorporated in your collective bargaining agreement.

To be eligible for participation, you must also be "Actively at Work" on the effective date of coverage and not have been hospitalized within the 90 days prior to your enrollment date. Likewise, your spouse and/or children must satisfy the "Normal Activities" provision (i.e., not confined at home under the care of a doctor due to sickness or injury) and not have been hospitalized within the 90 days prior to date of enrollment.

ENROLLMENT

If you are eligible to participate in the GUL Plan and wish to enroll, you can enroll directly with MetLife. Plan materials and forms are available at www.metlife.com/mybenefits or by calling MetLife at (800) GET-MET8. You must complete the Plan Insurer's application form, Statement of Health (if applicable – see below for Statement of Health requirements), and beneficiary designation form. You must enroll within thirty-one (31) days of your initial eligibility date for coverage to begin as of your eligibility date. If the Statement of Health is required, coverage will begin on the date the Plan Insurer approves the coverage. In order to cover your spouse and/or dependent children, you must enroll in the Plan for yourself.

If you do not enroll within thirty-one (31) days after you were first eligible, you can apply at any time for coverage as a Late Entrant. Late Entrants must meet Evidence of Insurability requirements and be approved for coverage by the Plan Insurer. Evidence of Insurability may include completing a Statement of Health, undergoing a physical exam (if required by the insurer), and providing any additional information regarding the applicant's insurability that may be reasonably necessary. GUL insurance subject to Evidence of Insurability becomes effective on the date the Plan Insurer approves the coverage or the date you complete one full day of active work, if later. Until underwriting approval is received from the Plan Insurer, which may take 30-60 days, no payroll deductions will be taken from your paycheck for premium payments. You will receive a certificate of coverage from the Plan Insurer upon approval.

COST

You pay the total cost of this benefit on an after-tax basis. Employee and spouse rates (cost per $1,000 of coverage) are based on the participant's age as of each January 1. The cost for dependent children is a flat rate, which covers all eligible children. Premium rates may be obtained at www.metlife.com/mybenefits or by calling MetLife at (800) GET-MET8.

BENEFIT AMOUNT

Employee

You may elect coverage from 1 to 5 times your annual Base Salary up to a maximum of $750,000 (rounded to the next higher $5,000). "Base Salary", which includes basic pay and scheduled overtime, is the salary or wage you would receive as a result of your normal work schedule. You are insurable for up to 3 times your annual salary up to $375,000 without evidence of insurability; however, if you want a higher level of coverage, you must complete a Statement of Health and meet the medical requirements of the Plan Insurer.

Spouse

If you enroll in the Plan, you may also purchase insurance for your spouse in $5,000 increments, up to a maximum of $100,000, or 100% of your coverage amount, whichever is less. Your spouse is insurable up to $25,000 without evidence of insurability; coverage in excess of this amount will require that your spouse complete a Statement of Health and meet the Plan Insurer's medical requirements.

Dependent Children

If you enroll in the Plan, you may also purchase insurance for your child(ren), aged 14 days to 19 years (or 23 years if enrolled at an accredited college or university), in the amount of $5,000 or $10,000 per child.

Cash Accumulation Fund

The GUL Plan lets you set aside money in a tax-deferred "Cash Accumulation Fund" at a competitive rate of interest. You select a certain dollar amount to contribute through payroll deductions above the cost of your life insurance coverage. You can also make lump sum contributions at any time ($100 minimum), subject to federal guidelines. You have access to your money through loans and withdrawals, and the extra funds you set aside may be used to purchase paid up or retirement life insurance when you retire.

Accelerated Benefits Option

If you or your covered spouse is diagnosed as terminally ill with a life expectancy of six months or less, you may be eligible to receive up to 50% of your specified face amount of GUL benefits, up to $250,000 maximum, before death. A physician's certification is required in all instances and is subject to the Plan Insurer's review and concurrence. An accelerated benefit is generally payable in a lump sum and can be elected only once. The certificate's death benefit will be reduced by the amount of accelerated life insurance benefits paid out and any associated interest and expense charge.

APPLYING FOR BENEFITS

In the event of a loss, your supervisor or the Corporate Benefits Department should be contacted to coordinate claim processing. (You may also contact the Plan Insurer, MetLife, directly at 1-800-GETMET8.) A claim should be made within 180 days of death and in no case more than 12 months after the 180-day period. Benefits are paid as a lump sum or through other options as provided by the Plan Insurer.

