andeavor

ACCOUNT-BASED BENEFIT PROGRAMS UNDER THE ANDEAVOR CAFETERIA PLANS

SUMMARY PLAN DESCRIPTION

As of January 1, 2018

This summary plan description (SPD) outlines the major features of the account-based benefit programs offered under the Andeavor Cafeteria Plans. If you have questions regarding your eligibility under an account-based program, contact the Andeavor Benefits Department.

This document describes the account-based benefit programs as of January 1, 2018. These programs are available to eligible Andeavor employees on the U.S. payroll. This information comprises the SPD for these programs, to the extent required by the Employee Retirement Income Security Act of 1974 (ERISA), as applicable.

This description doesn't cover every provision of the account-based benefit programs. 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.

HEALTH CARE FLEX SPENDING ACCOUNT PLAN

Highlights

The Health Care Flex Account, also known as the "Medical Care Flex-Account" (Health Care FSA) Plan can help you pay for certain health care expenses with before-tax dollars. The program is designed to reimburse you for qualified out-of-pocket medical, dental, vision and hearing expenses, including deductibles, co-insurance and co-payments, not covered by your health insurance plans.

Participation

Regular, full-time employees (other than Retail Store, Hourly Bakery Production and Bakery Driver Employees) of Andeavor or any subsidiary are eligible to participate in the Health Care FSA Plan upon hire. Retail Store, Hourly Bakery Production and Bakery Driver Employees of Andeavor or any subsidiary are eligible to participate in this Plan as of the first day of the month on or after completion of 60 days of active, full-time employment.

Employees who are employed by an Andeavor affiliate that is not participating in the Plan are ineligible. Please contact the Plan Administrator for a list of the Andeavor affiliates that are not participating in the Plan.

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 Plan unless participation in this Plan is provided or is deemed to be provided for in your collective bargaining agreement.

Types of Health Care FSAs

There are two types of Health Care FSAs offered under the Plan – a General Purpose Health Care FSA and a Limited Purpose FSA.

If you are a participant in the Andeavor Value Plus Plan (VPP) or Traditional VPP, with a Health Savings Account (described in the following Section), you may not enroll in the General Purpose Health Care FSA. Individuals who want to contribute to a Health Savings Account are prohibited under IRS regulations from having certain medical coverage that is not a qualified high deductible health plan (HDHP). For these purposes, the General Purpose Health Care FSA is considered disqualifying coverage because it could cover out-of-pocket medical expenses before the deductible is met.

You should note also that being eligible for reimbursement of your medical expenses under another family member's (e.g. your spouse) general-purpose health FSA will disqualify you from making contributions to a Health Savings Account.

However, VPP (with HSA) participants may elect to participate in the Limited Purpose Health Care FSA without adversely affecting their eligibility to make contributions to a Health Savings Account. Under the Limited Purpose Health Care FSA, however, only dental and vision expenses are reimbursable from the account.

Enrollment

If you are eligible to participate in the Plan, you must enroll and elect the amount of your contribution to the Health Care FSA within 31 days after your eligibility date (or, if applicable, the date of a qualified family status change, described below). You may enroll by completing your Online Benefits Enrollment through the respective legacy Tesoro or legacy Western benefits enrollment web sites. After you have completed your enrollment, you should print a Confirmation Form verifying your elections.

During each annual enrollment, you must re-enroll to participate in the Health Care FSA for the upcoming year. Your participation will end as of the end of the calendar year if you do not elect to participate at annual enrollment for the following year.

If you enroll in the Health Care FSA during annual enrollment, your participation begins the following January 1. If you enroll within your first 31 days of work at Andeavor, your participation begins on your eligibility date (normally your date of hire). If you enroll at any other time of the year because of a qualified family status change, your participation begins on the effective date of the change.

Amount of Contribution

The chart below shows the minimum and maximum amounts you can contribute to your Health Care FSA each calendar year:

Minimum Calendar-Year Contribution	Maximum Calendar Year Contribution
$130	**$2,600**

If you and your spouse are both Andeavor employees, each of you can direct up to $2,600 to a Health Care FSA each calendar year. If your spouse has a Health Care FSA with another employer, you can still contribute up to $2,600 each year.

If you're a new employee, you can have the maximum amount deducted from your pay during the year in which you join the company, no matter when you're hired. You should keep in mind that IRS contribution limits apply to all of the contributions you make to programs like this during the calendar year. If you contributed to a similar plan sponsored by your former employer, those contributions will count toward your annual limit under federal tax laws.

The amount of your contribution will be taken on a substantially pro rata basis each payroll period, in accordance with your election.

Your election is irrevocable for the calendar year with respect to which it is made, unless you experience a qualified family status change. You cannot redirect the amount designated on your enrollment form for the Health Care FSA to the Dependent Care FSA, or vice versa, for any reason during the year. In addition, funds in your Health Care FSA can't be used to pay for dependent care expenses. Similarly, funds in your Dependent Care FSA cannot be used to pay for health care expenses.

