TESORO CORPORATION

LOCAL HEALTH PLANS HMO/PPO SUPPLEMENT

As of January 1, 2017

If you choose a fully insured, local health plan through a health maintenance organization (HMO) or preferred provider organization (PPO) as your Tesoro medical coverage, you should review this section for information on plan eligibility and participation. For information on all other aspects of your coverage, you should review the benefit booklet (sometimes called a “certificate of coverage”) provided by the insurance company. The benefit booklet explains dependent eligibility, covered services, prescription drugs, supplies and treatment, and lists providers currently associated with your coverage. It also explains how to obtain care, file a claim (if necessary) and appeal a claim. You may be able to obtain this information from the insurance company’s website, or you can obtain a copy by contacting the insurance carrier directly. If you have questions regarding your Tesoro Health Plans, contact the Tesoro Benefit Center at (866) 787-6314.

This document supplements information provided for Tesoro’s fully insured, local health plans as of January 1, 2017. These Plans are available to eligible Tesoro employees on the U.S. payroll. This information, in conjunction with the insurance carriers’ benefit booklets, comprises the SPDs for these Plans 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.

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There is no substitute for good health and, with expensive health care costs, there is no substitute for good health care protection. Knowing that you have protection when health care is needed means security and peace of mind. Tesoro’s local health programs offered in certain areas help provide that protection and security for you and your family.

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);
- are on a U.S. payroll;
- live and/or work in the insurance carrier's service area; and
- meet the insurance carrier's eligibility requirements.

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 that has not adopted the Plan.

Dependent Eligibility

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

- your spouse (if you are not legally separated);
- your children under age 26[1]. 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 mentally or physically disabled dependent children of any age (see the box below); and
- your domestic partner and your domestic partner's dependent children (see the box below).

Certain fully-insured plans may have eligibility provisions that differ from the general description above. Please refer to your carrier benefit booklet for detailed eligibility information.

[1] For a dependent who becomes ineligible due to attaining age 26, coverage will extend through the end of the month in which that dependent's 26th birthday falls.

Continuing Coverage for a Disabled Child

Generally, coverage for a child will not terminate upon reaching age 26 if the child continues to be both:

1. Disabled, and
2. Dependent upon you for more than one-half of his support as defined by the Internal Revenue Code of the United States.

Disabled means any medically determinable physical or mental condition that prevents the child from engaging in self-sustaining employment. The disability must begin before the child attains age 26. You must submit satisfactory proof of the disability and dependency to the insurance carrier within 31 days following the child's attainment of age 26. For new employees, such proof must be submitted in connection with your initial enrollment.

As a condition to the continued coverage of a child as a Disabled Dependent beyond age 26, the insurance carrier may require periodic certification of the child's physical or mental condition. Please refer to your carrier benefit booklet for detailed eligibility information.

Domestic Partner Coverage

Domestic partner coverage includes a domestic partner meeting the eligibility criteria listed on Tesoro's Affidavit of Domestic Partnership and any requirements of the insurance carrier[2]. To qualify for benefits, you must register your domestic partnership with Tesoro by submitting a signed affidavit. This form is available through the Tesoro Benefit Center or may be downloaded from Tesoro's intranet site (see **Contacts** on page 32). The insurance carrier may have additional documentation requirements. Please refer to your carrier benefit booklet for detailed eligibility and documentation requirements.

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 and any insurance carrier requirements). 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

When you add any dependent during enrollment, you will be required to submit the appropriate documents within 31 days of eligibility (marriage certificate, birth certificate, etc.) to provide proof of dependent status. This process will apply whether the dependent is being added during your initial eligibility period, annual open enrollment or due to a life event.

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. However, covered medical expenses incurred for a newborn child within the first 31 days of life will generally be covered regardless of whether you enroll the child.

