andeavor

# RETAIL VOLUNTARY GROUP LONG-TERM DISABILITY PLAN

## SUMMARY PLAN DESCRIPTION

*As of January 1, 2018*

This Summary Plan Description (SPD) outlines the major features of the Andeavor Retail Voluntary Group Long Term Disability (LTD) Plan. If you have questions regarding your coverage under the Retail Voluntary Group LTD Plan, contact the Andeavor Benefits Department.

This document describes the Andeavor Retail Voluntary Group LTD 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

You are eligible to participate in the LTD Plan if you're a regular, full-time employee of one of Andeavor's participating subsidiary companies, you are working in a Retail Store, Hourly Bakery Production or Bakery Driver position and you have completed 60 days of employment in such position. You will be considered a full-time employee if you are regularly scheduled to work at least thirty (30) hours each week.

If you are in a job covered by a collective bargaining agreement, you are not eligible for participation in this LTD Plan unless participation in this LTD Plan is provided or is deemed to be provided for in your collective bargaining agreement.

## ENROLLING IN THE PLAN

If you are eligible to participate in the LTD Plan, you must enroll and elect coverage through your benefits enrollment portal.

## WHEN COVERAGE BEGINS

If you enroll, your coverage will begin on the first of the month coincident with or following your satisfaction of the eligibility requirements, as long as you are actively at work. If you are not actively at work on the day the coverage would otherwise begin, your coverage will begin on the day you start (or return to) active full-time work.

## COST OF COVERAGE

You pay the entire cost of benefits under the LTD Plan.

## BENEFITS

If you become disabled (as defined below) and your claim for LTD benefits is approved by the Plan insurer, LTD benefits become payable after you have satisfied the elimination period (described below).

The LTD benefit is a monthly benefit equal to 60% (rounded to the nearest dollar) of your pre-disability base salary[1], reduced by other income benefits and/or other income earnings. The monthly benefit received under the LTD Plan will normally be taxable income to you.

The maximum monthly LTD benefit under the Plan is $10,000 per month. The minimum monthly benefit is $100 or 10% of your gross monthly benefit, whichever is greater.

## DEFINITION OF DISABILITY

Disability or Disabled means:

- that during the elimination period and for the next 24 months of disability you, as a result of injury or sickness, are unable to perform the material and substantial duties of your own occupation[2]; and
- thereafter, you are unable to perform, with reasonable continuity, the material and substantial duties of any occupation[3].

Partial Disability or Partially Disabled means:

- you, as a result of injury or sickness, are unable to perform one or more, but not all, of the material and substantial duties of your own occupation or any occupation on an active employment or a part-time basis; or
- you, as a result of your injury or sickness, perform all of the material and substantial duties of your own occupation or any occupation on a part-time basis; and
- earn between 20.00% and 80.00% of your basic monthly earnings.

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[1] Base Salary is the salary or wage you would receive as a result of your normal work schedule, including scheduled overtime, but excluding unscheduled overtime.
[2] Own occupation means your occupation that you were performing when your disability or partial disability began. For pilots, co-pilots and crewmembers of an aircraft, disability means the inability to perform the material and substantial duties of any occupation.
[3] Any occupation means any occupation that you are or become reasonably fitted by training, education, experience, age, physical and mental capacity.

Successive Periods of Disability means:

- a period of disability which is related or due to the same cause(s) as a prior disability for which a benefit was payable.

A successive period of disability will be treated as part of the prior disability if, after receiving disability benefits under this Plan, you return to your own occupation on an active employment basis for less than six continuous months and perform all the material and substantial duties of your own occupation. If you return to your own occupation on an active employment basis for six continuous months or more, your disability will be treated as a new period of disability and you must complete another elimination period. Proof of continued disability may be required by the Plan Insurer.

## ELIMINATION PERIOD

The elimination period is the period of consecutive days of disability or partial disability for which no benefit is payable. The elimination period for LTD benefits is 180 days.

## ADDITIONAL BENEFITS

Rehabilitation Incentive Benefit

You may receive an increased monthly benefit, if approved by the insurance carrier, for participating in a rehabilitation program. If you are eligible for a rehabilitation incentive benefit, your LTD benefit will be increased by 10.00%, while fully participating in the program. The increased benefit will begin on the first day of the month after the Plan Insurer receives written proof of your full participation in the approved rehabilitation program. LTD benefits may be terminated if you fail to cooperate and fully participate in all phases of the rehabilitation plan and assessment.

