andeavor

PPO DENTAL PLAN

SUMMARY PLAN DESCRIPTION

As of January 1, 2018

This summary plan description (SPD) outlines the major features of the Andeavor PPO Dental Plan. If you have questions regarding your coverage under the PPO Dental Plan, contact the Andeavor Benefits Department.

This document describes the Andeavor PPO Dental Plan as of January 1, 2018. This Plan is available to eligible Andeavor 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 as of your employment commencement date if you:

- are an employee of Andeavor or one of its participating subsidiaries who is scheduled to work at least 30 hours per week (regular full-time employee);
- are not classified as a Retail Store, Hourly Bakery Production or Bakery Driver employee; and
- are on a U.S. payroll.

You are eligible to participate in the Plan on the first day of the month coincident with or following your completion of sixty (60) days of continuous employment if you:

- are an employee of Andeavor or one of its participating subsidiaries who is scheduled to work at least 30 hours per week (regular full-time employee);
- are classified as a Retail Store, Hourly Bakery Production or Bakery Driver employee; 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 unless it provides, or is deemed to 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 company that is not a participating subsidiary.

Dependent Eligibility

If you enroll for Plan coverage, you may also enroll your eligible Dependents, which are defined as follows:

- your spouse (if you are not legally separated);
- your Child under age 26. For these purposes, a Child includes the following:
  - biological child,
  - stepchild, and
  - foster child or legally adopted child, including a child placed with you for adoption for whom legal adoption proceedings have started even if not final;
  - child 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 Child of any age (see special rules below); and
- your Domestic Partner and your Domestic Partner's Child(ren) (see special rules below).

Eligibility Rules for a Disabled Child

Coverage for a Child who is Disabled at age 26 will not terminate merely because such Child has attained age 26. Such coverage may continue during the period the Child is 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 the Child suffers from 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 after the two-year period following the Child's attainment of age 26. Any such certification shall not be requested more frequently than once each plan year.

Eligibility Rules for Domestic Partner Coverage

An individual is eligible for domestic partner coverage if he or she meets the eligibility criteria listed on Andeavor's Affidavit of Domestic Partnership. To qualify for domestic partner coverage, you must register your domestic partnership with Andeavor's Benefits Administrator by submitting an executed Affidavit of Domestic Partnership and completing the Dependent verification process (see **Proof of Dependent Status**). Andeavor's Affidavit of Domestic Partnership is available through your benefits administrator or may be downloaded from Andeavor's intranet site (see **Contacts**). In event your Domestic Partnership ends, you must submit a signed Benefits Change Form to your benefits administrator.

Proof of Dependent Status

When you add any Dependent, you may be required to submit the appropriate documents (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.

Enrollment of your Dependents in the Plan will be pended until proof of Dependent status has been received by your benefits administrator. Such documentation generally must be received within 31 days of enrollment; otherwise, your Dependents will *not* be added to the Plan. Please contact your benefits administrator 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 Andeavor or an affiliate,
- an individual who no longer qualifies as a Dependent Child.
- an individual who no longer qualifies as a Domestic Partner or a Dependent Child of a Domestic Partner

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. Rather, your Dependent Child can only enroll in his or her capacity as an employee.

ENROLLING IN THE PLAN

You must enroll yourself and your eligible Dependents in the Plan (or waive coverage) within 31 days of your employment date, or within 31 days of the date you or, as applicable, your Dependent(s) first become eligible for the Plan (if later). If you enroll within such 31-day period, your coverage will be effective as of your employment date or, if applicable, your subsequent eligibility date.

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

- choose the Andeavor PPO Dental Plan; and
- decide which of your eligible Dependents you wish to cover, if any.
- submit verification documents for enrolled Dependents, if any.

Generally, the coverage levels available under the Plan are:

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

If you do not wish to participate, you may affirmatively decline coverage by selecting the "Waive" option. If you do not enroll within 31 days after you first become eligible, you will be treated as if you had waived coverage. If you decline (waive) coverage, or do not enroll within 31 days after you were first eligible, 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 a qualifying status change.

Coverage for your Dependents will not be completed until you submit required documentation verifying eligibility (see **Proof of Dependent Status**).

Each person enrolled for coverage under the Plan is referred to herein as an "Enrollee."

After you have completed your enrollment, you should print a Confirmation Form verifying your elections. It is important for you to keep a copy of your enrollment elections to show proof of your elections should an issue later arise. Your dental coverage will begin as of your eligibility date and any payroll deductions covering your elections will be made retroactively.

Annual Enrollment Period

During an annual open enrollment period designated by the Company (normally in October/November 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 Plan coverage levels and add/re-add Dependents to your coverage. If you waive coverage, you will not have coverage under the Plan for the following year. If you do not make an election at annual enrollment, your current coverage will continue into the next year.

You will not be allowed to change your election before the next open enrollment period, unless you experience a qualifying status change during the year. Coverage elections (and deemed elections) made during open enrollment become effective on January 1 of the immediately following year.

After you have completed your enrollment, you should print a Confirmation Form verifying your elections. It is important for you to keep a copy of your enrollment elections to show proof of your elections should an issue later arise. Your dental coverage will begin as of the first payroll period of the immediately following year.