- **Log in to the Tesoro Benefit Center at www.tsocorp.com/benefits.**
- **Proceed through the enrollment event (New Hire, Life Event, Annual Enrollment).**
- **At the first screen, upload the appropriate document(s) to provide proof of dependent status for any dependents (including a spouse) that you plan to enroll. You may also fax or mail the documents according to the instructions on the screen.**
- **Review your personal information, then create your dependent records. To select your benefit plan and add dependents, click on "Change" at the "Review Elections" screen.**
- **At the "Medical Benefit Options" screen, select a plan from the available options then click "Next" to select the dependents you want covered. You must add dependents for each plan you elect. You will receive an "Accept/Deny" dependent verification message once you complete this step. Click "Accept" and make sure the documents are submitted within 31 days of eligibility.**
- **Your dependent's enrollment will be confirmed once documents have been received and verified by the Tesoro Benefit Center (verification will be complete within three business days of receipt).**

Enrollment of your dependents in the Plan will be pended until proof of dependent status has been received by the Tesoro Benefit Center. If the required documentation is not received within 31 days of eligibility, your dependents will *not* be added. Please contact the Tesoro Benefit Center with any questions.

[2] Domestic partner definitions and eligibility may vary depending on the local medical plan elected.

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.

Certain fully-insured plans may have eligibility provisions that differ from the general description above. Please refer to your carrier benefit booklet for detailed eligibility information.

ENROLLING IN THE PLAN

To complete your Medical Plan election, 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).

Certain union groups may have alternative coverage levels. Please contact the Tesoro Benefit Center with any questions.

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 medical 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 Value Plus Plan at the Employee Only coverage level. The Value Plus Plan is considered a "high deductible health plan" under IRS rules. Please contact the Tesoro Benefit Center with any questions.

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 may make an election to enroll, re-enroll or decline (waive) participation for the coming year. You may change your medical plan election or coverage level and add or drop eligible dependents from your coverage. If you do not make an election during this period, your medical plan election (including a waive coverage election) will continue for the following year, if that medical plan election continues to be available.

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

Special Enrollment

Certain family status changes (see **Changes in Family Status** on page 8 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 person will be considered to be a Special Enrollee if all of the following apply:

- you did not elect medical coverage for that person within 31 days of the date the person first became eligible (or during an open enrollment period), because the person had medical 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 become legally separated,
  - the medical 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.

COST OF COVERAGE

You and the Company share the cost of medical 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. However, dependent coverage for eligible domestic partners (and their children) generally requires that the value of that coverage be included as income to the participant. The contribution amount for each coverage option and level of coverage is subject to change and is announced in advance.

WHEN COVERAGE BEGINS

Your coverage under the Plan begins as follows:

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 7)	On the effective date of the status change (unless otherwise prohibited by applicable law)

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 or other permissible event.

An eligible status change includes a change during the Plan Year in the following:

- 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 or other permissible event. You may complete the change event online in the Tesoro Benefit Center portal at www.tsocorp.com/benefits or request a change by calling 1-866-787-6314.

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 PPO Base Plan to the Value Plus Plan).

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 applicable law.)

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;
- establishment or termination of legal guardianship or conservatorship of a 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 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, commencement or return from unpaid leave of absence).

Other Permissible Events

You may make certain changes to your coverage during the Plan Year upon the occurrence of the following events:

- the receipt of a qualified medical child support order with respect to your child;
- a significant increase in the cost of the benefit option;
- a significant curtailment of coverage under the benefit option; or
- loss of coverage under another employer plan or coverage sponsored by a governmental or educational institution

IF YOU TAKE A LEAVE OF ABSENCE

Your Medical 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 15 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 or FMLA leave of absence. If you wish to waive coverage during a paid leave, you must notify the Tesoro Benefit 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 FMLA 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 for the period of active coverage will be deducted from your paycheck.

If coverage is terminated during your non-FMLA leave due to non-payment of contributions, you will not be eligible to enroll until the next annual enrollment period. In addition to terminating coverage due to non-payment of contributions, coverage may also be terminated:

- upon expiration of your Long-Term Disability benefit;
- after six months on an Employer Certified Personal Leave of Absence if you do not return to employment; 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 to receive COBRA continuation coverage in certain situations (see **Continuation of Coverage Under COBRA** on page 11).

