andeavor

POST-RETIREMENT FULLY-INSURED MEDICAL PLAN SUPPLEMENT

SUMMARY PLAN DESCRIPTION

As of January 1, 2018

This document applies to Andeavor's post-retirement fully insured medical plans (Plans) as of January 1, 2018.

This document, in conjunction with the applicable insurance carrier's benefit booklet (Benefit Booklet), comprises the summary plan description (SPD) for the applicable 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.

OVERVIEW

If you elect a fully insured, local health plan through a health maintenance organization (HMO) or preferred provider organization (PPO) as your Andeavor post-retirement medical coverage, you should review this document for general information regarding how the Plan works.

For information on all other aspects of your coverage, you should review the Benefit Booklet (sometimes called a "certificate of coverage") provided by the applicable insurance carrier. The Benefit Booklet explains dependent eligibility, covered services, and covered prescription drugs, supplies and treatments. The Benefit Booklet also lists providers currently associated with your coverage, or provides instruction on how to access that information. The Benefit Booklet includes details on how to obtain care, file a claim (if necessary) and appeal a claim. You may be able to obtain this information from the insurance carrier's website as well, or you can obtain a copy by contacting the insurance carrier directly. If you have questions regarding your Andeavor Health Plans, contact the Benefits Department.

WHO IS ELIGIBLE

Employee Eligibility

You are eligible to participate in the Plan if you:

- are classified by Andeavor as a Retiree of a legacy Tesoro subsidiary[1] (see below);
- were participating in the Andeavor Medical Plan (Active Employee Plan) on the day immediately prior to your retirement date;
- Hired or rehired prior to January 1, 2016; and
- meet all post-retirement eligibility criteria

(**Note:** These criteria differ for participant groups and may be subject to the terms of collective bargaining agreements or other agreements associated with those groups).

Retiree Eligibility[2]

Retirees – Employees Hired or Rehired Before January 1, 2006

If you were hired before January 1, 2006, you are eligible to participate in the Plan if you retire at age 55 or older with at least 5 years of service, or at age 50 with 80 points (the sum of your age plus years of service).

Retirees – Employees Hired or Rehired On or After January 1, 2006

If you were hired on or after January 1, 2006, you are eligible to participate in the Plan if you retire at age 55 or older with at least 5 years of service. Note, however, if you have less than 10 years of service, you will be required to pay 100% of the cost of coverage under the Plan (see **Cost of Coverage**).

Retirees – Employees Hired or Rehired On or After January 1, 2016

Post-retirement medical coverage is not available to retirees who were hired (or rehired) on or after January 1, 2016.

Rehired Retirees

If you are a Retiree with coverage under the Andeavor Post-Retirement Medical Plan and you are rehired by the Company, you will be eligible for coverage under the Andeavor Medical Plan for active employees. Upon your subsequent retirement from Andeavor, you may again participate in this Plan, provided you satisfied the eligibility conditions at the time of your initial retirement. Consult the Corporate Benefits Department or your local HR Business Partner/Manager for more information.

Effective January 1, 2014, coverage under the Plan is no longer available to most Retirees or their dependents who have attained age 65. A covered individual who will be age 65 or older on January 1, 2014 is no longer eligible to participate in the Plan. A covered individual who is not at least age 65 on January 1, 2014 will continue to be eligible to participate in the Plan until the date such individual turns age 65.

[1] Legacy Western subsidiary retirees are not eligible for Andeavor's fully-insured post-retirement medical plan options.

[2] Legacy Western subsidiary retirees have different eligibility criteria for post-retirement medical coverage.

Dependent Eligibility

If you enroll for Plan coverage, you may also enroll your eligible dependents as follows, provided that they were covered under your Active plan coverage on the day immediately prior to your retirement date:

- your spouse (if you are not legally separated);
- your Child under age 26.