Special Enrollment

Certain events may occur which 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 applicable event. A person will be considered to be a Special Enrollee if all of the following apply:

- you did not elect dental coverage for that person within 31 days of the date the person first became eligible (or during an open enrollment period), because the person had dental coverage from another source; and
- the person loses such coverage because:
  - of the person's termination of employment,
  - of reduction in hours of employment,
  - your spouse dies,
  - you and your spouse divorce or become legally separated,
  - your Dependent ceases to be eligible for coverage under such plan,
  - the dental coverage was COBRA continuation and the continuation is exhausted, or
  - the other plan terminates due to the employer's failure to pay the premium or any other reason; and

- you elect coverage under this Plan 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 your 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 applicable law)

*Note, however, claims for Dependents will be pended until adequate documentation is submitted.

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 a qualifying status change or other permissible event.

A qualifying status change includes a change during the Plan Year in the following:

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

A qualifying 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.

You must request any changes to your coverage within 31 days of the qualifying status change or other permissible event. You may complete the change event online via the respective legacy Tesoro or legacy Western benefits enrollment websites or by calling the benefits administrator.

Changes in your Plan coverage must be consistent with the status change. For example, you may change your level of coverage from "Employee + Spouse" to "Employee" if your status changes as a result of your divorce during the Plan Year.

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 Dependent Child status during the Plan Year; or
- death of a spouse, Domestic Partner, or a Dependent Child.

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 additional events:

- the receipt of a qualified medical child support order (QMCSO) 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

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), even if:

- you do not have legal custody of the Child; or
- the Child is not dependent on you for support (where applicable).

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 group health 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 pursuant to the terms of a QMCSO.

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. Andeavor 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 your benefits administrator.

COST OF COVERAGE

You and the Company share the cost of dental coverage for you and your eligible Dependents. Your cost is based on the level of coverage you choose. The contribution amount for each coverage option and level of coverage is subject to change and is announced in advance.

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 reported as taxable income to you and that the cost of such coverage be remitted on an after-tax basis.

SELECTING YOUR PROVIDER

Free Choice of Provider

You may see any Provider for your covered treatment whether the Provider is a PPO Provider, Premier Provider or a Non-Delta Dental Provider. This plan is a PPO plan and the greatest benefits – including out-of-pocket savings – occur when you choose a PPO Provider. To take full advantage of your Benefits, we highly recommend you verify a Provider's participation status within a Delta Dental network with your dental office before each appointment.

Locating a PPO or Premier Provider

You may access information through our website at www.deltadentalins.com. You may also call Delta Dental's Customer Service Center and one of their representatives will assist you.

Choosing a PPO Provider

Utilizing a PPO Provider potentially results in the greatest reduction in your out-of-pocket expenses since this select group of Providers will provide dental Benefits at a charge that has been contractually agreed upon. Payment for covered services performed by a PPO Provider is based on the Maximum Contract Allowance.

Choosing a Premier Provider

A Premier Provider is a Delta Dental Provider who has agreed to participate in a different network with a fee schedule that is different than the PPO network. Payment for covered services performed by a Premier Provider is based on the Maximum Contract Allowance. The amount charged by a Premier Provider may be above that accepted by PPO Providers but no more than the Delta Dental Premier Contracted Fee.

Additional Obligations of PPO and Premier Providers

- The PPO Provider or Premier Provider must accept assignment of Benefits, meaning these Providers will be paid directly by Delta Dental after your satisfaction of the Annual Deductible and Coinsurance. You do not have to pay all the dental charges while at the dental office and then submit the claim for reimbursement.
- The PPO Provider or Premier Provider will complete the dental Claim Form and submit it to Delta Dental for reimbursement.
- PPO and Premier Providers accept contracted fees as payment in full for covered services and will not balance bill if there is a difference between Submitted Fees and contracted fees.

Choosing a Non-Delta Dental Provider

If you utilize a Non-Delta Dental Provider, the amount charged to you may be above that accepted by PPO or Premier Providers. Payment for covered services performed by a Non-Delta Dental Provider is based on the Maximum Contract Allowance. However, you may be balance billed up to the Provider's Submitted Fee.

BENEFITS

Deductibles and Maximums

Annual Deductible	$50 per Enrollee each Calendar Year (waived for diagnostic and preventive services)
Annual Maximum	$2,000 per Enrollee per Calendar Year
Lifetime Orthodontic Maximum	$2,000 per dependent child Enrollee to age 26
Lifetime TMJ Deductible	$50 per Enrollee
Lifetime TMJ Maximum	$1,000 per Enrollee
Maximum Takeover Credit	The Plan will apply a credit for any amounts paid under previous dental administrators, if applicable, for Orthodontic and TMJ Services. These amounts will be credited towards the lifetime maximum amounts

Benefit Levels[1]

Dental Service Category	Delta Dental PPO Providers		Delta Dental Premier Providers		Non-Delta Dental Providers	
	Plan Portion	Enrollee Coinsurance	Plan Portion	Enrollee Coinsurance	Plan Portion	Enrollee Coinsurance
Diagnostic and Preventive Services	100%	0%	100%	0%	100%	0%
Basic Services	80%	20%	80%	20%	80%	20%
Major Services	50%	50%	50%	50%	50%	50%
Orthodontic Services	50%	50%	50%	50%	50%	50%
Non-Surgical TMJ Services	50%	50%	50%	50%	50%	50%

Covered Dental Services

Diagnostic and Preventive Services

- Diagnostic
  - procedures to aid the Provider in determining required dental treatment.
- Preventive
  - cleaning (including scaling in the presence of generalized moderate or severe gingival inflammation-full mouth, which is considered to be a Diagnostic and Preventive Benefit, and periodontal maintenance, which is considered to be a Basic Benefit for payment purposes), topical application of fluoride solutions, space maintainers.
- Sealants
  - topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay.