WHEN COVERAGE ENDS

Unless you are eligible to continue coverage as explained under **Continuation of Coverage Under COBRA** on page 11, your coverage under the Plan will end if:

- 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;
- you fail to make required contributions in a timely manner;
- you become enrolled in another Company-sponsored health care plan;
- you terminate employment, are not on an approved leave of absence and are not eligible to continue coverage as a retiree (see **Retiree Coverage** on page 5 of the main **Tesoro Corporation Medical Plan Summary Plan Description**);
- you lose your Long-Term Disability status under the Company-sponsored Long-Term Disability program and your 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 medical coverage).

Unless your dependent is eligible to continue coverage as explained under **Continuation of Coverage Under COBRA** on page 11, coverage for your dependent(s) ends if:

- you fail to make required contributions for your dependent's coverage;
- your own coverage ends for any of the reasons above;
- your dependent no longer meets the eligibility requirements for coverage under the Plan; or
- your dependent becomes an employee eligible for health care benefits under any health care plan offered by the Company.

If you are covering a domestic partner and 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; or
- For the domestic partner's child, the date such child no longer meets the Plan's definition of "dependent" with respect to the domestic partner

Coverage for dependents may continue for a period after your death. For more information see **Other Coverage Continuation Options** on page 14.

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 their covered children will be eligible for a continuation of benefit provision 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 Benefit Center (see **Contacts** on page 32) 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 Benefit 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 rules for changing your coverage level (see Changing Your Coverage on page 7).

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) OR 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 Benefit Center (see **Contacts** on page 32) 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 Benefit 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 Benefit 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 entitlement to 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. Note, however, if your first qualifying event was your entitlement to Medicare, the maximum amount of continuation coverage available for your spouse and dependents when a second qualifying event occurs is 36 months from the date on which you became entitled to Medicare. You must provide written notification to the Tesoro Benefit Center within 60 days after the second qualifying event occurs (see **Contacts** on page 32).

Enrolling in COBRA Coverage

Upon notification to the Tesoro Benefit Center of a COBRA qualifying event, COBRA election notices are prepared and mailed to your home address. Your medical 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** on page 12, 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 to be 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 3);
- you notify the Tesoro Benefit Center of your new dependent within 31 days of eligibility (see **Contacts** on page 32); and
- you pay any additional contributions for continuation coverage on a timely basis.

You must notify the Tesoro Benefit 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 medical 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 12), 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 Benefit Center 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 to your enrolled dependents if you die as an active employee.

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

Continuing Dependent Coverage After Your Death

If you die while enrolled in the Plan, your covered dependents may continue coverage under retirement provisions as long as:

- you were eligible for post-retirement benefits, as defined by the Company (Hired before January 1, 2016 with age plus years of service equal to or greater than 80, or age 55 with 5 years of service) at the time of death; and
- required payments are made for the coverage.

Note: Post-retirement medical coverage is not available to employees hired or rehired on or after January 1, 2016. Post-retirement coverage for surviving dependent spouses ends at age 65. Post-retirement coverage for surviving dependent children ends at age 26.

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 Benefit 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.

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 dependents’ 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. 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.

ADDITIONAL INFORMATION

Plan Administration

The Company has entered into a contract with the insurance carrier to provide insurance. The insurance carrier has the final authority and discretion to interpret the Health Benefit Plan provisions and to make benefit determinations. Such decisions shall be final and conclusive.

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.

Cost/Funding

Local health plans are fully-insured welfare benefit plans. This means that claims are paid through insurance purchased from an insurance company. Contributions from the Company and Plan participants are used to pay premiums to the insurance carrier.

Company Contributions

The amount of the Company's contribution toward the cost of benefits under the Plan will be reviewed periodically, and any increase or decrease will be based on several factors, including the Company's ability to continue making such contributions. The Company reserves the right to suspend 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 9.

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 Insurer 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 Medical 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.