Workplace Modification Benefit

If you are disabled or partially disabled and receiving an LTD benefit, an additional benefit may be payable to the Company for benefit for modifications to the workplace to accommodate your return to work or to assist in your remaining at work.

Work Incentive Benefit

If you are partially disabled, you may be able to receive partial disability benefits with a work incentive if you return to work after satisfying the elimination period and earn between 20% and 80% of your basic monthly earnings. For the first 24 months, the work incentive benefit will be an amount equal to your basic monthly warnings multiplied by the 60%, without any reductions from earnings. The work incentive benefit will only be reduced, if the monthly benefit payable plus any earnings exceed 100% of your basic monthly earnings. If the combined total is more, the monthly benefit will be reduced by the excess amount so that the monthly benefit plus your earnings does not exceed 100% of your basic monthly earnings.

Thereafter, to figure the amount of monthly benefit the formula (A divided by B) x C will be used.

> A = Your basic monthly earnings minus your earnings received while partially disabled. This figure represents the amount of lost earnings.
>
> B = Your basic monthly earnings.
>
> C = The monthly benefit as figured in the disability provision of this Plan plus your earnings received while partially disabled, not including any cost of living adjustments, if applicable.

No disability benefits will be paid, and insurance will end if you are able to work under a modified work arrangement and you refuse to do so.

Survivor Benefit

If you die while LTD benefits are payable after disability had continued for 180 days, a lump sum equal to three (3) times your monthly LTD benefit will be payable to your eligible survivor or to your estate.

## BENEFIT REDUCTIONS FOR OTHER INCOME BENEFITS AND EARNINGS

Your monthly LTD benefit will be reduced by other income. Other income is benefits and/or earnings you receive (or are eligible to receive) while LTD benefits are payable.

Other Income Benefits

- The amount for which you are eligible under:
  - Workers' or Workmen's Compensation Laws;
  - Occupational Disease Law;
  - Title 46, United States Code Section 688 (The Jones Act);
  - any work loss provision in mandatory "No-Fault" auto insurance;
  - Railroad Retirement Act;
  - any governmental compulsory benefit act or law; or
  - any other act or law of like intent.
- The amount of any disability benefits which you are eligible to receive under:
  - any other group insurance plan of the Company;
  - any governmental retirement system as a result of his employment with the Company; or
  - any individual disability income insurance plan where the premium is wholly or partially paid by the Company.
- The amount of benefits you receive under the Company's retirement plan as follows:
  - the amount of any disability benefits under a retirement plan, or retirement benefits under a retirement plan that you voluntarily elect to receive as retirement payment under the Company's retirement plan; and
  - the amount you receive as retirement payments when you reach the later of age 62, or normal retirement age as defined in the Company's plan.
- The amount of disability and/or retirement benefits under the United States Social Security Act, the Canada Pension Plan, the Quebec Pension Plan, or any similar plan or act, which:
  - you receive or are eligible to receive; and
  - your spouse, child or children receive or are eligible to receive because of your disability; or
  - your spouse, child or children receive or are eligible to receive because of your eligibility for retirement benefits.
- Any amount you receive from any unemployment benefits.

Other Income Earnings

- The amount of earnings you earn or receive from any form of employment, including severance; and
- Any amount you receive from any formal or informal sick leave or salary continuation plan(s).

Other income benefits, except retirement benefits, must be payable as a result of the same disability for which the Plan Insurer pays a benefit. The sum of other income benefits and other income earnings will be deducted in accordance with the provisions of the plan.

## MAXIMUM BENEFIT PERIOD

If you qualify, your LTD benefits will continue until the later of your Social Security Normal Retirement Age (SSNRA)* or the Maximum Benefit Period described below:

| Age at Disability | Maximum Benefit Period |
|---|---|
| Less than age 60 | Greater of SSNRA* or to age 65 (but not less than 5 years) |
| Age 60 | 60 months |
| Age 61 | 48 months |
| Age 62 | 42 months |
| Age 63 | 36 months |
| Age 64 | 30 months |
| Age 65 | 24 months |
| Age 66 | 21 months |
| Age 67 | 18 months |
| Age 68 | 15 months |
| Ag 69 and over | 12 months |

*SSNRA means the Social Security Normal Retirement Age as figured by the 1983 amendment to the Social Security Act and any subsequent amendments and provides:

| Year of Birth | Normal Retirement Age |
|---|---|
| Before 1938 | 65 |
| 1938 | 65 and 2 months |
| 1939 | 65 and 4 months |
| 1940 | 65 and 6 months |
| 1941 | 65 and 8 months |
| 1942 | 65 and 10 months |
| 1943 – 1954 | 66 |
| 1955 | 66 and 2 months |
| 1956 | 66 and 4 months |
| 1957 | 66 and 6 months |
| 1958 | 66 and 8 months |
| 1959 | 66 and 10 months |
| 1960 and after | 67 |