Basic Services

- Oral Surgery:
  - extractions and other surgical procedures (including pre- and post-operative care).
- General Anesthesia or IV Sedation
  - when administered by a Provider for covered Oral Surgery or selected endodontic and periodontal surgical procedures.
- Endodontics
  - treatment of diseases and injuries of the tooth pulp.
- Non-Surgical Periodontics
  - non-surgical treatment of gums and bones supporting teeth.
- Palliative
  - emergency treatment to relieve pain.
- Restorative
  - amalgam and resin-based composite restorations (fillings) and prefabricated crowns for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).
- Specialist Consultations
  - opinion or advice requested by a general dentist.

[1] Reimbursement is based on PPO Contracted Fees for PPO Providers, Premier Contracted Fees for Premier Providers and Program Allowance for Non-Delta Dental Providers.

Major Services

- Crowns and Inlays/Onlays
  - treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam or resin-based composites.
- Prosthodontics
  - procedures for construction of fixed bridges, partial or complete dentures and the repair of fixed bridges; implant surgical placement and removal; and for implant supported prosthetics, including implant repair and recementation.
- Surgical Periodontics
  - surgical treatment of gums and bones supporting teeth.
- Denture Repairs
  - repair to partial or complete dentures, including rebase procedures and relining.

Orthodontic Services

- Procedures performed by a Provider using appliances to treat malocclusion of teeth and/or jaws which significantly interferes with their function.

Non-Surgical Temporomandibular Joint (TMJ) Dysfunction Services

- Intra-oral services provided by a Provider, when necessary and customary according to the standards of generally accepted dental practice, for treatment of acute dental symptoms associated with myofacial pain dysfunction or malfunction of the temporomandibular (jaw) joint (TMJ).

Additional Services based on Medical Conditions

- The Plan will pay for additional services to help improve the oral health of the Enrollee for the following medical conditions (pregnancy, coronary artery disease, cardiovascular disease, cerebrovascular disease and diabetes). The additional services each Calendar Year while the Enrollee is covered under the Plan include either two (2) additional routine cleanings or two (2) additional periodontal maintenance procedure; one (1) additional periodontal scaling and root planing per quadrant, full mouth debridement, (localized delivery of antimicrobial agents for all medical condition excluding for Pregnancy). Written confirmation must be provided by the Enrollee or the Provider when the claim is submitted.

EXCLUSIONS AND LIMITATIONS

Exclusions

The PPO Dental Plan does not pay Benefits for:

- treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
- cosmetic surgery or procedures for purely cosmetic reasons.
- maxillofacial prosthetics.
- provisional and/or temporary restorations (except an interim removable partial denture to replace extracted anterior permanent teeth during the healing period for children 16 years of age or under). Provisional and/or temporary restorations are not separately payable procedures and are included in the fee for completed service.
- services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to newborn children for medically diagnosed congenital defects or birth abnormalities.
- treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting and abfraction.

- any Single Procedure provided prior to the date the Enrollee became eligible for services under this plan.
- prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.
- charges for anesthesia, other than General Anesthesia and IV Sedation administered by a Provider in connection with covered Oral Surgery or selected Endodontic and Periodontal surgical procedures. Local anesthesia and regional/or trigeminal bloc anesthesia are not separately payable procedures.
- extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
- laboratory processed crowns for Enrollees under age 12.
- fixed bridges and removable partials for Enrollees under age 16.
- interim implants and endodontic endosseous implant.
- indirectly fabricated resin-based Inlays/Onlays.
- charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.
- treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.
- charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening or tobacco counseling.
- dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.
- procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.
- any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Plan, will be the responsibility of the Enrollee and not a covered Benefit.
- Deductibles, amounts over plan maximums and/or any service not covered under the Plan.
- services covered under the Plan but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.
- services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except as provided under the Orthodontic Services section, if applicable.
- services for any disturbance of the Temporomandibular (jaw) Joints (TMJ) or associated musculature, nerves and other tissues) except as provided under the TMJ Benefit section, if applicable.
- missed and/or cancelled appointments.
- actions taken to schedule and assure compliance with patient appointments are inclusive with office operations and are not a separately payable service.
- the fees for care coordination are considered inclusive in overall patient management and are not a separately payable service.
- dental case management motivational interviewing and patient education to improve oral health literacy.
- non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum.
- extra-oral – 2D projection radiographic image and extra-oral posterior dental radiographic image.
- any services or supplies for which the Enrollee is not required to make payment (i.e. to satisfy the Deductible and/or Coinsurance that is otherwise due under the Plan), or for which the Enrollees would have no legal obligation to pay in the absence of this or other coverage.

Limitations

- Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called “Optional Services”. Optional Services also include the use of specialized techniques instead of standard procedures.

