TESORO CORPORATION VISION PLAN

SUMMARY PLAN DESCRIPTION

As of January 1, 2016

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

This document describes the Tesoro Vision Plan as of January 1, 2016. This Plan is available to eligible Tesoro employees on the U.S. payroll. This information comprises the SPD of this Plan as required by the Employee Retirement Income Security Act of 1974 (ERISA). This description doesn't cover every provision of the Plan. Some complex concepts may have been simplified or omitted in order to present a more understandable plan description. If this plan description is incomplete or if there's any inconsistency between the information provided here and the official plan texts, the provisions of the official plan texts will prevail.

To assist you with your routine eye care and vision needs, Tesoro provides vision benefits through Vision Service Plan (VSP) for eligible participants. VSP is a managed vision program providing benefits both inside and outside VSP's national network of eye-care professionals.

PARTICIPATION

You are eligible to participate in the Vision Plan if you're a regular full-time employee of one of Tesoro Corporation's participating subsidiary companies. You will be considered a full time employee if you are regularly scheduled to work at least thirty (30) hours each week. If you are in a job covered by a collective bargaining agreement, you are not eligible for participation in the Vision Plan unless the provisions are included or incorporated in your collective bargaining agreement.

COVERAGE FOR YOUR DEPENDENTS

You may also cover your eligible dependents on the same day your coverage begins. Generally, your eligible dependents include:

- your spouse, not legally separated from you, and
- your children under age 26. Dependent children include:
  - your biological children,
  - stepchildren, and
  - foster children or legally adopted children

Coverage for a child who is mentally or physically disabled may be continued beyond age 25 under certain circumstances. For more information, contact the Tesoro Benefit Center, the Corporate Benefits Department, or your local HR Manager at least 31 days before the child's 26th birthday. Subsequent proof of a child's continued disability or dependency may be required.

Coverage for new dependents requires enrollment within the first 31 days after the life event (birth, adoption, marriage). If an enrollment application is not made within the 31-day period, you must wait until a designated open enrollment period to enroll the dependents.

The following individuals will not be considered as eligible dependents:

- your legally separated spouse (or an individual who does not have documentation proving a legal marital relationship);
- a child who is employed by Tesoro Corporation or one of its affiliates and is eligible for coverage as an employee,
- a child who no longer qualifies as a dependent.

When both husband and wife are participants in the Plan, both may be considered as having dependents.

Domestic Partner Coverage

You may also cover your eligible domestic partner and domestic partner's dependent children on the same day your coverage begins. Domestic partner coverage includes those domestic partners meeting the eligibility criteria listed on Tesoro's Affidavit of Domestic Partnership.

To qualify for benefits, you must register your domestic partner with Tesoro. To do so, you and your partner must obtain and sign the Tesoro Affidavit of Domestic Partnership. This form is available on HR Connect, through the Tesoro Benefits Center at (866) 787-6314 or online at www.tsocorp.com/benefits.

Coverage for domestic partners and their dependent children requires enrollment within the first 31 days of the date they meet the eligibility requirements. If an enrollment application is not made within the 31-day period, you must wait until a designated open enrollment period.

If you have any changes in domestic partner status, you must submit your Online Change Request through the Tesoro Benefit Center at www.tsocorp.com/benefits or by calling (866) 787-6314 within 31 days of the change. A subsequent Affidavit of Domestic Partnership cannot be filed for at least six months.

Under IRS rules, the value of the domestic partner coverage elected will be included as taxable income on your W-2 form, unless you certify that your domestic partner qualifies as your tax dependent.

Qualified Medical Child Support Order (QMCSO)

The Plan also provides coverage for your child pursuant to the terms of a Qualified Medical Child Support Order (QMCSO), even if you do not have legal custody of the child, the child is not dependent on you for support, and regardless of any enrollment season restrictions that might otherwise exist for dependent coverage. 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. Additionally, Tesoro may withhold any contributions required for such coverage from your pay.

ENROLLMENT

If you are eligible to participate in the Plan, you will automatically be enrolled in Employee Only coverage. If you wish to waive vision coverage or to add dependents to your coverage, you must do so within 31 days of your eligibility date. 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. After you have completed your enrollment, you may print a Confirmation Form verifying your elections. Any payroll deductions covering your elections will be made automatically.