How the Health Care FSA Program Works

The entire amount you elect to contribute to your Health Care FSA is credited to a bookkeeping account set up in your name as of the first day of the plan year (or, if applicable, the effective date of your participation). The money deducted from your pay is taken on pre-tax basis and, therefore, will reduce the amount of your taxable compensation for the year.

You may pay your qualified expenses directly with your FSA debit card issued to you by the FSA claims administrator. Alternatively, you can file a claim for reimbursement by completing the claim submission process with your claims administrator. Supporting documentation must be provided including the dates of service, the provider's name, the name of the eligible person receiving the services (you or your eligible dependent), the services that were received, and the incurred cost. Claim forms are available online at the respective HR portal websites or enrollment sites for legacy Tesoro and legacy Western.

Also, the Internal Revenue Service (IRS) requires that claims administrators verify that all Health Care FSA debit card purchases are for eligible expenses. If you receive a request from the claims administrator for additional documentation for your card purchase and do not respond within the time permitted, your card may be temporarily suspended until you provide the requested documentation. Failure to validate any expenses paid with the FSA debit card will require Andeavor to report the unsubstantiated amounts as taxable income on your W-2. Additionally, the value of the unsubstantiated amounts will be entered as FSA imputed income on your paycheck. To avoid this from happening, please take immediate action as required by the IRS and provide the requested documentation.

Each time you file a claim, you'll be reimbursed for your qualified expenses, up to the amount of money credited to your account (i.e. the amount of your total contribution elected reduced by prior expenses reimbursed). If you file for reimbursement for an expense paid out of your pocket, reimbursements are made through direct deposit to your designated bank account on file with the claims administrator or by check issued to you by the administrator.

You may review your claims and account balance online by logging into your respective claim administrator's website. You must file your claims for reimbursement before March 31 of the year after the plan year in which you incur qualified health care expenses.

A portion of the balance credited to your Health Care FSA following the March 31st deadline may be forfeited. If your balance equals $500 or less, it will be automatically carried over to either a General Purpose Health Care FSA or a Limited Purpose Health Care FSA – depending on whether you are enrolled in a VPP (with HSA) option or non-HDHP coverage - to pay for qualified expenses incurred in the subsequent year (i.e. the year that includes the applicable March 31st deadline). Any balance in excess of $500 following the claims submission period will be forfeited. The forfeited amounts are not available for future expenses or a refund. Under certain circumstances if you terminate employment, you may be eligible for continued participation and reimbursement of qualified expenses through COBRA (see Events Affecting Coverage).

What Is a "Qualified Expense"?

Which expenses constitute "qualified expenses" will depend on whether you are enrolled in a General Purpose Health Care FSA or a Limited Purpose Health Care FSA.

General Purpose Health Care FSA

Under a General Purpose Medical FSA, qualified expenses are those that meet the requirements under IRC Section 213(d). Generally, these are out-of-pocket medical, dental, vision or hearing expenses, for you or an eligible dependent, of the type that would qualify for deduction on your federal income tax return.

Limited Purpose Health Care FSA

Under a Limited Purpose Health Care FSA, qualified expenses are limited to out-of-pocket dental and vision, expenses, for you or an eligible dependent, of the type that would qualify for deduction on your federal income tax return.

General Qualification Rules

Only expenses for goods bought or services provided (incurred) during the plan year while you're a participant in the Health Care FSA are eligible for reimbursement. These expenses include your deductibles, co-payments, and other out-of-pocket expenses under your group health plans – to the extent eligible for reimbursement under your applicable Health Care FSA (see above).

Over-the-Counter (OTC) medicines require a doctor's prescription before purchase in order to submit the expense under your Health Care FSA. Each calendar year, you must provide written documentation from your doctor stating your medical condition and indicating that the over-the-counter medication will treat or alleviate your condition. After you have provided the documentation from your doctor, you may submit claims for the medication for the rest of the calendar year.

Who's an "Eligible Dependent"?

An eligible dependent whose qualified medical expenses can be reimbursed from your Health Care FSA includes you and your spouse, all dependents you could claim on your tax return and your children until age of 26. Federal tax law does not permit you to claim expenses for your domestic partner or your domestic partner's children, unless they qualify as dependents on your federal income tax return for the year.

Tax Considerations

Your Social Security benefits may be lowered slightly at retirement if you participate in the Health Care FSA. This is because deductions under the program lower your taxable Social Security wages, and your Social Security benefits are based on your taxable wages. If you're earning less than the Social Security wage base, your future Social Security benefits will be reduced; however, the effect will usually be minimal. If your earnings are above the Social Security wage base after you subtract all pre-tax contributions for this program, the Dependent Care FSA, basic group life insurance, and medical and dental plan coverage, your Social Security benefits won't be affected.