For these purposes, a Child includes the following:

  - biological child,
  - stepchild, and
  - foster child or legally adopted child, including a child placed with you for adoption for whom legal adoption proceedings have started even if not final;
  - child for which there is a court order establishing your legal guardianship or conservatorship, which has not been terminated by the parties or operation of law;

- your mentally or physically disabled Child of any age (see special rules below); and
- your Domestic Partner and your Domestic Partner's Child(ren) (see special rules below).

Certain fully-insured plans may have eligibility provisions that differ from the general description above. Please refer to your Benefit Booklet for detailed eligibility information.

Eligibility Rules for a Disabled Child

Generally, coverage for a Child who is Disabled at age 26 will not terminate merely because such Child has attained age 26. Such coverage may continue during the period the Child is both:

1. Disabled, and
2. Dependent upon you for more than one-half of his support as defined by the Internal Revenue Code of the United States.

Disabled means the Child suffers from any medically determinable physical or mental condition that prevents the Child from engaging in self-sustaining employment. The disability must begin before the Child attains age 26. You must submit satisfactory proof of the disability and dependency through your Plan Administrator to the Claim Administrator within 31 days following the Child's attainment of age 26. For new employees, such proof must be submitted in connection with your initial enrollment.

As a condition to the continued coverage of a Child as a Disabled Dependent beyond age 26, the Claim Administrator may require periodic certification of the Child's physical or mental condition after the two-year period following the Child's attainment of age 26. Any such certification shall not be requested more frequently than once each plan year. Please refer to your Benefit Booklet for detailed eligibility information.

Eligibility Rules for Domestic Partner Coverage

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

Proof of Dependent Status

When you add any Dependent, you may be required to submit the appropriate documents (marriage certificate, birth certificate, etc.) to provide proof of Dependent status. This process will apply whether the Dependent is being added during your initial eligibility period, annual open enrollment or due to a life event.

Enrollment of your Dependents in the Plan will be pended until proof of Dependent status has been received by your benefits administrator. Such documentation generally must be received within 31 days of enrollment; otherwise, your Dependents will *not* be added to the Plan. Please contact your benefits administrator with any questions.

Ineligible Dependents

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

- your legally separated spouse;
- a Child who is employed by Andeavor or an affiliate,
- an individual who no longer qualifies as a Dependent Child.
- an individual who no longer qualifies as a Domestic Partner or a Dependent Child of a Domestic Partner

How Medicare Affects Eligibility

Coverage under the Plan is currently available to eligible Retirees up to age 65 regardless of eligibility for or entitlement to Medicare. If you are covered under the Plan when you otherwise become eligible for or entitled to Medicare, the Plan will be considered Secondary, and Medicare coverage will be Primary. If you are entitled to Medicare Part A or Part B and do not enroll in Part A or Part B, the Plan will estimate Medicare coverage that would have been provided under Part A or Bart B and coordinate with those estimated benefits.

ENROLLING IN THE PLAN

If eligible, you and your eligible dependents will be automatically enrolled in this Plan at the same coverage level provided to you under the Active Employee Plan as of the day immediately prior to your Retirement Date, unless you reduce or opt-out of such coverage within 31 days of your Retirement Date. Your Retirement Date is the day immediately following your last day of employment with the Company. Generally, if you reduce or opt-out of such coverage at the time of your initial eligibility, you will not be permitted to enroll or increase your level of coverage, except under very limited circumstances as described below.

Generally, the coverage levels for each benefit package available under the Plan are as follows:

- Retiree Only;
- Retiree + Child(ren);
- Retiree + Spouse; or
- Retiree + Family.

For purposes of Plan coverage level definitions, Domestic Partner and Domestic Partner's children are treated the same as Spouse or Family, as applicable.

Changes to Coverage/Opt-Out of Coverage

You may reduce your level of coverage or waive coverage by submitting a change request to the Plan Administrator/ Committee.

If you defer medical coverage when you retire, or you remove an eligible dependent from coverage under this Plan, you (or such dependent) will not be eligible to participate in the Plan at any future date, unless your reason for deferring coverage is because you (or such dependent) have other health coverage (including COBRA continuation coverage under the Active Employee Plan) at the time of your initial eligibility. In that event, you may be able to enroll yourself (or such dependent) in this Plan in the future, provided that you submit evidence of the other coverage at the time that you deferred coverage under this Plan and request enrollment within 31 days after your other coverage ends.