Payment of benefits due for loss of life will be paid according to the beneficiary designation in effect at the time of your death. Beneficiary designations may be made or changed by you at any time at www.metlife.com/mybenefits, without the consent of the beneficiary. If your beneficiary dies at the same time or within 24 hours of your death, benefits will generally be paid as if that beneficiary died before you.

If you fail to designate a beneficiary, your benefits will be paid to your estate.

EXCLUSIONS AND LIMITATIONS

The death benefit (or any increased portion of the death benefit) will not be paid if death by suicide occurs within two years of the effective date of the certificate of coverage (or for increased benefits, within two years of such increase). This exclusion is subject to state law and may not be applicable to residents in certain states.

EVENTS AFFECTING COVERAGE

Disability

If you become disabled before you reach age 60 and after you have been enrolled in the GUL Plan for one year and your waiver claim is approved, the Plan Insurer will waive the premiums for your coverage until the earliest of recovery, death, or age 65. The money in your Cash Accumulation Fund will continue to earn interest at the declared rate.

Leave Of Absence

If you are on a Company approved leave of absence (unpaid), you may continue your GUL coverage by contacting the Plan Insurer and arranging to pay your monthly premiums directly. If you fail to make a planned payment and the amount in your Cash Accumulation Fund, if any, is insufficient to cover your cost of insurance, you will have a grace period of 60 days to pay the amount of the monthly premium due. If the Plan Insurer does not receive sufficient payment by the end of the grace period, your GUL coverage will then end.

Reduction in Number of Hours Worked

If your regularly scheduled hours are reduced to less than thirty (30) hours per week, your GUL coverage eligibility will end as of the date the schedule change is effective. You may, however, continue your GUL coverage by contacting the Plan Insurer and arranging to pay your monthly premiums directly. If your regularly scheduled hours later increase to at least thirty (30) hours per week, you'll once again be eligible to participate in the GUL Plan through payroll deductions.

Labor Dispute

If you are a union member and absent from active work because of strike, lockout or other general work stoppage, you may continue the GUL coverage in which you were enrolled when active employment ceased by contacting the Plan Insurer and arranging to pay your monthly premiums directly. If you fail to make a planned payment and the amount in your Cash Accumulation Fund, if any, is insufficient to cover your cost of insurance, you will have a grace period of 60 days to pay the amount of the monthly premium due. If the Plan Insurer does not receive sufficient payment by the end of the grace period, your GUL coverage will then end.

Layoff or Termination of Employment

If you leave the company or retire, you may continue your full coverage amount until you reach age 70 by contacting the Plan Insurer and arranging to pay your monthly premiums directly. At age 70, coverage reduces to the lesser of your current amount and 5 times the amount in your Cash Accumulation Fund, but at no time can your coverage after age 70 exceed your current face amount. The minimum amount of coverage is $20,000.

Death

Coverage ends as of the date of your death.

PLAN AMENDMENT OR TERMINATION

Tesoro expects to continue the employee benefits described in this section, but reserves the right to amend or discontinue any or all parts at any time and for any reason. In no event will you become entitled to any vested rights under this Plan.

ADDITIONAL INFORMATION

The Plans that comprise your Benefits Package are part of the pay you receive from Tesoro for your contributions to the Company's continuing success. In addition to informing you about your employee benefits, this "Summary Plan Description" (SPD) is designed to meet disclosure requirements of a Federal law called the Employee Retirement Income Security Act of 1974 (ERISA). This SPD was written from the documents that legally govern the operations of the Plan. Although every attempt has been made to ensure that the SPD is accurate, the official documents will rule in case of any conflict in meaning.

In September 1974, the Employee Retirement Income Security Act (ERISA) was signed into law. The purpose of this law is to protect our rights as participants in employee benefit plans. Although the Tesoro Plans have always been written and administered to assure that each participant received his or her full benefits, we want you to be aware of the additional protection provided by this law.

As a participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit 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 benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a 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 Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a State or Federal court. In addition, if you disagree with a Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your 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.

As Plan Sponsor, Tesoro Corporation prides itself on operating its Plans fairly and objectively and is also proud of its open lines of communication with its employees. If you have any questions about the information presented here, please contact the Corporate Benefits Department or your local HR Manager.