Plan Documents

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 "Supplement" , along with the insurance carriers' benefit booklet, is designed to constitute the Summary Plan Description ("SPD") and 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.

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

Medical and prescription drug claim forms, if applicable, are available through the Insurer. You should promptly submit claims to the Insurer. Generally, all claims for benefits under the Health Benefit Plan must be properly submitted to the Insurer within twelve (12) months of the date you receive the service or supplies.

Medical Claims

If You Use a Network Provider *Your provider files the claim on your behalf*	When you receive treatment or care from a Provider or Covered Drugs dispensed from a Pharmacy that contracts with the Claim Administrator, you will generally not be required to file claim forms. The Provider will usually submit the claims directly to the Claim Administrator for you.
If You Use an Out-of-Network Provider *Your provider MAY file the claim. However, you are responsible for making sure this happens. Out-of-Network benefits may be limited or excluded entirely under some local health plans. See your Benefit booklet for details.*	When you receive treatment or care from a health care Provider or Covered Drugs dispensed from a Pharmacy that does not contract with the Claim Administrator, you may be required to file your own claim forms. Some Providers, however, will do this for you. If the Provider does not submit claims for you, you must file your own claim forms. **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.**

Filing Your Medical Claim

If your Provider does not submit your claims, you will need to submit them to the Insurer using a subscriber-filed claim form provided by the Plan. You can obtain copies of the form from the Insurer. Follow the instructions on the form to complete the claim.

Remember to file each participant's expenses separately because any deductibles, maximum benefits, and other provisions are applied to each participant separately. Include itemized bills from the health care providers, labs, etc., printed on their letterhead and showing the services performed, dates of service, charges, and name of the participant involved.

Be sure to read the instructions on the claim form carefully and complete and sign all claims completely and accurately. If you submit an incomplete or inaccurate form, processing of the claim may be delayed while the necessary information is obtained.

Prescription Drug Claims

When you receive Covered Drugs dispensed from a non-Participating Pharmacy, a Prescription Reimbursement Claim Form must be submitted. This form can be obtained from the Insurer.

The claim form, accompanied by an itemized bill obtained from the Pharmacy showing the prescription services you received, should be mailed to Insurer.

Follow the instructions for completing the claim form. You may need to obtain additional information, which is not on the receipt from the pharmacist, to complete the claim form.

Bills for Covered Drugs should generally show the name, address and telephone number of the Pharmacy, a description and quantity of the drug, the prescription number, the date of purchase and most importantly, the name of the Participant using the drug.

When to Submit Claims

All claims for benefits under the Health Benefit Plan must generally be properly submitted to the Insurer within twelve (12) months of the date you receive the services or supplies. Claims submitted and received by the Claim Administrator after that date may not be considered for payment of benefits except in the absence of legal capacity.

Payment of Claims

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; or
- payment may be made to an alternate payee or legal representative in the case of a QMCSO (see **Qualified Medical Child Support Orders**).

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.

The Insurer for the Plan may deduct from its benefit payment any amounts it is owed by the recipient of the payment. Payment to you or your Provider, or deduction by the Plan from benefit payments of amounts owed to it, will be considered in satisfaction of its obligations to you under the Plan.

ASSIGNMENT AND PAYMENT OF BENEFITS

Rights and benefits under the Plan are generally not assignable, either before or after services and supplies are provided. In the absence of a written agreement with a Provider, the Insurer may reserve the right to make benefit payments to the Provider or the Employee, as per the Insurer's agreement. Payment to either party discharges the Plan's responsibility to the Employee or Dependents for benefits available under the Plan.

Types of Claims and Timeframes

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 medical care has been received. Most claims are post-service claims. Within 30 days following receipt of a post-service claim, the Insurer will either:

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

The Insurer will notify you within this 30-day period if additional information is needed to process the claim and may request a one-time extension of up to an additional 15 days.

- Once notified of the need to provide additional information, you will have 45 days to provide the information.
- The period for the Insurer to make a determination on your claim will be tolled from the date on which the notice of extension is provided until the date on which you respond with the requested information.
- If you do not provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial (including the part of the Plan on which the denial is based) and the claim appeal procedures.