  Examples of Optional Services:

  - a composite restoration instead of an amalgam restoration on posterior teeth;
  - a crown where a filling would restore the tooth;
  - an inlay/onlay instead of an amalgam restoration;
  - porcelain, resin or similar materials for crowns placed on a maxillary second or third molar, or on any mandibular molar (an allowance will be made for a porcelain fused to high noble metal crown); or
  - an overdenture instead of denture.

  If an Enrollee receives Optional Services, an alternate Benefit will be allowed, which means Delta Dental will base Benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

- Exam and cleaning limitations:
  - The Plan will pay for oral examinations (except exams for observation) and cleanings (including scaling in presence of generalized moderate or severe gingival inflammation-full mouth) no more than twice in a Calendar Year.
  - The Plan will pay for two (2) periodontal cleanings or Procedure Codes that include periodontal cleanings during any Calendar Year if Enrollees have a previous history of periodontal therapy.
  - A full mouth debridement is allowed once in a 12-month period when the Enrollee has no history of prophylaxis, scaling and root planing, periodontal surgery or periodontal maintenance procedures within three (3) years. When allowed a full mouth debridement counts toward the maintenance frequency in the year provided.
  - Note that periodontal maintenance, Procedure Codes that include periodontal maintenance and full mouth debridement are covered as a Basic Benefit and that routine cleanings (including scaling in the presence of generalized moderate or severe gingival inflammation-full mouth) are covered as a Diagnostic and Preventive Benefit. See note on additional Benefits during pregnancy.
  - Caries risk assessments are allowed once in 36 months.
- X-ray limitations:
  - The Plan will limit the total reimbursable amount to the Provider’s Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.
  - When a panoramic film is submitted with supplemental film(s), Delta Dental will limit the total reimbursable amount to the Provider’s Accepted Fee for a complete intraoral series.
  - If a panoramic film is taken in conjunction with an intraoral complete series, Delta Dental considers the panoramic film to be included in the complete series.
  - A complete intraoral series or panoramic film are each limited to once every 36 months.
  - Bitewing x-rays are limited to two (2) times in a Calendar Year when provided to Enrollees under age 18 and one (1) time each Calendar Year for Enrollees age 18 and over. Bitewings of any type are disallowed within 12 months of a full mouth series unless warranted by special circumstances.
- Topical application of fluoride solutions is limited to Enrollees to age 19 and no more than twice in a Calendar Year.

- Space maintainer limitations:
  - Space maintainers are limited to the initial appliance and are a Benefit for an Enrollee to age 16. However, a distal shoe space maintainer-fixed-unilateral is limited to children eight (8) and younger. A separate/additional space maintainer can be allowed after the removal of a unilateral distal shoe.
  - Recementation of space maintainer is limited to once per lifetime.
  - The removal of a fixed space maintainer is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different Provider/Provider's office.
- Pulp vitality tests are allowed once per day when definitive treatment is not performed.
- Cephalometric x-rays, oral/facial photographic images and diagnostic casts are covered once per lifetime in conjunction with Orthodontic Services only when Orthodontic Services are a covered benefit. If Orthodontic Services are covered, see Limitations as age limits may apply. However, 3D x-rays are not a covered benefit.
- Sealants are limited as follows:
  - to permanent first molars and to permanent second molars to age 16 if they are without caries (decay) or restorations on the occlusal surface.
  - repair or replacement of a Sealant on any tooth within 36 months of its application is included in the fee for the original placement.
- Specialist Consultations, screenings of patients, and assessments of patients are limited to once per lifetime per Provider and count toward the oral exam frequency.
- Delta Dental will not cover replacement of an amalgam or resin-based composite restorations (fillings) within 12 months of treatment if the service is provided by the same Provider/Provider office. Replacement restorations within 12 months are included in the fee for the original restoration.
- Delta Dental will not cover replacement of a prefabricated crowns within 60 months of treatment if the service is provided by the same Provider/Provider office. Replacement restorations within 60 months are included in the fee for the original restoration.
- Protective restorations (sedative fillings) are allowed once per tooth per lifetime when definitive treatment is not performed on the same date of service.
- Prefabricated crowns are allowed on baby (deciduous) teeth and permanent teeth up to age 19. Replacement restorations within 24 months are included in the fee for the original restoration.
- Therapeutic pulpotomy is limited to once in a 12-month period for baby (deciduous) teeth only and is considered palliative treatment for permanent teeth.
- Pulpal therapy (resorbable filling) is limited to once in a 12-month period. Retreatment of root canal therapy by the same Provider/Provider office within 12-months is considered part of the original procedure.
- Apexification is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation. Apexification visits have a lifetime limit per tooth of one (1) initial visit, four (4) interim visits and one (1) final visit to age 19.
- Retreatment of apical surgery by the same Provider/Provider office within 24 months is considered part of the original procedure.
- Palliative treatment is covered per visit, not per tooth, and the fee includes all treatment provided other than required x-rays or select Diagnostic procedures.
- Periodontal limitations:
  - Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period. See note on additional Benefits during pregnancy. No more than two quadrants of scaling and root planing will be covered on the same date of service.
  - Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or scaling and root planing performed within 36-months by the same Provider/Provider office.