If Your Spouse is Also an Eligible Retiree

If both you and your spouse are eligible to enroll in the Plan, each of you may elect Plan coverage as a retiree and as a dependent spouse

WHEN COVERAGE BEGINS

If you are enrolled ...	Coverage for you and your enrolled Dependents begins ...
On your Retirement Date, if you do not defer or reduce coverage within 31 days.	On your Retirement Date
Within 31 days of an eligible status change (see **Changing Your Coverage**)	On the effective date of the status change (unless otherwise prohibited by applicable law)

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

CHANGING YOUR COVERAGE

Changes to your coverage can be made only under certain limited circumstances. If permitted, however, such changes to your coverage and any change in your required contributions will take effect as of the date of the event.

Permissible Elections

If you previously deferred coverage under the Plan for you (or an eligible dependent) because you (or such dependent) had other health coverage (including COBRA continuation coverage under the Active Employee Plan) and you (or such eligible dependent) subsequently lose that coverage, you may elect to enroll yourself (or, if applicable, your eligible dependent) in this Plan within 31 days of such loss of coverage, provided that you previously informed the Plan Administrator/Committee of such other coverage at the time of your initial eligibility to participate in the Plan.

In addition, if you move out of the service area for your benefit package, you may elect another benefit package (if available) under the Plan, provided that you are eligible to receive benefits under that benefit package.

Automatic Changes to Coverage

If you have a change in your family status or a change in employment status, your coverage may change. Note: If you die, your spouse and other enrolled dependents will continue to be eligible to participate in this Plan until they fail to satisfy the applicable conditions for coverage under the Plan or, solely with respect to your spouse, he or she remarries.

Changes in Family Status

An eligible change in family status includes:

- divorce or legal separation from your spouse;
- termination of a domestic partnership;
- death of a spouse or a dependent child; or
- loss of dependent eligibility

You must request any changes to your coverage within 31 days of the eligible status change or other permissible event. You may complete the change event online in the Andeavor Benefits Center portal at andeavor.com/benefits or request a change by calling (866) 787-6314.

Qualified Medical Child Support Orders (QMCSOs)

The Plan will provide coverage for your eligible Child pursuant to the terms of a Qualified Medical Child Support Order (QMCSO), even if:

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

A QMCSO is an order from a state court or other state agency, usually issued as a part of a settlement agreement or divorce decree that provides for health care coverage for the Child of a group health plan participant. A QMCSO must meet certain legal requirements to be considered "qualified."

You are required to be enrolled in the Plan in order to enroll your eligible Child pursuant to the terms of a QMCSO.

If the Plan receives a valid QMCSO and you do not enroll the Dependent Child, the custodial parent or state agency may enroll the affected Child. Andeavor may withhold the contributions required for the Child's coverage from your pay.

A copy of the Plan's QMCSO procedures is available, free of charge, upon request to your benefits administrator.

COST OF COVERAGE

You and the Company share the cost of medical coverage for you and your eligible dependents under the Plan. The cost sharing is based upon your date of hire and years of service immediately prior to your date of retirement, and the cost of coverage under the Andeavor Post-Retirement Medical Plan.

Retirees — Employees Hired Before January 1, 2006

If you were hired before January 1, 2006, you are required to pay 20% of the premium cost under the Andeavor Post-Retirement Base Medical Plan, plus (if applicable) any excess cost for coverage under the benefit package in which you are enrolled. The company contribution toward coverage will be capped effective January 1, 2013 with retirees paying for all future cost increases above the company contribution cap.

Retirees — Employees Hired On or After January 1, 2006

If you were hired on or after January 1, 2006, and retire with 10 or more years of service, you are required to pay 50% of the premium cost under the Andeavor Post-Retirement Base Medical Plan, plus (if applicable) any excess cost for coverage under the benefit package in which you are enrolled.