Pre-Service Claims

Pre-service claims are claims that require notification or approval prior to receiving medical care. If your pre-service claim was submitted properly, you will receive written notice of the claim decision from the Insurer within 15 days of receipt of the claim. If your pre-service claim was filed improperly, the Insurer will notify you of the improper filing and how to correct it within five days after receipt of the claim.

If additional information is needed to process the claim, the Insurer will notify you within 15 days of receipt and may request a one-time extension of up to an additional 15 days.

- Once notified of the need to provide additional information, you will have 45 days to provide the information.
- If all of the information is received by the Insurer within the 45-day timeframe, the Insurer will notify you of the determination within 15 days after the information is received.
- If you do not provide the needed information within the 45-day period, your claim will be denied.

You will be notified of the decision, whether adverse or not, as soon as possible but not later than the last day of the applicable period for reviewing the claim. A denial notice will explain the reason for denial (including the part of the Plan on which the denial is based) and the claim appeal procedures.

Urgent Care Claims

Urgent care claims are claims that require notification or approval prior to receiving medical care, where a delay in treatment:

- could seriously jeopardize your life or health or your ability to regain maximum function; or
- in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

For an urgent care claim, you or your physician should call the Insurer as soon as possible. The claim does not need to be submitted in writing.

If the Insurer or your physician determines that it is an urgent care claim, you will be notified of the decision, whether adverse or not, as soon as possible but not later than 72 hours after the claim is received.

If your urgent claim was filed improperly, the Insurer will notify you of the improper filing and how to correct it within 24 hours after receipt of the claim.

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

- the Insurer'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.

A denial notice will explain the reason for denial (including the part of the Plan on which the denial is based) and the claim appeal procedures.

Ongoing Course of Treatment

If you have received pre-authorization for an ongoing course of treatment, you will be notified in advance if the previously authorized course of treatment is intended to be terminated or reduced so that you will have an opportunity to appeal any decision to the Insurer and receive a decision on that appeal before the termination or reduction takes effect. If the course of treatment involves urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

IF A CLAIM FOR BENEFITS IS DENIED

Appealing a Denied Claim

Whenever a claim is denied, you, your beneficiary(ies) or a duly authorized representative have the right to appeal the decision. If you have a question or concern about a benefit determination, you should first call the Customer Service Helpline before requesting a formal appeal. If you still wish to submit a formal appeal, you can submit a written appeal to the Insurer.

If the appeal relates to a claim for payment, your written appeal to the Insurer should include:

- the group name (employer name);
- the patient's name and the identification number from the ID card;
- the date(s) of medical service(s);
- the provider's name;
- the reason you believe the claim should be paid; and
- any documentation or other written information to support your request for claim payment.

Your appeal must be submitted to the Insurer 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 physician should call the Insurer as soon as possible; and
- the Insurer will provide you with a written or electronic determination within 72 hours after receipt of your appeal, taking into account the seriousness of your condition.

The Insurer has the exclusive right to interpret and administer provisions of the Plan for urgent care claim appeals. The Insurer's decision is conclusive and binding, except to the extent explained in the **External Review** section below.

To make a determination on your appeal, the Insurer:

- will appoint a qualified individual to resolve or recommend the resolution of the appeal. Neither this individual nor his subordinate will have been involved in the decision being appealed;
- will 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, medical experts as part of the appeal resolution process.

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

Determinations for Appeals

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

- within 30 days from receipt of a request for appeal of a denied pre-service claim;
- within 60 days from receipt of a request for appeal of a denied post-service claim; and
- within 72 hours after receipt of your appeal of a denied urgent care claim, taking into account the seriousness of your condition.

External Review

Notwithstanding any determination made by the Insurer during the claims process, certain determinations made by the Insurer are subject to an External Review process, upon your request.   A request for External Review must be filed with the Insurer within 4 months of the date of adverse benefit determination under the internal appeal process. The External Review process under this Plan gives you the opportunity to receive review of an Adverse Benefit Determination (whether as an initial denial or upon internal appeal) conducted by an independent review organization (IRO) pursuant to applicable law. The decision of the IRO is binding on you, the Insurer and the Plan unless otherwise allowed by law.