  - Periodontal services, including bone replacement grafts, guided tissue regeneration, graft procedures and biological materials to aid in soft and osseous tissue regeneration are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants. Guided tissue regenerations and/or bone grafts are not benefited in conjunction with soft tissue grafts in the same surgical area.
  - Periodontal surgery is subject to a 30 day wait following periodontal scaling and root planing in the same quadrant.
  - Cleanings (regular and periodontal) and full mouth debridement are subject to a 30 day wait following periodontal scaling and root planing if performed by the same Provider office.
- Oral Surgery services are covered once in a lifetime except removal of cysts and lesions and incision and drainage procedures, which are covered once in the same day.
- The following Oral Surgery procedure is limited to age 19 (or orthodontic limiting age): transseptal fiberotomy/supra crestal fiberotomy, by report.
- The following Oral Surgery procedures are limited to age 19 (or orthodontic limiting age) provided Orthodontic Services are covered: surgical access of an unerupted tooth, placement of device to facilitate eruption of impacted tooth, and surgical repositioning of teeth.
- Crowns and Inlays/Onlays are limited to Enrollees age 12 and older and are covered not more often than once in any 60 month period except when Delta Dental determines the existing Crown or Inlay/Onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.
- Core buildup, including any pins, are covered not more than once in any 60 month period.
- Post and core services are covered not more than once in any 60 month period.
- Crown repairs are covered not more than twice in any 60 month period. Crowns, inlays/onlays and fixed bridges include repairs for 24 months following installation.
- Denture Repairs are covered not more than once in any six (6) month period except for fixed Denture Repairs which are covered not more than twice in any 60 month period.
- Prosthodontic appliances, implants and/or implant supported prosthetics that were provided under any Delta Dental program will be replaced only after 60 months have passed, except when Delta Dental determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Fixed prosthodontic appliances are limited to Enrollees age 16 and older. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under a Delta Dental program will be made if Delta Dental determines it is unsatisfactory and cannot be made satisfactory. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Delta Dental's payment for implant removal is limited to one (1) for each implant during the Enrollee's lifetime whether provided under Delta Dental or any other dental care plan.
- When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a Benefit.
- Recementation of Crowns, Inlays/Onlays or bridges is included in the fee for the Crown, Inlay/Onlay or bridge when performed by the same Provider/Provider office within six (6) months of the initial placement. After six (6) months, payment will be limited to one (1) recementation in a lifetime by the same Provider/Provider office.
- Delta Dental limits payment for dentures to a standard partial or complete denture (Enrollee Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post delivery care including any adjustments and relines for the first six (6) months after placement.
  - Denture rebase is limited to one (1) per arch in a 36-month period and includes any relining and adjustments for six (6) months following placement.
  - Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment or reline, adjustments are limited to two (2) per arch in a Calendar Year and relining is limited to one (1) per arch in a 36-month period.

  - Tissue conditioning is limited to two (2) per arch in a 12-month period. However, tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture, reline or rebase service.
  - Recementation of fixed partial dentures is limited to once in a lifetime.
- Limitations on Orthodontic Services:
  - The maximum amount payable for each Enrollee is shown in Attachment A.
  - Benefits for Orthodontic Services will be provided in periodic payments based on the Enrollee's continuing eligibility.
  - Benefits are not paid to repair or replace any orthodontic appliance received under this plan.
  - Benefits are not paid for orthodontic retreatment procedures.
  - Benefits for Orthodontic Services are limited to dependent child Enrollees under age 26.
- Limitations on Non-Surgical TMJ Services:
  - TMJ Benefits are subject to all the limitations, exclusions and other terms and conditions in the Plan.
  - Delta Dental will not pay for the repair or replacement of any appliance furnished in whole or in part under this or any other health plan which provides TMJ Benefits.
  - Benefits are limited to: those intra-oral services which would normally be provided by a Provider in relief of oral symptoms associated with TMJ and will not include those services which would normally be provided under medical care including, but not limited to, psychotherapy, special joint exams and x-rays, joint surgery and medications.
  - Fixed appliances and restorations are excluded. Diagnostic procedures not otherwise covered under this plan are excluded.
  - Any procedure paid under any other category of Benefits by the Plan is not covered as a TMJ Benefit.
- The replacement of an appliance for an Occlusal Guard is limited to once every three (3) years. The repair/reline of an Occlusal Guard is limited to once in a 24-month period. The adjustment of an Occlusal Guard is limited to once in a 12-month period.

COORDINATION OF BENEFITS

Coordination of benefits (COB) applies when you or your Dependents have coverage under more than one plan or other program. In these situations, it's necessary to determine which plan has primary responsibility for the payment of benefits. If you or a covered Dependent are covered under more than one plan and you incur an expense that is covered — partially or in full — under this Plan and at least one other plan:

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

How COB Works

The order of benefit determination rules determine which plan will pay as the Primary Plan.

When an individual is covered under more than one plan:

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

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

Determination of Primary and Secondary Plans

A plan that does not contain a coordination of benefits provision that is consistent with this provision is always the Primary Plan, with two exceptions:

- Coverage that is designed to supplement a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan.
  - Examples of these types of coverages are:
    - **–** major medical coverages that are superimposed over base plan hospital and surgical benefits, and
    - **–** insurance-type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
- Automobile insurance coverage that is mandatory under state law, whether or not the Participant is in compliance with such mandate.