You may generally enroll once each year, for one calendar year at a time. During the annual open enrollment period designated by the Company (normally in October of each year for coverage beginning January 1st), you can enroll, re-enroll or stop participation (waive coverage) for the upcoming year. If you choose to keep your elections for the next calendar year, you must actively re-enroll your dependents each year to continue their coverage for the following calendar year and you will not be allowed to change that election unless you experience a qualified family status event.

If you decline (waive) coverage, or do not enroll dependents within thirty-one (31) days after you were first eligible, you must wait until the next open enrollment period to enroll, unless you are otherwise eligible as a result of a qualifying family status event.

LEVELS OF COVERAGE

You may generally choose from these levels of coverage:

- Employee Only
- Employee + Child(ren)
- Employee + Spouse
- Employee + Family

COST

You and the Company share the cost of vision coverage for you and your eligible dependents. You pay your portion of the premium through automatic payroll reductions. Employee contributions are made on a pretax basis. The actual dollar amounts are listed on your Enrollment Form and are subject to change. In the event cost changes occur, you will be given advance notice.

CHANGING COVERAGE

You may change your coverage (or your dependents coverage) under the Plan during the annual open enrollment period (usually during the month of October). If your eligible dependents change during the year (due to birth, marriage, death, or divorce, etc.), you must complete your Online Change Request through the Tesoro Benefit Center at www.tsocorp.com/benefits or by calling (866) 787-6314. You may make coverage changes that are consistent with a qualified Family Status Change within 31 days of the change. If you wait more than 31 days to submit the form and complete the enrollment change, you must wait until the next open enrollment period to change your coverage.

BENEFITS

VSP In-Network Services

To receive in-network benefits, you must select a VSP network service provider from the provider directory, schedule an appointment and inform the service provider that you are a VSP participant. After your eligibility is verified, the provider will confirm your appointment. **Benefit Authorization must be obtained prior to receiving plan benefits from a network doctor.**

Benefits for you and your eligible dependents include:

Exams

- Routine eye examination every 12 months (from your last date of service) for a co-payment of $10.
- Eye examination & medical services for Type 1 & Type 2 Diabetic Patients for a co-payment of $20.

Prescription Glasses

- Lenses every 12 months (from your last date of service) for a co-payment of $10 (single vision, lined bifocal, lined trifocal, and polycarbonate lenses for dependent children).
- Frames every 24 months (from your last date of service). Frames of your choice are covered up to $150 plus 20% off any out-of-pocket costs.
- Discounts off additional glasses and sunglasses, including lens options from the same VSP doctor on the same day as your WellVision Exam. Some restrictions apply.

OR

Contact Lenses

- Contact lenses every 12 months (from your last date of service). When you choose contact lenses instead of glasses, you receive a $150 allowance plus a 15% discount off the contact lens fitting and evaluation exam, with no co-payment.
- Visually necessary[1] contact lenses, together with necessary professional services, are covered in full but must first be reviewed and authorized by one of VSP's optometric consultants.

VSP also offers discounts on laser vision correction through their Laser Vision Care Program.

Additional information, including assistance in finding a VSP doctor, may be obtained by calling VSP at (800) 877-7195 or by accessing their website at www.vsp.com.

VSP Out-Of-Network Services

If you use out-of-network providers, you must pay for services and supplies received and file a claim for partial reimbursement from VSP. Claims must be filed within 180 days after you see the provider. Co-pays for the exam and prescription glasses still apply. Claim forms are available online or by contacting VSP at (800) 877-7195.

VSP will reimburse up to the following amount for out-of-network benefits:

Out-of-Network Service	Reimbursed Up To
Examination	$50
Single Vision Lenses	$50
Lined Bifocal Lenses	$75
Lined Trifocal Lenses	$100
Frames	$70
Contact Lenses	$105 elective, or $210 visually necessary[2]

[1] Visually necessary means services and materials medically or visually necessary to restore or maintain a patient's visual acuity and health for which there is no less expensive professionally acceptable alternative, as determined by VSP. Prior authorization by VSP is required for visually necessary contact lenses.

You should mail your out-of-network claims (claim form and receipts) to:

Vision Service Plan
P.O. Box 997105
Sacramento, CA 95899-7105

Low Vision Services

The Plan also provides services for severe visual problems not correctable with regular lenses (subject to prior approval by VSP consultants), including:

- Supplemental Testing (includes evaluation, diagnosis, and prescription of vision aids where indicated), covered in full when using member doctors, covered up to $125.00 when using non-member doctors.
- Supplemental Aids, covered up to 75% of the allowable cost when using member doctors or non-member doctors.
- There is a maximum allowable for all Low Vision benefits of $1,000.00 every two (2) years.