If, however, the premium cost for your coverage under the Andeavor Post-Retirement Base Medical Plan is greater than $1,000 per month, the Company's portion is capped at $1,000 and any additional premium cost is your responsibility.

If you retire with 5 but less than 10 years of service, you are eligible to participate in this Plan but you must pay 100% of the premium cost for your coverage under the benefit package in which you are enrolled.

Payment Arrangements

Your coverage will be paid for on an after-tax basis. Your portion of the premium may be paid through automatic withdrawals from your financial institution, or you may send a monthly check or money order to the Andeavor Benefits Center.

The actual dollar amounts for coverage under the Plan are listed on your Confirmation Form and are subject to change periodically. If changes occur, you will be given advance notice. Monthly invoices, mailing instructions and direct payment forms will be sent to you shortly after you retire and as necessary during your retirement.

SELECTING YOUR PROVIDER

Refer to your Benefit Booklet for more information regarding covered providers of medical services.

BENEFITS

Refer to your Benefit Booklet for more information regarding covered medical services, supplies and treatments, benefit levels and patient responsibility levels, such as the deductible, coinsurance and copay amounts.

EXCLUSIONS AND LIMITATIONS

Refer to your Benefit Booklet for more information regarding exclusions and limitations of coverage under the Plan.

COORDINATION OF BENEFITS

Refer to your Benefit Booklet for more information regarding coordination of benefits under the Plan.

GENERAL CLAIMS PROCEDURE

Filing Claims for Benefits

You are required to pay all applicable co-pays and/or coinsurance at the time you receive covered services, supplies and treatments. You may be entitled to payment or reimbursement under the Plan of other expenses incurred in connection with covered services, supplies and treatments.

In order to receive benefits under the Plan, a claim must be submitted. If you use an in-network provider, the provider will submit the claim directly to the Plan. If you use an out-of-network provider (and your Plan covers out-of-network providers), you must pay for services and supplies received and file a claim for benefits.

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

When to Submit Claims

All claims for benefits under the Plan must be properly submitted to the Claim Administrator within three hundred sixty-five (365) days of the date you receive the services or supplies. Claims submitted and received by the Claim Administrator after that date will not be considered for payment of benefits under the Plan, unless required by state or federal law.

Authorized Representative

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

Payment and Assignment of Benefits

Please see your Benefit Booklet for limitations on assignments of benefits.

Overpayment of Benefits

Please see your Benefit Booklet regarding the insurance carrier's rights with respect to overpayment of benefits.

Notice of Decision

Depending on the type of claim (pre-service, post-service, concurrent service or urgent care), different rules may apply. Please see your Benefit Booklet regarding the time periods applicable to notices under the Plan's claim procedures.

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 insurance carrier 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 insurance carrier, and shall be considered filed on the date the claim is received by the insurance carrier.

Appeal Standards

The insurance carrier shall provide the claimant the opportunity to submit written comments, documents, records, and other information related to the claim. The insurance carrier 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 insurance carrier 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 insurance carrier 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 insurance carrier 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 of a request for appeal, the insurance carrier shall notify the claimant of its decision by delivery or by certified or registered mail to the claimant's last known address. However, such notices must be provided prior to deadlines prescribed by ERISA. The applicable deadline depends on the type of claim (pre-service, post-service, concurrent service or urgent care) that is the subject of the appeal. Please see your Benefit Booklet regarding the time periods applicable to notices under the Plan's claim procedures.

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

Exhaustion of Claims Procedures

The decision of the insurance carrier 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.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Plan may use and disclose protected health information without an authorization from the individual only to the extent of and in accordance with the uses and disclosures permitted by HIPAA and the HIPAA Regulations, including for payment, treatment and health care operations of the Plan. You will be provided with a notice describing the Plan's privacy practices and other information regarding your privacy rights with respect to protected health information. This notice is provided at the time of enrollment to new Plan enrollees. In addition, an updated notice will be provided to all Plan participants within 60 days of any material revision of the notice. Copies of the notice are available at all times through the Andeavor Benefit Center.