Only the following types of claims are eligible for External Review:

- a claim that relates to a rescission, which is defined as a cancellation or discontinuance of coverage which has retroactive effect, or
- a claim that involves medical judgment

An Adverse Benefit Determination based upon your eligibility is not eligible for External Review.
Your request for External Review of an eligible claim will be provided if the following are satisfied:

- The Insurer, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under federal law, unless such failure constitutes a "de minimis violation"; or
- the standard levels of internal appeal have been exhausted.

A failure to abide by the internal claims procedure will not be considered "de minimis violation" unless the Insurer determines that the violation does not cause, or is not likely to cause, prejudice or harm to the participant so long as the Insurer demonstrates that the violation was for good cause or due to matters beyond the control of the Insurer and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the participant. For these purposes, the participant may request an explanation of the basis upon which the Insurer asserts that such violation does not result in a deemed exhaustion of these claims procedures with respect to a claim, which shall be provided to the participant within ten (10) days of such request. If an IRO or court rejects the participant's request for immediate review based on the Insurer's assertions, the Insurer shall, within ten (10) days thereof, notify the participant of the opportunity to resubmit and pursue the internal appeal of such claim(s) in accordance with the foregoing claims procedures, and the otherwise applicable time period shall begin to run as of the date of such notice to the participant.

Within five (5) business days following the date of its receipt of a claimant's request for an External Review of a claim for benefits, the Insurer or its delegate shall complete a preliminary review of the request for External Review to determine the following:

- Whether the Claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
- Whether the Adverse Benefit Determination relates to the claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
- Whether the claimant has exhausted (or is deemed to have exhausted) the Plan's internal claims procedures; and
- Whether the claimant has provided all the information and forms required to process the request for an External Review of the claim for benefits.

Notice to Claimant

Ineligible Claim. If the claimant's request for External Review is complete, but the claim is not eligible for an External Review, the Insurer Administrator or its delegate shall, within one (1) business day following completion of its preliminary review, provide the claimant with written notice of the reason(s) for the claim's ineligibility for External Review and the contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).

Incomplete Request. If the claimant's request for External Review is incomplete, the Insurer or its delegate shall, within one (1) business day following completion of its preliminary review, provide the claimant with written notice describing the information or materials needed to complete the request for External Review and the Plan shall provide the claimant an opportunity to perfect the request for External Review within the later of the applicable four-month filing period described above or the 48-hour period following the receipt of the notification, whichever is later.

Referral to Independent Review Organization. Upon receipt of a completed and eligible request for External Review, the Plan must, in accordance with applicable law, assign an IRO to conduct the External Review. Within five (5) business days following the date of assignment of the IRO, the Plan shall provide to the IRO the documents and any information considered in making the Adverse Benefit Determination. With respect to a Claimant's request for an expedited External Review, the Plan must provide or transmit such information to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. Notwithstanding the foregoing, the Plan's failure to timely provide the documents and information shall not delay the External Review. If the Plan fails to timely provide the documents and information, the IRO may terminate the External Review and make a decision to reverse the Adverse Benefit Determination. Within one (1) business day after making the decision to terminate the External Review and reverse the prior Adverse Benefit Determination, the IRO must notify the claimant and the Plan of its determination.

Communication by Independent Review Organization. The IRO will notify the claimant, in writing, of the eligibility and acceptance of the claim for External Review, and will include a statement that the claimant may, within ten (10) business days following the date of receipt of such notice, submit, in writing, to the IRO additional information for the IRO to consider when conducting the External Review of the claim for benefits. Upon receipt of any information submitted by the claimant, the IRO must within one (1) business day forward the information to the Plan.