The IRS does not allow you to take an income tax deduction for expenses reimbursed through your Health Care FSA. When you consider whether or not to enroll in the Health Care FSA, you need to consider whether you're eligible to take the federal income tax deduction for health care expenses on your income tax return. Under current tax laws, health care expenses are normally deductible on your federal income tax return only if they exceed 7.5 percent (for 2018) of your adjusted gross income. IRS Publication 502, available at www.irs.ustreas.gov, provides more information about expenses that are deductible for income tax purposes. Keep in mind that over-the-counter medications may be eligible for reimbursement under the Health Care FSA, but they are not tax-deductible.

If you are not eligible for the federal income tax deduction, the Health Care FSA will provide tax savings on your health care expenses. If you are eligible for the income tax deduction, either the Health Care FSA or the federal income tax deduction may provide greater tax savings, depending on your situation and the amount and type of your expenses. It's best to talk with a tax adviser to determine which approach provides the greatest tax savings for you.

An Example of How the Health Care FSA Can Help You Save

When you elect to contribute to the Health Care FSA, your taxable income is reduced. Here's an example of how a spending account could help you save. Assume all of the following:

- You are single.
- You have an annual income of $50,000.
- You contribute $2,600 to your Health Care FSA.

	With HCFSA	Without HCFSA
Your salary	$50,000	$50,000
Minus your contribution to the Health Care FSA	($2,600)	$0
Taxable pay	$47,400	$50,000
Estimated Taxes (25%)	($11,850)	($12,500)
After Tax Health Care Expenses	$0	($2,600)
Net Pay	$35,550	$34,900
Savings	**$650**	**$0**

In this example, you save $650 by paying for health care expenses using the Health Care FSA. Keep in mind that this is only an example. Your own tax savings will depend on your personal situation. Tax laws are complex and change frequently. Please see a tax adviser for the tax savings that apply to you.

Continuation of Coverage – Health Care FSA

COBRA

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

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

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

COBRA continuation for Health Care FSAs is a limited obligation and only available to those with "underspent" accounts as of the date of the qualifying event. If you (or your qualified dependents) have an "underspent" account and elect to continue coverage, you will be required to pay the full monthly contribution (on an after-tax basis) plus

a 2% COBRA administration fee. Health Care FSA COBRA continuation eligibility will cease at the end of the year in which the qualifying event occurs.

Your account will be considered “underspent” if the amount available in your Health Care FSA for the remainder of the plan year in which the "qualifying event" occurs is more than the maximum amount the Health Care FSA may charge you to maintain continued coverage under the plan.

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

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

1. the Plan Sponsor no longer provides group coverage to any of its employees;
2. the monthly contribution is not paid on or before the date it is due;
3. the period during which COBRA was applied for ends.

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 Medical Flexible Spending Account Plan under the Andeavor Cafeteria Plans (which are 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 contributions
Type of Administration	Administrative Services Only (ASO) contract
Plan Insurer	Self-insured

Claims Administrator	**Legacy Tesoro Participants** PayFlex Systems USA, Inc. P.O. Box 4000 Richmond, KY 40476-4000 Phone: 844-729-3539 Fax: 888-238-3539 www.payflex.com **Legacy Western Participants** Businessolver FSA Services P.O. Box 65948 West Des Moines, IA 50265 Phone: 844-408-2575 Fax: 855-883-8541 www.andeavor.com/benefits2018
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.

ERISA Rights

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.

DEPENDENT CARE FLEX SPENDING ACCOUNT PLAN

Highlights

The Dependent Care Flex Spending Account (Dependent Care FSA) Plan can help you pay for dependent care expenses with before-tax dollars. The program is designed to reimburse you if you pay for the care of an eligible dependent so you and your spouse can work or look for work.

Participation

Regular, full-time employees (other than Retail Store, Hourly Bakery Production and Bakery Driver Employees) of Andeavor or any subsidiary are eligible to participate in the Dependent Care FSA Plan upon hire. Retail Store, Hourly Bakery Production and Bakery Driver Employees of Andeavor or any subsidiary are eligible to participate in this Plan as of the first day of the month on or after completion of 60 days of active, full-time employment.

Employees who are employed by an Andeavor affiliate that is not participating in the Plan are ineligible. Please contact the Plan Administrator for a list of the Andeavor affiliates that are not participating in the Plan.

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 Plan unless participation in this Plan is provided or is deemed to be provided for in your collective bargaining agreement.

In order to participate, you must also pay for day care for a qualified dependent so you can work, and one of the following must apply to you:

- You're single or legally separated;
- You're married and your spouse also works;
- You're married and your spouse attends school full-time outside the home at least five months during the year; or
- You're married and your spouse is mentally or physically incapable of caring for himself or herself because of a disability.