TERMINATION OF COVERAGE

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

- the date you fail to make required contributions in a timely manner;
- the date you no longer meet the eligibility requirements of the Plan;
- the date you cease to participate in the Plan (e.g., you become covered under another employer's health plan);
- the date you fail to comply with the subrogation and reimbursement provisions of the Plan;

- the date you make a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Plan; or
- the date the Company terminates the Plan.

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

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

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

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

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

COBRA COVERAGE CONTINUATION

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (known as "COBRA"), you and your eligible Dependents that lose group health plan coverage may continue coverage under the Plan for a period of time. COBRA continuation rights are available only if coverage is lost due to certain "qualifying events" (see **COBRA Qualifying Events** below). Your covered Domestic Partner and their covered Children will be eligible for a continuation of benefit provision similar to COBRA if they lose coverage under the Plan due to a qualifying event.

COBRA continuation coverage with respect to the Plan is the same coverage that the Plan gives to other participants or Dependents who are covered under the same option under the Plan and who are not receiving continuation coverage. Each person who elects COBRA continuation coverage will have the same rights under the Plan as other participants or Dependents covered under the Plan, including special enrollment rights and the right to add or change coverage during the open enrollment period.

COBRA Qualifying Events

Employees

As an employee, you will be eligible for COBRA continuation coverage if you lose coverage due to:

- termination of employment, for reasons other than gross misconduct; or
- a reduction in hours of employment that results in loss of coverage (including upon expiration of an applicable disability leave continuation period).

Covered Dependents

Your covered Dependents will be eligible for COBRA continuation coverage if they lose coverage due to:

- your death;
- your termination of employment, for reasons other than gross misconduct;
- a reduction in your hours of employment;
- your divorce or legal separation; or
- your Dependent Child no longer meeting the definition of a Dependent Child.

It is you or your covered Dependent's responsibility to notify your benefits administrator (see **Contacts**) within 60 days of a qualifying event if your covered spouse or Dependent Child(ren) lose coverage under this Plan due to:

- divorce or legal separation; or
- your Dependent's loss of eligibility under the Plan.

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

If you notify your benefits administrator more than 60 days after the qualifying event, your covered Dependents may not be entitled to elect COBRA continuation coverage. Please note that you must provide notification in writing within 31 days (not 60) to comply with rules for changing your coverage elections during the Plan Year (see Changing Your Coverage).

Length of COBRA Coverage

COBRA is a temporary continuation of coverage. Depending on the qualifying event, coverage may be continued from the date coverage would otherwise end, as follows:

COBRA Qualifying Event	Maximum Amount of Time Coverage May Continue Under COBRA	
	For You	For Your Qualified Beneficiary
You terminate employment (other than for gross misconduct) **OR** **Your hours of employment are reduced, resulting in a loss of coverage**	18 months (may be extended due to disability — see below)	18 months (may be extended due to disability or for a second qualifying event — see below)
You die	N/A	36 months
You become entitled to Medicare	N/A	36 months (special rules apply)
You divorce or legally separate	N/A	36 months
Your Child no longer meets the definition of a Dependent Child	N/A	36 months

Concurrent USERRA Coverage

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

Extension of COBRA Coverage Due to Disability

You and each qualified beneficiary may be eligible to extend your 18-month COBRA period to a total of 29 months if a qualified beneficiary is determined to be disabled under Title II or Title XVI of the Social Security Act at any time during the first 60 days of continuation coverage.

- To receive the extension, you must provide notice of the disability determination to your benefit administrator (see **Contacts**) within 60 days of the date of the Social Security Administration's determination and before the end of the initial 18-month continuation period.
- If the qualified beneficiary is later determined to not be disabled, you must notify your benefit administrator within 30 days of the Social Security Administration's determination. If the date of the determination is after the original 18-month COBRA period, your COBRA benefits will cease effective as of the date of determination.