EXCLUSIONS AND LIMITATIONS

Patient Options

This Plan is designed to cover visual needs rather than cosmetic or optional materials. If you select any of the following extras, the Plan will pay the basic cost of the allowed lenses, and you must pay the additional costs for the options.

- Optional cosmetic processes
- Anti-reflective coating
- Color coating
- Mirror coating
- Scratch-resistant coating
- Blended lenses
- Cosmetic lenses
- The laminating of the lens or lenses
- Oversize lenses
- Progressive multifocal lenses
- Photochromic lenses; tinted lenses except Pink #1 and Pink #2
- UV (ultraviolet) protected lenses
- Certain limitations on low vision care
- A frame that costs more than the Plan allowance
- Contact lenses (except as noted elsewhere in the Benefits section)

Average 35% to 40% savings are available on some lens extras such as scratch-resistant and anti-reflective coatings and progressives.

Not Covered

No benefit will be paid for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than a +/- 0.50 diopter power); or two pair of glasses in lieu of bifocals;
- Replacement of lenses and frames furnished under this Plan which are lost or broken, except at the normal intervals when services are otherwise available;
- Medical or surgical treatment of the eyes;
- Corrective vision treatment of an experimental nature;
- Costs for services and/or materials above Plan Benefit allowances;

- Services and/or materials not indicated as covered Plan Benefits.

VSP may, at its discretion, waive any of the Plan limitations if, in the opinion of VSP's optometric consultants, it is necessary for the visual welfare of the participant.

EVENTS AFFECTING PARTICIPATION

Change in Family Status

If you have a qualified change in family status, you may elect to change or discontinue your participation (or your dependent's participation) in the Plan if you complete your Online Change Request through the Tesoro Benefits Center at www.tsocorp.com/benefits or (866) 787-6314 within 31 days of the event and your request is consistent with the event.

Qualified family status changes include:

- Marriage
- Divorce
- Birth or adoption of a child
- Death of a spouse or child
- Loss of dependent eligibility
- Company authorized transfer or relocation
- Employment or unemployment of your spouse
- Change in part-time/full-time status for you or your spouse

Disability

If you are disabled and receiving Long-Term Disability income benefits from a program to which the Company contributes, the vision insurance coverage that was in effect at the time your disability began will be continued[2]. During the disability period, you are responsible for the payment of any required premiums. This continuance will end the earlier of:

- the date any required contributions are not made,
- the date you stop receiving disability benefits under the Company's LTD program, or
- the date you retire.

Continued coverage is subject to the same rules that would apply if you were an active employee. However, if benefits reduce for others in the class, they will also reduce for you.

Personal Leave of Absence – Employer Certified

You may remain eligible for a limited time if active, full-time work ceases due to a Company certified personal leave of absence. During the leave, you are responsible for arranging for the payment of premiums due. This continuance will end the earlier of:

- the date any required contributions are not made, or
- the expiration of six months of continuation coverage.

While continued, coverage will be that which was in force on the last day you worked as an active employee. Continued coverage is subject to the same rules that would apply if you were an active employee. However, if benefits reduce for others in the class, they will also reduce for you.

Family and Medical Leave

Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993, as amended. During any leave taken under the Family and Medical Leave Act, your coverage will continue under the same conditions as coverage would have been provided if you had been continuously employed during the entire leave period.

[2] Coverage for disabled individuals is contingent upon the Company continuing the Plan. The Company reserves the right to change the cost sharing rules, including the right to charge disabled employees for part or all of the cost of coverage (See Plan Amendment or Termination).

Military Leave

USERRA (Uniformed Services Employment and Reemployment Rights Act of 1994, as amended) provides a way for you and your eligible dependents who would otherwise lose group health plan coverage as a result of a leave of absence for duty in the uniformed services, to continue coverage for a period of time. If you are on a military leave of absence, the maximum period of coverage for you and your dependents would extend from the date on which your leave of absence begins to the earlier of:

- twenty-four (24) months after that date, or
- the day after the date on which you fail to apply for or return to a position of employment with Tesoro, or as determined under Section 4312(3) of the Act.