Enrollment

If you are eligible to participate in the Plan, you must enroll and elect the amount of your contribution to the Dependent Care FSA within 31 days after your eligibility date (or, if applicable, the date of a qualified family status change, described below). You may enroll by completing your Online Benefits Enrollment through the respective legacy Tesoro or legacy Western benefits enrollment websites. After you have completed your enrollment, you should print a Confirmation Form verifying your elections.

During each annual enrollment, you must re-enroll to participate in the Dependent Care FSA for the upcoming year. Your participation will end as of the end of the calendar year if you do not elect to participate at annual enrollment for the following year.

If you enroll in the Dependent Care FSA during annual enrollment, your participation begins the following January 1. If you enroll within your first 31 days of work at Andeavor, your participation begins on your eligibility date (normally your date of hire). If you enroll at any other time of the year because of a qualified family status change, your participation begins on the effective date of the change.

Amount of Contribution

Federal tax laws limit the amount of money you can contribute each year to the Dependent Care FSA. The limitations vary depending on your marital status, how you file your income tax return, and other factors as outlined below:

If you're:	You can contribute up to this amount:
Single	$5,000 a year
Married, you and your spouse file a joint tax return, and your spouse does not have access to a Dependent Care FSA	$5,000 a year, limited to your spouse's earned income for the year
Married, you and your spouse file a joint tax return, and your spouse has access to a Dependent Care FSA	You and your spouse can contribute up to $5,000 a year combined
Married, and you and your spouse file separate tax returns	You can each contribute up to $2,500 a year
If your spouse earns less than $5,000 a year	Your combined contributions are limited to an amount equal to your spouse's annual income. For example, if your spouse earns $4,000 a year, your contributions can't be more than $4,000.

The minimum amount you can contribute each calendar year is $130 or $5 per biweekly pay period ($2.50 per weekly pay period).

If you're a new employee, you can have the maximum amount deducted from your pay during the year in which you join the company, no matter when you're hired. You should keep in mind that IRS contribution limits apply to all of the contributions you make to programs like this during the calendar year. If you contributed to a similar plan sponsored by your former employer, those contributions will count toward your annual limit under federal tax laws.

The amount of your contribution will be taken on a substantially pro rata basis each payroll period, in accordance with your election.

Your election is irrevocable for the calendar year with respect to which it is made, unless you experience a qualified family status change. You cannot redirect the amount designated on your enrollment form for the Dependent Care FSA to the Health Care FSA, or vice versa, for any reason during the year. In addition, funds in your Dependent Care FSA can't be used to pay for medical care expenses. Similarly, funds in your Health Care FSA cannot be used to pay for dependent care expenses.

How the Dependent Care FSA Program Works

Each contribution you make to your Dependent Care FSA is credited to a bookkeeping account set up in your name as of the first day of the plan year (or, if applicable, the effective date of your participation). The money deducted from your pay is taken on pre-tax basis and, therefore, will reduce the amount of your taxable compensation for the year.

After you pay your eligible dependent care expenses, you can file a claim for reimbursement by submitting a completed Flexible Spending Account Claim Form and a copy of your bill or receipt for the dependent care expenses incurred to the claims administrator. The bill must show for whom the care was provided, when the care was provided, the day care provider's name and tax ID or social security number, and the amount paid. Canceled checks or credit card receipts are not acceptable as documentation for reimbursement. Claim forms are available online at the respective HR portal websites or enrollment sites for legacy Tesoro and legacy Western.

Each time you file a claim, you'll be reimbursed for your qualified expenses, up to the amount of money credited to your account (i.e. the amount of your contributions made reduced by prior expenses reimbursed). If your expenses are greater than the amount in your account, you'll be reimbursed for the remaining amount after additional before-tax contributions are credited to your account. Reimbursements are made through direct deposit to your designated bank account on file or by check issued to you by the claims administrator.

You may submit claims and review your account balance at:

Legacy Tesoro Participants

PayFlex Systems USA, Inc.
P.O. Box 4000
Richmond, KY 40476-4000
Phone: 844-729-3539
Fax: 888-238-3539
www.payflex.com

Legacy Western Participants

Businessolver FSA Services
P.O. Box 65948
West Des Moines, IA 50265
Phone: 844-408-2575
Fax: 855-883-8541
www.andeavor.com/benefits2018

You must file your claims for reimbursement by March 31 of the year after the plan year in which you incur qualified dependent care expenses. Any amounts remaining in your account balance following the claims submission period will be forfeited. This money is not available for future expenses or a refund.

Who's an "Eligible Dependent"?

You can take advantage of the tax savings offered by the Dependent Care FSA if you're an eligible employee and you have to pay someone to take care of a qualified dependent so you, and your spouse if you're married, can work or look for work.