Extension of Continuation Coverage Due to a Second Qualifying Event

If you are receiving COBRA continuation coverage as a result of your termination of employment or reduction in hours of employment, up to an 18-month extension of coverage may be available to your qualified beneficiaries if a second qualifying event occurs during the first 18 months of COBRA coverage (or within the first 29 months in the case of a disability).

A second qualifying event includes:

- your death;
- your divorce or legal separation;
- your entitlement to Medicare; or
- your Dependent Child's eligibility for coverage ends.

The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months from the date of the first qualifying event. Note, however, if your first qualifying event was your entitlement to Medicare, the maximum amount of continuation coverage available for your spouse and Dependents when a second qualifying event occurs is 36 months from the date on which you became entitled to Medicare.

You must provide written notification to your benefit administrator within 60 days after the second qualifying event occurs (see **Contacts**).

Electing COBRA Coverage

Upon notification to your benefit administrator of a COBRA qualifying event, COBRA election notices are prepared and mailed to your home address. You and/or your covered Dependent(s) will have 60 days from the date coverage would be lost due to a qualifying event (or the date you are notified of your right to continue coverage, if later) to elect COBRA continuation coverage.

You and each of your covered Dependents may independently elect COBRA coverage. You or your spouse, however, may elect COBRA coverage on behalf of all the covered Children who are under age 18.

If you choose to waive coverage during the 60-day election period, you may revoke the waiver in writing at any time before the 60-day period ends, and you will be entitled to COBRA continuation coverage as long as you and/or your covered Dependent(s) meet all of the other conditions for continuation of coverage and the required contributions are paid on a timely basis.

If you do not elect continuation coverage, your benefits will terminate in accordance with the terms of the Plan.

Paying for COBRA Coverage

In order to continue your coverage under COBRA, you will be required to pay the **full** cost of coverage (your premium and the Company's contribution), plus a 2% COBRA administration fee. If you or your qualified beneficiaries is receiving the additional 11 months of COBRA coverage because of disability (**see Extension of COBRA Coverage Due to Disability)**, the cost for each of those additional 11 months is 150% of the full monthly cost.

- The first payment of premiums will be due within 45 days of the date you elect to continue coverage.
- Premiums for coverage will be retroactive to the date you and/or your qualified beneficiaries lost eligibility due to the qualifying event.
- Claims for reimbursement will not be processed and paid until you have elected COBRA continuation coverage and the first contribution payment has been timely paid and received.

  To continue COBRA coverage, you will need to make ongoing contribution payments. Each contribution payment is due on the first day of the month for which COBRA coverage is to be provided. If payment is not received by the 30th day following such due date, your COBRA coverage may be terminated.

If you do not make the full payment for any coverage period, COBRA coverage will be terminated retroactively to the end of the month for which the last full payment was made, and you will lose all rights to further COBRA continuation coverage under the applicable COBRA plan, except as otherwise prohibited by applicable law. Once coverage is terminated, it cannot be reinstated.

Adding Dependents During a COBRA Continuation Period

If through birth, adoption, marriage or completion of six months in a new domestic partnership, you acquire a new Dependent during the continuation period, your Dependent can be added to your coverage for the remainder of the continuation period if:

- he or she meets the definition of an eligible Dependent (see **Dependent Eligibility**);
- you notify your benefit administrator of your new Dependent within 31 days of eligibility (see **Contacts**); and
- you pay any additional contributions for continuation coverage on a timely basis.

You must notify your benefit administrator if, at any time during your continuation period, any of your qualified beneficiaries cease to meet the eligibility requirements for coverage.

Termination of COBRA Coverage

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

- the Company no longer provides group health plan coverage to its employees;
- you or your qualified beneficiaries do not pay the premium on or before its due date;
- you and/or your qualified beneficiaries' applicable COBRA continuation period ends;
- you become entitled to Medicare following an election of COBRA coverage;
- you or your qualified beneficiaries becomes covered under another group health plan following an election of COBRA coverage. However, if the other plan contains an exclusion or limitation with respect to any preexisting conditions, you or your qualified beneficiaries to whom such an exclusion or limitation applies may continue COBRA coverage under the Plan; or
- in the case of extended coverage due to disability (see **Extension of COBRA Coverage Due to Disability**), the disabled individual is no longer determined to be disabled under the Social Security Act.