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

1. **Non-Dependent or Dependent.** The plan that covers the person other than as a Dependent — for example as an employee, member or subscriber — is **primary,** and the plan that covers the person as a Dependent is **secondary.** However, if the person is a Medicare beneficiary, and by federal law Medicare is secondary to the plan covering the person as a Dependent and primary to the plan covering the person other than as a Dependent, then the order of benefits is reversed, so that the plan covering the person as an employee, member or subscriber is secondary and the other plan is primary.
2. **Child Covered Under More than One Plan**. The order of benefits is:
   - The Primary Plan is the plan of the parent whose birthday (month and day of birth) is earlier in the year if:
     - The parents are married and are not legally separated; or
     - A court order awards joint custody without specifying that one party has responsibility to provide health care coverage, or states that both parents are responsible for health care coverage.

Note: If both parents have the same birthday, the plan that has covered a parent longer is primary.

   - If the terms of a court order state that one of the parents is responsible for health care coverage and the plan of that parent is aware of those terms, that plan is primary. If the parent with responsibility has no health care coverage but that parent's spouse does, the plan of the parent's spouse is primary.
   - If the parents are separated or divorced, or are not living together whether or not they have ever been married, and there is no court order assigning responsibility for health care coverage, the order of benefits is:
     - The plan of the custodial parent;
     - The plan of the spouse of the custodial parent;
     - The plan of the noncustodial parent; and then
     - The plan of the spouse of the noncustodial parent.

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

3. **Active Employee or Retired or Laid Off Employee.** The plan that covers a person as an active employee (neither laid off nor retired) or as a Dependent of an active employee is the Primary Plan. The plan covering the same person as a retired or laid off employee or as a Dependent of a retired or laid off employee is the Secondary Plan.
4. **Continuation Coverage.** If a person whose coverage is based on continuation rights under federal or state law is also covered under another plan, the plan covering the person as an employee, member or subscriber (or as that person's Dependent) is primary, and the continuation coverage is secondary.

5. **Longer or Shorter Length of Coverage.** The plan that has covered the person as an employee, member or subscriber longer is primary.
6. **If the preceding rules do not determine the Primary Plan**, allowable expenses (expenses covered at least in part by any of the plans covering the person) will be shared equally between the plans. However, this Plan will not pay more than it would have paid had it been primary.

Medicare Coordination

Your benefits under the Plan may be coordinated and, in some cases, reduced by benefits that you receive (or would have received) from other plans or under other coverage, including Medicare. To the extent required by federal law, however, this Plan will be considered Primary to Medicare. Accordingly, your benefits under the Plan as an active employee will not be reduced as a result of eligibility or entitlement to Medicare, regardless of whether such eligibility or entitlement is a result of your attainment of age 65 or due to a disability.

However, in the event that you become eligible for or entitled to Medicare as a result of end-stage renal disease (ESRD), the Plan will be considered Primary to Medicare only during the thirty (30) month period commencing on the earlier of such dates. Thereafter, the Plan becomes Secondary to Medicare and your benefits under the Plan will be reduced by the amounts payable by Medicare for such services or treatments.

Medicare will be Primary to benefits under this plan for inactive participants who are eligible for Medicare, including those in LTD or retirement status.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Plan may 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 for payment, treatment and health care operations of the Plan. You will be provided 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 Andeavor Benefit Center.

EVENTS AFFECTING COVERAGE

Leave of Absence

Your Plan coverage will continue, and contributions will be deducted from your paycheck, during any Company-approved absences with full or adequate partial pay. Your coverage will also continue during the following leaves of absence, subject to the conditions described below:

Types of Leave

Disability Leave

If you are disabled and receiving Long-Term Disability (LTD) income benefits from a program to which the Company contributes, the Plan coverage that was in effect at the time your disability began will continue for up to twenty-four (24) months from the initial date of your receipt of LTD benefits. During the disability period, you are responsible for the payment of any required premiums.

Coverage will end upon the earlier of:

- the date any required contributions are not made,
- the date you stop receiving disability benefits under the Company's LTD program,
- the date you retire, or
- the expiration of the applicable twenty-four (24) month period described above.

Note, if, prior to January 1, 2018, you became disabled and were receiving LTD income benefits from a program to which the Company contributes, your benefit continuation period for this purpose will be governed by the terms of the Plan in effect on December 31, 2017.

Personal Leave of Absence

You may remain eligible for coverage under the Plan during an approved personal leave of absence. During the leave, you are responsible for arranging for the payment of premiums due.

Coverage will end upon the earlier of:

- the date any required contributions are not made, or
- the expiration of the leave or, if earlier, twenty-four months (unless you return to regular, full-time employment prior to such dates).

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 your 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 Andeavor, 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. 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.

Under circumstances in which both COBRA and USERRA apply, an election for continuation coverage under USERRA will be an election to take concurrent COBRA and USERRA coverage for the employee and any covered Dependents who elect USERRA, unless the employee specifically elects COBRA-only or USERRA-only.

Terms of Coverage

Continued coverage during your leave of absence is subject to the same rules that would apply if you were an active employee. If benefits change under the Plan, such changes will apply equally to you. If coverage terminates during your leave of absence, you may be able to elect to continue coverage under COBRA (see **Continuation of Coverage**, below).

Payment of Contributions While on Leave

If you are not receiving a paycheck, you must make the required contributions at the time prescribed by the Plan Administrator. Contact your benefits administrator to set up payment arrangements.