# EXCLUSIONS AND LIMITATIONS

The LTD Plan will not cover any disability due to:

- war, declared or undeclared, or any act of war;
- intentionally self-inflicted injuries, while sane or insane;
- active participation in a riot;
- the committing of or attempting to commit a felony or misdemeanor;
- cosmetic surgery unless such surgery is in connection with an injury or sickness sustained while you were covered under the Plan; or
- a gender change, including, but not limited to, any operation, drug therapy or any other procedure related to a gender change.

In addition, the Plan will not pay disability benefits for any period of incarceration in a penal or corrections institution.

Pre-existing Conditions

The Plan will not cover any disability or partial Disability:

- which is caused or contributed to by, or results from, a pre-existing condition; and
- which begins in the first 12 months immediately after your effective date of coverage.

Pre-Existing Condition means a condition resulting from an injury or sickness for which you are diagnosed or received treatment within three months prior to your effective date of coverage.

Mental Illness and/or Substance Abuse

If you are disabled due to alcohol, drug or substance abuse or addiction, your LTD benefits will not exceed a combined period of 24 months. If you are in a Hospital or Institution for Mental Illness and/or Substance Abuse at the end of the combined period of 24 months, the monthly benefit will be paid during the confinement. If you are not confined in a Hospital or Institution for Mental Illness and/or Substance Abuse, but are fully participating in an extended treatment plan for the condition that caused disability, the monthly benefit will be payable for up to a combined period of 36 months. In no event will the monthly benefit be payable beyond the maximum benefit period.

# EVENTS AFFECTING COVERAGE

## Leave Of Absence

You will remain eligible for coverage under the Plan during a Company approved, paid leave of absence. If you are on a Company approved unpaid leave of absence, you may continue the LTD coverage you had when active employment ceased up to a maximum of twelve (12) months. Your cost for this coverage, if any, will be the same as for an active employee. You must make arrangements with the Benefits Department to pay any necessary contributions (if required) for the entire period of the leave, prior to going on leave.

Such coverage may also be continued for a leave of absence taken under the Family and Medical Leave Act of 1993 (as amended).

## 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.

## Labor Dispute

If you are a union member and absent from active work because of strike, lockout or other general work stoppage, you may continue the coverage in which you were enrolled when active employment ceased. Your cost for this coverage will be the entire premium paid by the Company for such insurance. You must make arrangements with the Benefits Department to pay your contributions. Your coverage will end on the earlier of the date you fail to make the required premium payment or the date you are absent from work for six (6) months. If less than 75% of the eligible employees fail to continue LTD coverage under this paragraph, the Plan Insurer providing this benefit may cancel your coverage as of any premium due date.

# TERMINATION OF COVERAGE

Your coverage under the Plan will end upon the earliest to occur of the following:

- The date on which your Maximum Benefit Period expires,
- The date your employment is terminated, other than by reason of your Disability (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, other than by reason of your Disability,
- Your death,
- As applicable, the date you fail to pay the required premiums/contributions toward coverage under the Plan,
- The date you no longer meet the eligibility requirements under the Plan, other than by reason of your Disability, and
- The date the Company discontinues the Plan.

# GENERAL CLAIMS PROCEDURE

## Filing Claim for Benefits

All such claims shall be submitted on a Claim Form provided by the Plan Insurer, which shall be signed by you and shall be considered filed on the date the claim is received by the Plan Insurer. Fill out the Claim Form completely and send it to:

**Liberty Mutual Insurance Group**
**175 Berkeley Street**
**Boston, MA 02117**
**(800) 344-0197**

To constitute a claim for purposes of this Plan, the claim must identify: (1) you and (2) your treating physician's description of your disability and the date on which it began. You may also be required to submit additional evidence of your disability upon request of the insurance carrier.

Effective for claims filed after April 1, 2018, the Plan Insurer shall ensure that all claims and appeals for benefits are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decisions.

## When to Submit Claims

After you have been disabled for approximately three (3) months, or possibly sooner if your condition warrants it, you should complete your application for LTD benefits. Your supervisor or HR Business Partner/Manager can help you initiate the process by contacting the Corporate Benefits Department. You will receive a letter from the Plan Insurer with instructions and the forms you and your attending physician will need to complete to file your LTD claim.