You and/or your qualified beneficiaries must notify your benefit administrator if, after electing COBRA, you become entitled to Medicare, become covered under other group health plan coverage or are determined by the Social Security Administration to no longer be disabled.

OTHER CONTINUATION OPTIONS

In addition to the option to continue benefits under the provisions of COBRA, certain continuation benefits are available to your enrolled dependents if you die as an active employee. There is no option to convert coverage to an individual policy.

Continuing Dependent Coverage After Your Death

If you die while enrolled in the Plan, your covered dependents may continue coverage under retirement provisions as long as:

- you were eligible for post-retirement benefits, as defined by the Company (hired before January 1, 2016 with age plus years of service equal to or greater than 80, or age 55 with 5 years of service) at the time of death; and
- required payments are made for the coverage.

Note: Post-retirement medical coverage is not available to employees hired or rehired on or after January 1, 2016. Post-retirement coverage for surviving dependent spouses ends at age 65. Post-retirement coverage for surviving dependent children ends at age 26.

ADDITIONAL INFORMATION

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

Plan Name	The Andeavor Fully Insured Medical Plans are constituent benefit programs of the Andeavor Omnibus Group Welfare Benefits Plan
Type of Plan	Welfare benefit plan
Plan Sponsor	Andeavor, 19100 Ridgewood Parkway San Antonio, TX 78259 (210) 828-8484
Plan Sponsor's Employer Identification Number	95-0862768
Plan Administrator	Andeavor Employee Benefits Committee, 19100 Ridgewood Parkway San Antonio, TX 78259; (866) 688-5465, press options 3, then option 5
Plan Number	501
Plan Year	January 1 – December 31
Plan Funding	The Plan is funded by employee and employer contributions.
Type of Administration	Insurance contract
Plan Insurer	BlueCross BlueShield of North Dakota, 4510 13th Avenue S.W. Fargo, ND 58121 Kaiser Foundation Health Plan, Inc., 1350 Treat Blvd. Suite 380 Walnut Creek, CA 94597
Agent for Service of Legal Process	Andeavor, c/o General Counsel 19100 Ridgewood Parkway, San Antonio, TX 78259 In addition, service of legal process may be made upon the Plan Administrator.

CONTACTS

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

Andeavor Benefits Center

P.O. Box 3129
Bellaire, TX 77402
www.tsocorp.com/benefits
(866) 787-6314

Andeavor Corporate Benefits Department

19100 Ridgewood Parkway
San Antonio, TX 78259
Email: SAT – Benefits Department (satbenefits@andeavor.com)
(866) 688-5465

Fully Insured Health Plans

Location	Plan Name	Web Site	Customer Service #	Group #
CA	Kaiser Health Plan - Northern California	www.kp.org	(800) 464-4000	48446-0000
CA	Kaiser Health Plan - Southern California	www.kp.org	(800) 464-4000	228845-00
ND	Blue Cross Blue Shield of North Dakota	www.bcbsnd.com	(800) 342-4718	28032-01

ERISA

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

Receive Information About Your Plan and Benefits

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a State or Federal court if you have exhausted the Plan's claims procedures. In addition, if you disagree with a Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, as applicable, you may file suit in Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

FUTURE OF THE PLAN

Andeavor expects to continue the Plan indefinitely, but reserves the right to amend or discontinue any or all parts of the Plan at any time and for any reason. In no event will you become entitled to any vested rights under this Plan.

INTERPRETATION OF THE PLAN

Only the Plan Administrator, or its delegate, is authorized to make administrative interpretations of the Plan and will do so only in writing. You should not rely on any representation, whether oral or in writing, which another person may make concerning provisions of the Plan and your entitlements under them. The Plan Insurer has authority to administer claims and to manage and interpret the Group Policy, consistent with the provisions of the Plan.