Reconsideration by Plan. Upon receipt of any information forwarded by the IRO, the Plan may reconsider its Adverse Benefit Determination that is the subject of the External Review. Reconsideration by the Plan shall not delay the External Review of the claim for benefits. Notwithstanding the foregoing, if the Plan decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination and provide coverage or payment, the External Review of the claim for benefits may be terminated. Within one (1) business day after making such decision, the Plan must provide written notice of its decision to the claimant and the IRO. The assigned IRO must terminate the External Review upon receipt of the notice from the Plan.

Review by Independent Review Organization. In conducting its review, the IRO shall consider the information forwarded by the Plan and any additional information and documents timely submitted by the claimant and shall utilize legal experts where appropriate to make coverage determinations under the Plan. In reaching its decision, the IRO will review the claim *de novo* and shall not be bound by any decisions or conclusions reached during the Plan's internal claims process. In addition to the documents and information provided by the Plan and the claimant, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following information in reaching a decision on External Review:

1. The Participant's medical records;
2. The attending health care professional's recommendation;
3. Reports from appropriate health care professionals and other documents submitted by the Plan, claimant, or the Participant's treating provider;
4. The terms of the Plan, to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
5. Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;
6. Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
7. The opinion of the IRO's clinical reviewer or reviewers after considering the information to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

Decision by Internal Review Organization. The IRO must, within forty-five (45) days after the IRO receives the request for the External Review, provide written notice of the Final External Review Decision to the claimant and the Plan. Notwithstanding the foregoing, with respect to a claimant’s request for an expedited External Review of a claim for benefits, the IRO shall provide notice of the Final External Review Decision to the claimant as expeditiously as the Participant’s medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the claimant’s request for an expedited External Review of the claim for benefits. Notice of the Final External Review Decision may be given orally, but only if the IRO furnishes the claimant a written notification of the Final External Review Decision within forty-eight (48) hours after the date of providing the oral notice.

Contents of Notice. The notice of the Final External Review Decision by the IRO shall set forth the following:

1. A general description of the reason for the Claimant’s request for an External Review of the claim for benefits, including information sufficient to identify the claim (including the date or dates of service, the Health Care Provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
2. The date the IRO received the assignment to conduct the External Review of the claim for benefits and the date on which the Final External Review Decision was made;
3. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching the Final External Review Decision;

4. A discussion of the principal reason or reasons for the Final External Review Decision, including the rationale for the Final External Review Decision and any evidence-based standards that were relied on in making the Final External Review Decision;
5. A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Plan or to the Claimant;
6. A statement that judicial review may be available to the Claimant; and
7. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

Retention of Records. Following a Final External Review Decision, the IRO must maintain records of all claims and notices associated with the External Review of a claim for benefits for six (6) years and must make such records available for examination by the claimant, the Plan, or any state or federal oversight agency, upon request, except where such disclosure would violate state or federal privacy laws.

Reversal of Adverse Benefit Determination. Upon receipt of a notice of a Final External Review Decision reversing the Adverse Benefit Determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim, regardless of whether the Plan intends to seek judicial review of the Final External Review Decision and unless or until there is a judicial decision.

Expedited External Review. The Plan must allow a Claimant to make a request for an expedited External Review at the time the Claimant receives:

1. An Adverse Benefit Determination that involves a medical condition of the Participant for which the timeframe for completion of an expedited Internal Appeal would seriously jeopardize the life or health of the Participant or would jeopardize the Participant's ability to regain maximum function and with respect to which the claimant has filed a request for an expedited Internal Appeal; or
2. An Adverse Benefit Determination, if the Participant has a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize the life or health of the Participant or would jeopardize the Participant's ability to regain maximum function, or if the Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Participant received emergency services, but has not been discharged from a facility.

Exhaustion of Appeals Process

You must exhaust the appeals process before you pursue other action. After that you may pursue litigation, arbitration or administrative proceedings.