IRS regulations define a taxpayer's dependent for purposes of the Dependent Care FSA reimbursement as a "qualifying individual" who is:

- A qualifying child who has not attained age 13. (See definition of qualifying child under Health Care FSA, Who's an "Eligible Dependent?")
- A qualifying child, qualifying relative, or spouse who is physically or mentally incapable of self-care and who has the same principal place of abode as you for more than half of the taxable year. (See definitions of qualifying child and qualifying relative under Health Care FSA, Who's an "Eligible Dependent?")

There are 3 exceptions that apply:

- If you are a dependent (as defined above) of a taxpayer, then you are treated as having no dependents (e.g., your son or daughter cannot be your qualifying child if you are the dependent of another).

- If an individual files a joint return with his/her spouse, that individual cannot be another person's dependent (e.g., your married son who files a joint return cannot be your qualifying child).
- An individual cannot be a dependent unless he/she is a citizen or resident of the U.S. or resident of Canada or Mexico (except in the case of adopted children).

Special Rule for Divorced Parents

Even if you cannot claim your child as a dependent, he or she is treated as a qualifying individual if:

- The child is under age 13 or was not physically or mentally able to care for himself or herself,
- The child received over half of his or her support during the calendar year from one or both parents who are divorced or legally separated under a decree of divorce or separate maintenance, are separated under a written separation agreement, or lived apart at all times during the last 6 months of the calendar year,
- The child was in the custody of one or both parents for more than half the year, and
- You are the child's custodial parent. The custodial parent is the parent with whom the child lived for the greater number of nights in the year. If the child was with each parent for an equal number of nights, the custodial parent is the parent with the higher adjusted gross income. For details and an exception for a parent who works at night, see Pub. 501.

The noncustodial parent cannot treat the child as a qualifying individual even if that parent is entitled to claim the child as a dependent under the special rules for a child of divorced or separated parents.

What Is a "Qualified Expense"?

For information regarding qualified expenses, visit www.aetna.com/fsa or refer to IRS Publication 503, available at www.irs.ustreas.gov.

Tax Considerations

Your Social Security benefits may be lowered slightly at retirement if you participate in the Dependent Care FSA. This is because deductions under the program lower your taxable Social Security wages, and your Social Security benefits are based on your taxable wages. If you're earning less than the Social Security wage base, your future Social Security benefits will be reduced; however, the effect will usually be minimal. If your earnings are above the Social Security wage base after you subtract all pre-tax contributions for this program, the Health Care FSA, basic group life insurance, and medical and dental coverage, your Social Security benefits won't be affected.

You can save income taxes on dependent care costs in two ways: through the Andeavor Dependent Care FSA or by claiming a federal tax credit. The IRS permits you to take a federal income tax credit for dependent care expenses depending on your tax filing status and taxable income. This credit currently ranges from 20% to 35% of your eligible dependent care expenses.

Contributions you make to the Dependent Care FSA reduce, dollar-for-dollar, the dollar limit on expenses eligible for the dependent care tax credit. You can't take the tax credit and be reimbursed under Andeavor's Dependent Care FSA for the same expense. You have to decide which tax advantage is best for you — the Dependent Care FSA, the tax credit, or a combination of both. It's best to talk with a tax adviser to determine which approach provides the greatest tax savings for you.

FSA ELECTION CHANGE PROCEDURES

Events Affecting Participation

Change in Family Status

The following life events could qualify you to make appropriate changes in your FSA elections. However, the change you request must be consistent with the life event. For example, if you become a parent, you can enroll in the Medical Care and/or Dependent Care FSA or increase your contributions to provide health care or day care for the child.

- Marriage
- Divorce, legal separation, or annulment of your marriage
- Birth, adoption, or placement for adoption of a child

- Death of a spouse or child
- Loss or establishment of dependent eligibility
- Loss or establishment of Medicaid or Medicare coverage
- Transfer or relocation
- Employment or unemployment of your spouse or an eligible dependent
- Leave of absence under the Family and Medical Leave Act ("FMLA") or other approved leave of absence
- Strike or lockout
- Change in COBRA coverage for you, your spouse, or an eligible dependent
- Judgment, decree or order regarding coverage for an eligible dependent
- Change in part-time/full-time work schedule for you or your spouse
- Change in part-time/full-time school schedule for your spouse
- Change in day care providers
- Disability of you, your spouse, or another dependent
- Significant increase or decrease in benefit plan costs
- Significant reduction in plan coverage
- Significant change in plan benefits provided

If you experience a qualified change in family status and need to change your FSA election during the plan year, make the change through your respective legacy Tesoro or legacy Western benefits enrollment web sites. within 31 days after the event that necessitates the change. If you don't, you cannot make a change until the next annual enrollment, unless you have another qualifying life event.

The rules related to a qualified change in family status are established by the IRS and are subject to revision. Because the rules are complex, you will need to check with your respective legacy Tesoro or legacy Western benefits enrollment department to determine if you have a qualifying event and what change, if any, you can make to your FSA election.