If payments are not made at the time prescribed (or within the 30-day grace period), coverage may be terminated provide you have received written notice of such termination of coverage.

However, if coverage is terminated during your FMLA leave due to non-payment of contributions, all previously owed contributions for the period of active coverage will be deducted from your paycheck and you will not be eligible to enroll in the Plan until the next annual enrollment period.

TERMINATION OF COVERAGE

Unless you are eligible for COBRA continuation coverage, your coverage under the Plan will end upon the earliest to occur of the following:

- The date your employment is terminated (including as a result of a layoff or your failure to return to regular, full-time employment following expiration of a FMLA or USERRA leave of absence),
- The date your regularly scheduled hours are reduced to less than 30 hours per week,
- With respect to eligibility for coverage based on your receipt of LTD benefits, the date you stop receiving disability benefits under the Company's LTD program or, if earlier, the expiration of the applicable twenty-four (24) month period described above,
- Your death,
- The date you no longer meet the eligibility requirements under the Plan,
- The date you fail to pay the required premiums/contributions toward coverage under the Plan, and
- The date the Company discontinues the Plan.

**Note, dental care benefits are not included as part of Andeavor's Post-Retirement Group Health Plan coverage.

Unless your Dependent is eligible to continue coverage as explained under **Continuation of Coverage,** see below, coverage for your Dependent(s) ends if:

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

If you are covering a Domestic Partner and your Domestic Partner's Children under the Plan, they will no longer be considered eligible Dependents and coverage will end on the earlier of:

- the date the Plan no longer provides for such coverage; or
- the date your Domestic Partnership ends.; or
- For the Domestic Partner's Child, the date such Child no longer meets the Plan's definition of "Dependent" with respect to the Domestic Partner.

However, your Domestic Partner and your Domestic Partner's Children may be eligible to elect continuation coverage.

COBRA COVERAGE CONTINUATION

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 coverage under the Plan for a period of time. COBRA continuation rights are available only 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 (including upon expiration of an applicable disability leave continuation period).

Covered 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;
- your divorce or legal separation; or
- your Dependent Child no longer meeting the definition of a Dependent Child.

It is you or your covered Dependent's responsibility to notify your benefits administrator (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.

*Additional notifications are required in connection with extensions of COBRA continuation due to disability. See below for details.

If you notify your benefits administrator 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 elections during the Plan Year (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 Qualified 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

Concurrent USERRA Coverage

Under circumstances in which both COBRA and USERRA apply, an election for continuation coverage under COBRA will be an election to take concurrent COBRA and USERRA coverage for the employee and any covered Dependents who elect COBRA, unless the employee specifically elects COBRA-only or USERRA-only.

Extension of COBRA Coverage Due to Disability

You and each qualified beneficiary may be eligible to extend your 18-month COBRA period to a total of 29 months if a qualified beneficiary 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 your benefit administrator (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 the qualified beneficiary is later determined to not be disabled, you must notify your benefit administrator 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 as of the date of determination.

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 qualified beneficiaries 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 your benefit administrator within 60 days after the second qualifying event occurs (see **Contacts**).

Electing COBRA Coverage

Upon notification to your benefit administrator of a COBRA qualifying event, COBRA election notices are prepared and mailed to your home address. 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 qualified beneficiaries 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 qualified beneficiaries 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, except as otherwise prohibited by applicable law. 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 your benefit administrator 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 your benefit administrator if, at any time during your continuation period, any of your qualified beneficiaries cease to meet the eligibility requirements for coverage.

Termination of COBRA Coverage

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

- the Company no longer provides group health plan coverage to its employees;
- you or your qualified beneficiaries do not pay the premium on or before its due date;
- you and/or your qualified beneficiaries' applicable COBRA continuation period ends;
- you become entitled to Medicare following an election of COBRA coverage;
- you or your qualified beneficiaries 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 qualified beneficiaries 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 qualified beneficiaries must notify your benefit administrator 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.

GENERAL CLAIMS PROCEDURE

Filing Claims for Benefits

Claims for Benefits must be filed on a standard Claim Form that is available in most Provider offices. PPO and Premier Providers will fill out and submit your claims paperwork for you. If you receive services from a Non-Delta Dental Provider, you must submit a claim directly to us. Some Non-Delta Dental Providers may fill out and submit your claim upon your request. Your dental office should be able to assist you in filling out the Claim Form. Fill out the Claim Form completely and send it to:

Delta Dental Insurance Company
P.O Box 1809
Alpharetta, GA 30023

To constitute a claim for purposes of this Plan, the claim must identify: (1) the claimant, (2) a specific medical condition or treatment to which the claim relates, and (3) a specific treatment, service, or product for which approval is requested and must be received by a person or organizational unit that customarily is responsible for handling benefit matters.

When to Submit Claims

All claims for benefits under the Plan must be properly submitted to the Claim Administrator within three hundred sixty-five (365) days of the date you receive the services or supplies. Claims submitted and received by the Claim

Administrator after that date will not be considered for payment of benefits under the Plan, unless required by state or federal law.

Authorized Representative

A claim may be filed by you or your authorized representative (the “claimant”). Such authorization must be provided in the form and manner prescribed under the Plan; provided, however, a health care professional with knowledge of the Participant's medical condition shall be permitted to act as the Participant's authorized representative hereunder without submitting evidence of his or her authority to act as such.