## Authorized Representative

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

## Notice of Decision

The Plan Insurer shall notify you of an adverse benefit determination within a reasonable period of time after receipt of the claim by the LTD Plan, but not later than forty-five (45) days after receipt of the claim, unless special circumstances require an extension of time for processing such request for review.

The Plan Insurer may extend this period for up to thirty (30) days; provided that the Plan Insurer: (1) determines that such an extension is necessary due to matters beyond the control of the LTD Plan and (2) notifies you before the end of the initial 45-day period of the circumstances requiring the extension of time and the date by which the

LTD Plan expects to render a decision. The Plan Insurer may extend the period an additional thirty (30) days, if due to matters beyond the control of the Plan Insurer, a decision cannot be rendered within the initial 30-day extension period and the Plan Insurer notifies you before the end of the initial 30-day extension period of the circumstances requiring the extension of time and the date by which the LTD Plan expects to render a decision. If any such extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the standards on which entitlement to benefits is based, the unresolved issues that prevent a decision from being made and 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 in order for you submit additional information necessary to decide the claim, 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 written in a manner that is intended to be understood by you, shall be delivered to you by certified or registered mail to your 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 LTD Plan upon which the denial is based;
- A description of any additional material or information needed from you and an explanation of why the material or information is needed;
- A description of the LTD Plan's review procedures and the time limits that apply, including a statement of your right to sue under Section 502(a) of ERISA following an adverse benefit determination on review;
- Effective for claims filed after April 1, 2018, a discussion of the decision that includes the basis for disagreeing with or not following: (a) the views of health care professionals treating you or vocational professionals who evaluated you that have been presented to the LTD Plan; (b) the views of medical or vocational experts whose advice was obtained on behalf of the LTD Plan in connection with the denial, regardless of whether the advice was relied on in making the denial; and (c) a disability determination made by the Social Security Administration regarding you, if presented to the LTD Plan;
- If the denial is based on a medical necessity or experimental treatment (or similar exclusion or limit), an explanation of the scientific or clinical judgment relied on, applying the LTD Plan's provisions to your medical circumstances, or statement that this information will be provided free of charge upon request;
- A copy of any internal rule, guideline, other protocol or similar criteria relied upon to make the denial or a statement that this information is available for free on request (or, effective for claims filed after April 1, 2018, either the specific internal rules, guidelines, protocols, standards or other similar criteria of the LTD Plan relied upon in making the adverse benefit determination or, alternatively, a statement that such rules guidelines, protocols, standards or other similar criteria of the LTD Plan do not exist); and
- Effective for claims filed after April 1, 2018, a statement that you are entitled to receive, free and upon request, documents relevant to your claim for benefits.

Effective for claims filed after April 1, 2018, such notice of adverse benefit determination shall be written in a culturally and linguistically appropriate manner.

## 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 Plan Insurer 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 Plan Insurer, and shall be considered filed on the date the claim is received by the Plan Insurer.

## Appeal Standards

The Plan Insurer shall provide you the opportunity to submit written comments, documents, records, and other information related to the claim. The Plan Insurer will provide you, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim. In conducting its review, the Plan Insurer shall consider all comments, documents, records and other information submitted by you in support of the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The Plan Insurer will not afford deference to the initial adverse benefit determination and will be conducted by an appropriate named fiduciary of the LTD Plan who is neither the individual who made the adverse benefit determination or a subordinate of such individual. Where applicable, the Plan Insurer shall consult with a

health care professional or vocational professional who has the appropriate training and experience in the field of medicine involved in the claim, and shall provide you the identification of any such professional, without regard to whether the advice was relied upon in making the benefit determination. Such professional shall neither be an individual who was consulted in connection with the initial adverse benefit determination nor a subordinate of such individual.

Effective for claims filed after April 1, 2018, the Plan Insurer shall provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by or on behalf of the Plan Insurer in connection with the claim and, if applicable, the rationale for the decision if the denial is upheld. The Plan Insurer shall provide this information to you as soon as possible and sufficiently in advance of the date on which the denial notice on review is required to be provided.

## Notice on Appeal

Within a reasonable period of time, but not more than 45 days, after receipt by the Plan Insurer of a written request for review of the claim, the Plan Insurer shall notify you of its decision on appeal. The Plan Insurer may extend this period, one time, for a period of up to 45 days; provided that the Plan Insurer: (1) determines that such an extension is necessary due to special circumstances and (2) notifies you before the end of the initial 45-day period of the circumstances requiring the extension of time and the date by which the LTD Plan expects to render a decision.

