TESORO CORPORATION

VISION PLAN

SUMMARY PLAN DESCRIPTION

As of January 1, 2017

Table of Contents

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

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

WHO IS ELIGIBLE

Employee Eligibility

You are eligible to participate in the Plan if you:

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

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

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

Dependent Eligibility

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

- your spouse (if you are not legally separated);
- your children under age 26[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 information at the top of the next page).

CONTINUING COVERAGE FOR A DISABLED CHILD

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 through your Plan Administrator to the Claim Administrator 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 Claim Administrator may require periodic certification of the child's physical or mental condition, but no more frequently than annually after the two-year period following the child's attainment of age 26.

[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.

DOMESTIC PARTNER COVERAGE

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

You must enroll your domestic partner and his or her dependent children within the first 31 days of the date they meet the eligibility requirements (upon hire or completion of six months of the domestic partner relationship). If you don't enroll within the 31-day period, you must wait until the next open enrollment period. Note, however, that dependent coverage for eligible domestic partners generally requires that the value of that coverage be included as taxable income to the participant.

PROOF OF DEPENDENT STATUS

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.

- Log in to the Tesoro Benefit Center at 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 "Vision 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.

Ineligible Dependents

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

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

ENROLLING IN THE PLAN

To complete your Vision Plan election, you'll need to:

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

Generally, the coverage levels available under the Plan are:

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

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

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

IF YOUR SPOUSE IS ALSO AN ELIGIBLE EMPLOYEE

If both you and your spouse are eligible to enroll in the Plan, you may elect Plan coverage as an employee and as a dependent spouse. Your coverage as a dependent spouse will be Secondary to your coverage as an employee. See **Coordination of Benefits (COB)** section for more information on Primary coverage and Secondary coverage. However, you may not receive coverage as both an employee and dependent child.

Enrollment

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

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

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

You may enroll by completing your Online Benefits Enrollment through the Tesoro Benefit Center at 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 vision 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 Tesoro Vision Plan at the Employee Only coverage level.

Annual Open Enrollment Period

During an annual open enrollment period designated by the Company (normally in October of each year for coverage beginning the following January 1), you may make an election to enroll, re-enroll or decline (waive) participation for the coming year. You may change your Vision Plan coverage levels and add/re-add dependents to your coverage. If you do not make an election during this period, your current coverage will be continued for the 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. Coverage elections (and deemed elections) made during open enrollment become effective on January 1 of the immediately following year.

Special Enrollment

Certain family status changes (see **Changes in Family Status**) 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 vision 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 vision 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 vision coverage was COBRA continuation and the continuation is exhausted, or
  - the other plan terminates due to the employer's failure to pay the premium or any other reason; and
- you elect coverage within 31 days of the date the person loses coverage for one of the above reasons.

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

WHEN COVERAGE BEGINS

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

CHANGING YOUR COVERAGE

After your initial enrollment, you can make changes to your coverage only during the open enrollment period or as the result of an eligible status change 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 tsocorp.com/benefits or request a change by calling (866) 787-6314 within 31 days of the change.

An eligible status change allows you to:

- change your level of coverage (for example, from "Employee Only" to "Employee + Spouse" coverage);
- elect coverage if you previously waived coverage; or
- terminate coverage.

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

COST OF COVERAGE

You and the Company share the cost of vision coverage for you and your eligible dependents. Your cost is based on the 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.

BENEFITS

VSP In-Network Services

To receive in-network benefits, you must select a VSP network service provider from the provider directory (available at www.vsp.com), 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[2] 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 at www.vsp.com 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]

[2] 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
Attention: Claims Services
P.O. Box 385018
Birmingham, AL 35238-5018

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.

Other Services Offered

VSP offers other services to vision care members. Information about the following services is available when you login at www.vsp.com under the "Special Offers" tab.:

- TruHearing Hearing Aid Discount Program – Savings of up to 60% on a pair of digital hearing aids and savings on batteries for you and your extended family members through TruHearing. Learn more about this program at vsp.truhearing.com or call (877) 396-7194.
- VSP Direct – Individual and family vision insurance is available after coverage eligibility ends with Tesoro. Learn more about this option at www.vspdirect.com or call (800) 785-0699.

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.

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.

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[3]. 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.

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.

[3] 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).

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[4]. 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.

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.

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

It is your or your covered dependent's responsibility to notify the Tesoro Benefit Center (see **Contacts**) 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).

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) 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**).

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 vision 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)**, 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**);

you notify the Tesoro Benefit Center of your new dependent within 31 days of eligibility (see **Contacts**); 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), 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.

ADDITIONAL INFORMATION

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

Plan Name	The Tesoro Vision 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 Benefits Committee 19100 Ridgewood Parkway San Antonio, TX 78259 (866) 688-5465, press options 3, then option 5
Plan Number	501
Plan Year	January 1 – December 31
Plan Funding	The Plan is funded by employee and employer contributions.
Type of Administration	Insurance contract with Vision Service Plan
Plan Insurer	Vision Service Plan
Claims Administrator	**Vision Service Plan** Vision Service Plan 3333 Quality Drive Rancho Cordova, CA 95670
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.

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**).

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.

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 Plan to provide you with a notice describing the Plan's privacy practices and other information regarding your privacy rights with respect to protected health information. This notice is provided at the time of enrollment to new Plan enrollees. In addition, an updated notice will be provided to all Plan participants within 60 days of any material revision of the notice. Copies of the notice are available at all times through the 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, TX1-055
San Antonio, TX 78259
Email: SAT – Benefits Department (satbenefits@tsocorp.com)
(866) 688-5465

Claims Administrator

Vision Service Plan

3333 Quality Drive
Rancho Cordova, CA 95670
(800) 877-7195

FUTURE OF THE PLAN

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.

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.

QUESTIONS

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