If you elect to continue coverage, you may be required to pay the full cost of coverage (employer and employee portions) plus a 2% administration fee[3]. Plan exclusions and waiting periods may be imposed for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

Reduction in Number of Hours Worked

If you are a full-time employee and your regularly scheduled hours are reduced to less than 30 hours per week, your coverage will end as of the date the schedule change is effective. However, you may be able to continue coverage under COBRA. If, later on, your regularly scheduled hours increase to at least 30 hours a week, you'll once again be eligible to enroll in the Plan.

Layoff or Termination of Employment

Your coverage will end if you're laid off due to lack of work or if your employment is terminated. However, you may be able to continue coverage under COBRA (see Continuation of Coverage, below).

Retirement

Vision Care benefits are not included as part of Tesoro's Post-Retirement Group Health Plan coverage, but may be continued under COBRA.

Death

In the event of your death, your dependents participating in the Plan may elect continued coverage through COBRA.

Plan Amendment or Termination

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

CONTINUATION OF COVERAGE

COBRA

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985, as amended) provides a way for you and your eligible dependents who lose group health plan coverage to continue coverage for a period of time. If you are an employee, you may continue coverage if your eligibility terminated because of a reduction in hours of employment or if your employment terminated for reasons other than gross misconduct.

Your dependent may continue coverage if coverage is lost due to:

1. Your death;
2. Your termination of employment (for reasons other than gross misconduct) or a reduction in your hours of employment;
3. Your divorce or legal separation;
4. You become entitled to Medicare; or
5. Your dependent child ceases to meet the definition of a dependent child.

[3] Participants performing uniformed service lasting less than 31 days shall not be required to pay the employer contribution for coverage

You or your family member has the responsibility to inform the Tesoro Benefits Center of a divorce, legal separation, or child losing dependent status within 60 days of the event. The election to continue coverage must be made within 60 days of the date that you or your dependent was notified of the right to continue coverage. The monthly premium required to make coverage retroactive to your date of ineligibility must be paid within 45 days of the date you elect to continue coverage.

COBRA continuation coverage is a temporary continuation of coverage. In general, the maximum extension of coverage provided under COBRA is 36 months; however, when eligibility ceases due to termination of employment or reduction in hours, the extension of coverage is limited to 18 months, unless you are disabled.

Disability Extension

The 18-month period may be extended to 29 months if you are determined to be disabled (for Social Security disability purposes) at any time during the first 60 days of COBRA coverage. Notice of the determination must be given to the Tesoro Benefits Center within 60 days and before the end of the initial 18- month period. Any loss of disability status must also be given to the Tesoro Benefits Center within 30 days of the determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events include the death of a covered employee, divorce or separation from the covered employee, the covered employee's enrolling in Medicare, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. You must notify the Tesoro Benefits Center within 60 days after a second qualifying event occurs.

If you elect to continue coverage, you will be required to pay the full cost of coverage (employer and employee portions) plus a 2% COBRA administration fee. Disabled persons will be charged 150% rather than 102% of the full cost of coverage for the additional 11 months of coverage when an 18-month period is extended to 29 months because of disability.

Coverage under this provision will automatically terminate for any of the following reasons:

1. the Plan Sponsor no longer provides group coverage to any of its employees;
2. the monthly premium is not paid on or before the date it is due;
3. the period during which COBRA was applied for ends;
4. you or your dependent becomes covered under another group health plan which does not contain any exclusion or limitation with respect to any preexisting conditions;
5. you become entitled to Medicare; or
6. recovery from disability, if you are receiving continued coverage due to disability extension.

ADDITIONAL INFORMATION

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

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

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

Receive Information About Your Plan and Benefits

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plans. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a State or Federal court. In addition, if you disagree with a Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

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

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

GENERAL CLAIMS PROCEDURE

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

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

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

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

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

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

Future of the Plan

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

Interpretation of the Plan

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

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

IMPORTANT FACTS ABOUT THE PLAN

Plan Name

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

Plan Sponsor

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

Plan Administrator

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

Plan Funding

The plan is funded by employer and employee contributions.

Plan Insurer

Vision Service Plan Insurance Company
3333 Quality Drive
Rancho Cordova, CA 95670

Other Employers Whose Employees Are Covered By the Plan

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

Agent for Service of Legal Process

General Counsel
Tesoro Corporation
19100 Ridgewood Parkway San Antonio, TX 78259
Note: Legal process may also be served upon the Plan Administrator.

Plan Type

Welfare benefit plan.

Plan Number

The plan number is 501.

Employer Identification Number (EIN)

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

Plan Year

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

Questions

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