Payment and Assignment of Benefits

Rights and benefits under the Plan shall not be assignable, either before or after services and supplies are provided. In the absence of a written agreement with a Provider, the Claim Administrator reserves the right to make benefit payments to the Provider or the Employee, as the Claim Administrator elects. Payment to either party discharges the Plan’s responsibility to the Employee or Dependents for benefits available under the Plan.

Overpayment of Benefits

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

Notice of Decision

Depending on the type of claim, different rules may apply. As a general matter, however, only post-service claims will be submitted under this Plan.

In the case of a Post-Service Claim, the Claims Administrator shall notify you of an adverse benefit determination within a reasonable period of time after receipt of the claim by the Plan, but not later than thirty (30) days after receipt of the claim.

The Claims Administrator may extend this period, one time, for a period of up to fifteen (15) days; provided that the Claims Administrator: (1) determines that such an extension is necessary due to matters beyond the control of the Plan and (2) notifies you before the end of the initial 30-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the additional information required. You will be given at least forty-five (45) days from receipt of such notice to provide the specified information. If such extension is necessary, the period for making the claim determination

shall be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Written notice of the adverse benefit determination 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
- Such other information as may be required by applicable law.

Internal Appeals

A participant who feels he or she is being denied any benefit or right provided under the Plan shall have the right to file an appeal with the Claims Administrator within 180 days after receipt of notice of an adverse benefit determination as provided above. Such claim may be filed directly by you or your authorized representative. All such appeals shall be submitted in the form and manner prescribed by the Claims Administrator, and shall be considered filed on the date the claim is received by the Claims Administrator.

Appeal Standards

The Claims Administrator shall provide the claimant the opportunity to submit written comments, documents, records, and other information related to 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 appeal. In conducting its review, the Plan Administrator shall consider any written statement or other evidence presented by the claimant in support of the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The Plan Administrator will not afford deference to the initial adverse benefit determination and will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination or a subordinate of such individual. Where applicable, the Claims Administrator shall consult with a health care professional who has the appropriate training and experience in the field of medicine involved in the claim, and shall provide for the claimant the identification of any such professional, without regard to whether the advice was relied upon in making the benefit determination.

Notice on Appeal

Within a reasonable period of time, but not more than 60 days, after receipt by the Claims Administrator of a request for appeal, the Claims Administrator shall notify the claimant of its decision by delivery or by certified or registered mail to the claimant's last known address

The Claims Administrator may extend this period, one time, for a period of up to sixty (60) days; provided that the Claims Administrator: (1) determines that such an extension is necessary due to special circumstances and (2) notifies you before the end of the initial 60-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Written notice of the adverse benefit determination shall be delivered or mailed to the claimant by certified or registered mail to the claimant's last known address. The notice of the decision on appeal shall include the specific reasons for the decision, references to all relevant Plan provisions on which the decision was based, your right to file a claim under ERISA, and any other information as may be required by law.

Exhaustion of Claims Procedures

The decision of the Claims Administrator shall be final and conclusive.

You must exhaust the internal claims procedures provided hereunder prior to pursuing any other legal or equitable remedy. No legal action may be brought after three (3) years from the date the claimant's participation in the Plan ends or, if earlier, the date the claim is denied following exhaustion of the appeal procedures outlined above.

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 Andeavor PPO Dental Plan (a constituent benefit program of the Andeavor Omnibus Group Welfare Benefits Plan)
Type of Plan	Welfare benefit plan
Plan Sponsor	Andeavor, 19100 Ridgewood Parkway San Antonio, TX 78259 (210) 828-8484
Plan Sponsor's Employer Identification Number	95-0862768
Plan Administrator	Andeavor 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	Administrative Services Only (ASO) contract with Delta Dental Insurance.
Plan Insurer	Self-insured
Claims Administrator	Delta Dental Insurance Company P.O Box 1809 Alpharetta, GA 30023
Agent for Service of Legal Process	Andeavor, c/o General Counsel 19100 Ridgewood Parkway, San Antonio, TX 78259 In addition, service of legal process may be made upon the Plan Administrator.

CONTACTS

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

Benefits Administrator

Legacy Tesoro Employees:

Andeavor Benefits Center
P.O. Box 3129
Bellaire, TX 77402
www.andeavor.com/benefits
(866) 787-6314

Legacy Western Employees:

Benefits Department
1250 W. Washington Street
Tempe, AZ 85281
www.andeavor.com/benefits2018
(844) 224-4996

Andeavor Benefits Department

Legacy Tesoro Employees:

Corporate Benefits Department
19100 Ridgewood Parkway, TX1-055
San Antonio, TX 78259
satbenefits@andeavor.com
(866) 688-5465

Legacy Western Employees:

Benefits Department
1250 W. Washington Street
Tempe, AZ 85281
Benefits.department@andeavor.com
(844) 224-4996

ERISA

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 if you have exhausted the Plan's claims procedures. 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, as applicable, 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.

FUTURE OF THE PLAN

Andeavor expects to continue the Plan indefinitely, but reserves the right to amend or discontinue any or all parts of the Plan 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, or its delegate, 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 Claims Administrator has authority to administer claims consistent with the benefit provisions of the Plan.