Disability

Your contributions to the Health Care or Dependent Care FSA continue while you receive salary continuation benefits from an Andeavor Short-Term Disability Plan. They'll stop if you begin to receive benefits from the Long-Term Disability Plan. Under certain circumstances, you may be able to continue making contributions to the Health Care FSA on an after-tax basis through COBRA for the remainder of the plan year. Contact your respective Benefits Department for additional information.

Leave of Absence

If you are on a Company approved leave of absence, your participation in the Health Care or Dependent Care FSA will continue to the extent that you are receiving Company pay. If you are on leave without pay, your participation in the plan will end.

If your leave of absence is taken under the Family and Medical Leave Act (FMLA), you may continue participation and can (1) prepay your contributions on a pre-tax basis (provided that your leave doesn't extend beyond the end of the current plan year); (2) make contributions (pre-tax if you are receiving salary continuation, e.g. short-term disability or vacation pay, and after-tax if your leave is unpaid); or (3) catch-up on your pre-tax contributions when you return from FMLA leave. If your leave extends beyond the end of the current plan year, you must make a new FSA election when you return to work.

Note: If your spouse goes on a leave of absence, you should stop your contributions to the Dependent Care FSA because you can't be reimbursed for expenses incurred while your spouse isn't working, unless your spouse is disabled or attending school.

Reduction in Number of Hours Worked

If your regularly scheduled hours are reduced to less than thirty (30) hours per week, your participation will end as of the date the schedule change is effective. Under certain circumstances, you, your spouse and your qualified dependents may be able to continue making contributions to the Health Care FSA on an after-tax basis through COBRA for the remainder of the plan year. Contact your respective Benefits Department for additional information. If your regularly scheduled hours later increase to at least thirty (30) hours per week, you'll once again be eligible to participate in the FSA plan.

Layoff or Termination of Employment

Participation ends when your employment terminates. When you leave the Company during the plan year, you have until March 31 of the next year to submit claims for expenses incurred before your termination of employment. Under certain circumstances, you, your spouse and your qualified dependents may be able to continue making Health Care FSA contributions on an after-tax basis through COBRA for the remainder of the plan year. Contact your respective Benefits Department for additional information.

Death

Participation ends as of the date of your death. Your survivors must file requests for reimbursement of qualified expenses, up to the full amount you have elected to contribute to the Health Care FSA and up to the amount available in your Dependent Care FSA no later than March 31st of the following year. Under certain circumstances, your spouse and qualified dependents may be able to continue making Health Care FSA contributions on an after-tax basis through COBRA for the remainder of the plan year. Contact your respective Benefits Department for additional information.

Exclusions and Limitations

Under certain circumstances, tax laws may require that your pre-tax contributions under the cafeteria plan be reduced or terminated. You will be notified if such adjustments are required.

HEALTH SAVINGS ACCOUNT PROGRAM

Highlights

The Health Savings Account Program enables eligible individuals to contribute, on a pre-tax basis, to a Health Savings Account maintained by a trustee or custodian selected by Andeavor. Earnings on amounts held in your Health Savings Account are not taxable to you. Amounts distributed from your Health Savings Account are also not taxable to you, if such amounts are used to pay for certain medical expenses incurred by you and your eligible dependents. For these purposes, the term "eligible dependents" has the same meaning as provided under the Health Care FSA Plan, except that, for purposes of the Health Savings Account Program, the term "eligible dependent" does not include a child who does not otherwise satisfy the conditions to be your tax dependent (with certain exceptions).

Participation

Regular, full-time employees (other than Retail Store, Hourly Bakery Production and Bakery Driver Employees) of Andeavor or any subsidiary are eligible to participate in the Health Savings Account Program upon hire. Retail Store, Hourly Bakery Production and Bakery Driver Employees of Andeavor or any subsidiary are eligible to participate in this Plan as of the first day of the month on or after completion of 60 days of active, full-time employment.

Employees who are employed by an Andeavor affiliate that is not participating in the Plan are ineligible. Please contact the Plan Administrator for a list of the Andeavor affiliates that are not participating in the Plan.

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 Plan unless participation in this Plan is provided or is deemed to be provided for in your collective bargaining agreement.

High Deductible Health Plan Coverage

You must generally be enrolled in a HDHP as of the first day of the calendar month in order to be an eligible participant for that month.

A high deductible health plan means a health plan which has an annual deductible that is not less than the applicable dollar amounts, as provided under the Code, for self-only and family coverage (for 2018, $1,350 for self-only coverage and $2,700 for family coverage), with respect to which the sum of the annual deductible and out-of-pocket expenses to be paid for covered expenses under the plan do not exceed applicable dollar amounts for self-only and family coverage (for 2018, $6,650 for self-only coverage and $13,300 for family coverage), and which otherwise satisfies the requirements of the Internal Revenue Code. Note, the dollar limitations may be increased by the IRS from time to time to reflect cost-of-living adjustments.