Written notice of the determination on appeal shall be presented in manner calculated to be understood by you, shall be delivered to you by certified or registered mail to your last known address., and shall contain the following information:

- The specific reason or reasons for the denial of benefits;
- A specific reference to the pertinent provisions of the LTD Plan upon which the denial is based;
- A statement that you may receive, upon request and free of charge, copies of all documents and other information relevant to the claim;
- A statement describing any voluntary appeal procedures offered by the LTD Plan and your right to obtain information about these procedures, a statement of your right to sue under Section 502(a) of ERISA, and, effective for claims filed after April 1, 2018, a description of any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which such period expires for the claim;
- Effective for claims filed after April 1, 2018, a discussion of the decision that includes the basis for disagreeing with or not following: (a) the views of health care professionals treating you or vocational professionals who evaluated you that have been presented to the LTD Plan; (b) the views of medical or vocational experts whose advice was obtained on behalf of the LTD Plan in connection with the denial, regardless of whether the advice was relied on in making the denial; and (c) a disability determination made by the Social Security Administration regarding you, if presented to the LTD Plan;
- If the denial is based on a medical necessity or experimental treatment (or similar exclusion or limit), an explanation of the scientific or clinical judgment relied on, applying the LTD Plan's provisions to your medical circumstances, or statement that this information will be provided free of charge upon request; and
- A copy of any internal rule, guideline, other protocol or similar criteria relied upon to make the denial or a statement that this information is available for free on request (or, effective for claims filed after April 1, 2018, either the specific internal rule, guideline, protocol, standard or other similar criteria of the LTD Plan relied upon in making the adverse benefit determination or, alternatively, a statement that such rules guidelines, protocols, standards or other similar criteria of the LTD Plan do not exist).

Effective for claims filed after April 1, 2018, such notice of determination on appeal shall be written in a culturally and linguistically appropriate manner.

## Exhaustion of Claims Procedures

The decision of the Plan Insurer shall be final and conclusive.

You must exhaust the internal claims procedures provided hereunder prior to pursuing any other legal or equitable remedy. However, if the Plan Insurer fails to strictly adhere to the requirements of the claims procedures, you will be deemed to have exhausted the claims procedures.

Notwithstanding the foregoing, these claims procedures will not be deemed exhausted based on *de minimis* violations (unless such violations are part of a pattern or practice of violations by the Plan Insurer) that do not cause, and are not likely to cause, prejudice or harm to you so long as the Plan Insurer demonstrates that the violation was

for good cause or due to matters beyond its control and that the violation occurred in the context of an ongoing, good faith exchange of information between you and the Plan Insurer. In the event a violation of the claims procedures occurs, you may request that the Plan Insurer provide you an explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the claims procedures to be deemed exhausted.

No legal action may be brought after 3 years from the date the claim is denied following exhaustion of the appeal procedures outlined above.

# ADDITIONAL INFORMATION

As a participant 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 Retail Voluntary Group Long-Term Disability 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<br>19100 Ridgewood Parkway San Antonio, TX 78259<br>(866) 688-5465, press options 3, then option 5 |
| **Plan Number** | 501 |
| **Plan Year** | January 1 – December 31 |
| **Plan Funding** | The Plan is funded through an insurance contract. The cost of coverage is paid for solely by employee contributions |
| **Type of Administration** | Insurer |
| **Plan Insurer** | Liberty Mutual Insurance Group<br>175 Berkeley Street<br>Boston, MA 02117<br>(800) 344-0197 |
| **Agent for Service of Legal Process** | Andeavor, c/o General Counsel<br>19100 Ridgewood Parkway, San Antonio, TX 78259<br>In addition, service of legal process may be made upon the Plan Administrator. |

## Other Employers Whose Employees Are Covered By the Plan

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

# 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
(866) 688-5465
SatBenefits@andeavor.com

Legacy Western Employees:

Benefits Department
(844) 224-4996
Benefits.department@andeavor.com

# ERISA

As a participant in this LTD 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 LTD Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the LTD 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 LTD 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 LTD 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 LTD Plan, called "fiduciaries" of the LTD Plan, have a duty to do so prudently and in the interest of you and other LTD 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 LTD Plan documents or the latest annual report from the LTD Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a State or Federal court. In addition, if you disagree with a LTD Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

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

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

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

## FUTURE OF THE PLAN

Andeavor expects to continue the LTD Plan indefinitely, 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 LTD Plan.

## INTERPRETATION OF THE PLAN

Only the Plan Insurer, 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 Plan Insurer has authority to administer claims consistent with the benefit provisions of the Plan.