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

IMPORTANT FACTS ABOUT THE PLAN

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 26. Other important information about the Plan is provided below:

Plan Name	The Tesoro Medical Plan (a constituent benefit program of the Tesoro Corporation Omnibus Group Welfare Benefits Plan)
Type of Plan	Welfare benefit plan
Plan Sponsor	Tesoro Corporation 19100 Ridgewood Parkway San Antonio, TX 78259 (210) 828-8484
Plan Sponsor's Employer Identification Number	95-0862768
Plan Administrator	Tesoro Employee Benefit Committee 19100 Ridgewood Parkway San Antonio, TX 78259 (866) 688-5465, press option 3, then option 5
Plan Number	501
Plan Year	January 1 – December 31
Plan Funding /Contributions	The Plan is funded by insurance contracts. The premiums for coverage are paid with employee and employer contributions.
Type of Administration	Contract with Insurance carrier.
Plan Insurers	BlueCross BlueShield of North Dakota 4510 13th Avenue S.W. Fargo, ND 58121 Kaiser Foundation Health Plan, Inc. 1350 Treat Blvd. Suite 380 Walnut Creek, CA 94597
Agent for Service of Legal Process	General Counsel Tesoro Corporation 19100 Ridgewood Parkway, San Antonio, TX 78259 In addition, service of legal process may 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.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under a group health plan, if you have continuous creditable coverage from another group health plan, such as this Plan. You should be provided a certificate of creditable coverage, free of charge, from this Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for the 12-month period commencing on your employment commencement date under another group health plan. **Note: Participants in this Plan are not subject to preexisting condition exclusions under this Group Health Plan and the right to receive a certificate of creditable coverage will expire on December 31, 2014.**

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 those 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 that 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 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 Tesoro Benefit Center or your local HR Manager (see **Contacts** on page 32).

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 program.

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.

REQUIRED WRITTEN NOTICE OF CURRENT BENEFITS

Two pieces of legislation apply to self-insured group health plans that are governed under ERISA:

- Women's Health and Cancer Rights Act of 1998
- Newborns' and Mothers' Health Protection Act of 1996

These amendments represent benefits that were already provided under the Plan.

Women's Health and Cancer Rights Act of 1998

The Plan provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses and for complications resulting from a mastectomy, including lymphedemas.

If you elect breast reconstruction in connection with a mastectomy, coverage will be provided in a manner determined in consultation with you and your physician for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedemas.

These benefits are subject to all terms of the Plan, including relevant deductibles, coinsurance and out-of-pocket provisions applicable to other medical and surgical benefits provided under the Plan.

Newborns' and Mothers' Health Protection Act of 1996

The Newborns' and Mothers' Health Protection Act of 1996 (the Newborns' Act), signed into law on September 26, 1996, requires plans that offer maternity coverage to pay for at least a 48-hour hospital stay following childbirth (96-hour stay in the case of a cesarean section).

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable).

In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours, as applicable).

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 that 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 that 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:

(a) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements;
(b) 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;
(c) resolution of internal grievances;
(d) 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
(e) 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. Note, however, that protected health information disclosed to the Plan Sponsor can be used only for Plan administrative functions performed by 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 the 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 Tesoro Benefit Center;
- Human Resources employees with responsibility for investigating appeals and recommending decisions to the Plan Administrator;
- Human Resources employees with access to the data that 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 that 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 insurers 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 from the insurers and through the Tesoro Benefit Center.

CONTACTS

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

Tesoro Benefits Center

P.O. Box 3129
Bellaire, TX 77402
www.tsocorp.com/benefits
(866) 787-6314

Tesoro Corporate Benefits Department

19100 Ridgewood Parkway
San Antonio, TX 78259
Email: SAT – Benefits Department (satbenefits@tsocorp.com)
(866) 688-5465

Local Health Plans

State	Plan Name	Web Site	Customer Service #	Group #
CA	Kaiser Health Plan - Northern California	www.kp.org	(800) 464-4000	48446-0000
CA	Kaiser Health Plan - Southern California	www.kp.org	(800) 464-4000	228845-00
ND	Blue Cross Blue Shield of North Dakota	www.bcbsnd.com	(800) 342-4718	28032-01