Impermissible Coverage

Participants in Andeavor's Value Plus Plan (VPP) or Traditional VPP, qualified High Deductible Health Plans (HDHPs), with HSA are prohibited under IRS regulations from having certain medical coverage other than HDHP coverage. Meaning, an HSA-eligible individual cannot be covered by any health plan that provides coverage below the statutory minimum HDHP deductible.

Note, a General Purpose Health Care FSA is considered non-HDHP coverage because it could cover out-of-pocket medical expenses before the deductible is met. Therefore, VPP (with HSA) participants may not participate in the General Purpose Health Care FSA. Similarly, VPP (with HSA) participants may not be covered under a family member's (e.g. your spouse's) general-purpose health FSA such participant could be reimbursed for any medical expenses incurred before the VPP deductible is met.

However, VPP (with HSA) participants may elect to participate in the Limited Purpose Health Care FSA without adversely affecting HSA eligibility. Under the Limited Purpose Health Care FSA, however, only dental and vision expenses are reimbursable prior to your satisfying the minimum statutory deductible for the applicable plan year. Once you have met the minimum statutory deductible for the plan year, all eligible medical expenses incurred during the remaining of the plan year can be reimbursed. For a detailed explanation of the Health Care Flexible Spending Account Program, see the prior Section.

Enrollment

If you are eligible to participate in the Health Savings Account Program, you can enroll and elect the amount of your contribution to your Health Savings Account at any time following your eligibility. You may enroll by completing your Online Benefits Enrollment through the respective legacy Tesoro or legacy Western benefits enrollment websites. After you have completed your enrollment, you should print a Confirmation Form verifying your elections. Your election will be effective as of the first day of the following payroll period.

During each annual enrollment you must re-enroll to participate in the Health Savings Account for the upcoming year for the employee contribution. If your Health Savings Account is open, you will automatically receive the employer contribution in your account after each payroll. Your participation in the employee contribution will end as of the end of the calendar year if you do not elect to participate at annual enrollment for the following year, unless you make a mid-year election to participate in the program.

Amount of Contributions

The total contributions to your Health Savings Account may not exceed the sum of the monthly limits prescribed under the Code for all months during the calendar year for which you are eligible to make contributions to a health savings account. For the Plan Year commencing on January 1, 2018, the monthly limit is $^{1}/_{12}$ of, for single coverage, $3,450 and, for family coverage, $6,900. Notwithstanding the foregoing, if you are an eligible individual who is otherwise eligible to participate in the Health Savings Account Program on December 1st, you will be treated as having been an eligible individual for each month of the applicable calendar year and, therefore, permitted to make the maximum contribution for the taxable year. In addition, if you are age 55 or older during the year, you may contribute an additional $1,000 to your Health Savings Account. Note, certain restrictions apply to married individuals. You are solely responsible for determining the maximum amount of your pre-tax contributions to your Health Savings Account.

Andeavor may make contributions to the Health Savings Accounts of all participants in the Health Savings Account Program. The amount of such contribution, if any, may vary depending on the benefit options and level of coverage

you elect and, if made, must be considered with your pre-tax contributions when determining the maximum contributions that can be made to your Health Savings Account for such calendar year.

If the amount of your pre-tax contributions and employer contributions to your Health Savings Account during a calendar year exceeds the sum of the monthly limit for all months within your taxable year for which you are eligible to make contributions to a Health Savings Account, you will be subject to a 6% excise tax on your "excess contributions", unless you contact the trustee or custodian and request a distribution of the excess contributions (and income) prior to the due date for filing your federal income tax return (including extensions). Any excess contributions discovered by Andeavor will be reported as taxable wages to you for the applicable taxable year.

Health Savings Account Election Changes

You may make an election to commence making pre-tax contributions to your Health Savings Account, or to increase, decrease or revoke such contributions, on a prospective basis, at any time during the plan year. Such election must be submitted in the time and manner prescribed by the plan administrator and shall be effective as soon as administratively feasible, generally the first day of the immediately succeeding pay period.

How the Health Savings Account Program Works

After your enrollment you must open your Health Savings Account with the custodian or trustee selected by Andeavor. Once your account is open, each contribution is deposited into your Health Savings Account after each payroll. The money deducted from your pay is taken on pre-tax basis and, therefore, will reduce the amount of your taxable compensation for the year.

You may pay your qualifying health care expenses directly with your debit card issued to you by the custodian or trustee, or by submitting a request for distribution. You are not required to submit evidence of the medical expense to the custodian or trustee. Note, however, that you are required to retain proof of your medical expenses to substantiate such distributions upon request of the Internal Revenue Service. You may receive a distribution up to the amount of your balance in your Health Savings Account (i.e. the amount of your total contributions made to the account reduced by prior distributions).