If you have any questions about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor Management Services Administration, Department of Labor.

GENERAL CLAIMS PROCEDURE

A participant or beneficiary who feels he or she is being denied any benefit or right provided under the Plans shall have the right to file a written claim with the Plan Administrator. All such claims shall be submitted on a form provided by the Plan Administrator, which shall be signed by the claimant and shall be considered filed on the date the claim is received by the Plan Administrator.

Upon the receipt of such a claim and in the event the claim is denied, the Plan Administrator shall, within a reasonable period of time, provide such claimant a written statement which shall be delivered or mailed to the claimant's last known address and shall contain the following:

- The specific reason or reasons for the denial of benefits;
- A specific reference to the pertinent provisions of the Plan upon which the denial is based;
- A description of any additional material or information which is necessary;
- An explanation of the review procedures and the time limits that apply; and
- In the case of a plan providing disability benefits, a copy of the internal rules, guidelines, other protocols or similar criteria will be provided free on request following an adverse benefit determination.

Within 90 days (180 days in the case of a claim for disability benefits) after receipt of notice of denial of benefits as provided above, the claimant or authorized representative may request, in writing, to appear before the Plan Administrator for a review of the claim. In conducting its review, the Plan Administrator shall consider any written statement or other evidence presented by the claimant or authorized representative in support of the claim. The Plan Administrator will give the claimant and/or authorized representative reasonable access to all pertinent documents necessary for the preparation of the claim.

Within 60 days after receipt by the Plan Administrator of a written request for review of the claim, unless special circumstances require an extension of time for processing such request for review, but not later than 120 days after receipt of such request, the Plan Administrator shall notify the claimant of its decision by delivery or by certified or registered mail to the claimant's last known address. In the case of a claim for disability benefits, the notification of the Plan Administrator's decision shall be made not later than 45 days after receipt of the claim, unless special circumstances require an extension of time for processing such request for review, and such extension shall require a decision not later than 105 days after receipt of such request and following appropriate notice of extension (limited to two 30-day extensions).

The decision of the Plan Administrator shall be in writing and shall include the specific reasons for the decision presented in a manner calculated to be understood by the claimant and shall contain references to all relevant Plan provisions on which the decision was based. The decision of the Plan Administrator shall be final and conclusive.
In addition to the General Claims Procedure described above, the Plan Insurer may have specific requirements, which you will need to follow in filing your claim.

Future of the Plan

Tesoro expects and intends to continue the employee benefits described in this SPD indefinitely, but reserves the right to amend or discontinue any or all parts at any time.

Interpretation of the Plan

Only the Plan Administrator is authorized to make administrative interpretations of the Plan and will do so only in writing. You should not rely on any representation, whether oral or in writing, which another person may make concerning provisions of the Plan and your entitlements under them.

The Plan Insurer has authority to administer claims and to manage and interpret the Group Policy, consistent with the provisions of the Plan.

IMPORTANT FACTS ABOUT THE PLAN

Plan Name

The Tesoro Corporation Group Universal Life Insurance Plan is a Constituent Benefit Program of the Tesoro Corporation Omnibus Group Welfare Benefits Plan.

Plan Sponsor

Tesoro Corporation
19100 Ridgewood Parkway
San Antonio, TX 78259
(210) 828-8484

Plan Administrator

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

Plan Funding

The plan is funded by employee contributions.

Plan Insurer

Metropolitan Life Insurance Company
One Madison Avenue
New York, NY 10010

Other Employers Whose Employees Are Covered By the Plan

Upon written request to the Plan Administrator, a complete list of the employers participating in the Plan will be provided.

Agent for Service of Legal Process

General Counsel
Tesoro Corporation
19100 Ridgewood Parkway
San Antonio, TX 78259

Note: Legal process may also be served upon the Plan Administrator.

Plan Type

Welfare benefit plan.

Plan Number

The plan number is 501.

Employer Identification Number (EIN)

The EIN under which the documents and reports for this plan are filed with the U.S. Department of Labor is 95-0862768.

Plan Year

The plan year is a calendar year beginning January 1 and ending December 31.

QUESTIONS

If you have questions about your Tesoro employee benefits, contact the Tesoro Benefits Center at (866) 787-6314.