Andeavor's Health Savings Account custodians/trustees are:

Legacy Tesoro Participants:

Fidelity
www.netbenefits.com
(877) 295-2413

Legacy Western Participants:

HSA Bank
www.hsabank.com
(800) 357-6246

There is no deadline for requesting a distribution from your account to reimburse you for qualifying medical expenses. So long as the qualifying medical expenses were incurred any time following the establishment of your Health Savings Account, you can request a distribution to cover those expenses at any time without incurring income or excise taxes.

Any amounts deposited in your Health Savings Account are entirely yours and cannot be forfeited, even if your employment with Andeavor is subsequently terminated.

What is a "Qualified Expense"?

In order to qualify for tax-free reimbursement from your Health Savings Account, the expenses must be described under Section 213(d) of the Internal Revenue Code, be incurred on or after your date your health savings account is established and not be covered by Andeavor's medical plan or other health plan or arrangement (including a plan maintained by your spouse's employer). For these purposes, an expense is "incurred" when the individual is provided with the care that gives rise to the expense, rather than the date on which the individual is billed or otherwise pays for the care.

For example, deductibles and coinsurance for medical treatment are reimbursable expenses from your Health Savings Account if not otherwise reimbursable by insurance or a similar arrangement. In addition, unlike the Health Care Flexible Account Plan, you may be reimbursed for long-term care services and insurance programs from your

health savings account. Note, however, you may not be reimbursed the costs of "over-the-counter" medicines and drugs from your Health Savings Account, unless such drugs or medicines have been prescribed by your physician, or is insulin.

Tax Considerations

Similar to contributions made to a Health Care FSA, contributions made to a Health Savings Account maintained by an eligible individual will not be subject to withholding for income or employment taxes. However, if contributions are made to your Health Savings Account during a time when you are not eligible to make such contributions, the contributions will be subject to income tax. In addition, an excise tax of 6% for each taxable year is imposed unless the excess contributions (and earnings) are timely distributed from the account on or before the deadline for filing your income tax return (including extensions).

Distributions from your Health Savings Account are tax-free to the extent that they pay or offset otherwise unreimbursed qualified medical expenses incurred after the establishment of the account. If a distribution is made from your Health Savings Account that is not used to pay or reimburse for qualified medical expenses, the distribution will be subject to income tax, plus an additional 20% tax.

Termination of Eligibility

If you terminate employment with Andeavor, your pre-tax contributions (and contributions made by Andeavor, if any) will cease, and no further contributions will be made to your Health Savings Account on your behalf. However, you will continue to have access to your Health Savings Account following your termination of employment and may directly contribute to your account on an after-tax basis (and claim a Federal income tax deduction for such amount).

If you become ineligible to make contributions to your Health Savings Account, you must notify Andeavor to cease your payroll deductions (and the contributions made by Andeavor, if any). Contributions made to your account while ineligible, you could be subject to adverse tax consequences as described above. Nonetheless, you will continue to have access to your Health Savings Account following your loss of eligibility.

GENERAL CLAIMS PROCEDURE

Filing Claims for FSA Benefits

Claims for Benefits under your FSA plans must be filed on a standard Claim Form that is available from your Claims Administrator. Fill out the Claim Form completely and send it to:

Legacy Tesoro Participants

PayFlex Systems USA, Inc.
P.O. Box 4000
Richmond, KY 40476-4000
Phone: 844-729-3539
Fax: 888-238-3539

Legacy Western Participants

Businessolver FSA Services
P.O. Box 65948
West Des Moines, IA 50265
Phone: 844-408-2575
Fax: 855-883-8542

When to Submit Claims[1]

All claims for benefits under the Plan must be properly submitted to the Claim Administrator by March 31st following the plan year in which the claim was incurred. 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.

[1]You do not file claims for benefits under your Health Savings Account. Rather, you can request a distribution from your account from the custodian or trustee at any time.

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. 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 claims administrator and the type of claim, different rules may apply. As a general matter, however, only post-service claims will be submitted under this Plan. Unless otherwise prescribed by the claims administrator, the claims procedures described in this SPD apply.

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, 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. For Legacy Tesoro participants, such notice shall be provided no later than 60 days following receipt of a request for appeal. For Legacy Western participants, such notice shall be provided no later than 30 days following receipt of a request for initial appeal.

The Claims Administrator may extend this period, one time, for a period of up to sixty (60) days (or thirty (30) days for Legacy Western participants); 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 (or 30-day period for Legacy Western participants) 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.

If you are a Legacy Western participant and you disagree with the decision on the initial appeal, you may file a second appeal directly with your Benefits Department. The Benefits Department shall notify the claimant of its decision by delivery or by certified or registered mail to the claimant's last known address no later than 30 days following receipt of the claimant's request for a second appeal.

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.

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:

Tempe 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:

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

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.