VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE PLAN

SUMMARY PLAN DESCRIPTION

As of January 1, 2018

This Summary Plan Description (SPD) outlines the major features of the Andeavor Voluntary Accidental Death & Dismemberment (AD&D) Insurance Plan. If you have questions regarding your coverage under the Voluntary AD&D Plan, contact the Andeavor Benefits Department.

This document describes the Andeavor Voluntary AD&D Plan as of January 1, 2018. This Plan is available to eligible Andeavor employees on the U.S. payrolls. This information comprises the SPD of this Plan as required by the Employee Retirement Income Security Act of 1974 (ERISA).

This description doesn't cover every provision of the Plan. Some complex concepts may have been simplified or omitted in order to present a more understandable plan description. If this plan description is incomplete, or if there's any inconsistency between the information provided here and the official plan texts, the provisions of the official plan texts will prevail.

WHO IS ELIGIBLE

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 Voluntary AD&D Insurance 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.

Dependent Eligibility

You may also purchase life insurance coverage for your eligible Dependents, which are defined as follows:

- your spouse (if you are not legally separated);
- your Child under age 26. For these purposes, a Child includes the following:
  - biological child,
  - stepchild, and
  - foster child or legally adopted child, including a child placed with you for adoption for whom legal adoption proceedings have started even if not final;
  - child for which there is a court order establishing your legal guardianship or conservatorship, which has not been terminated by the parties or operation of law;
- your mentally or physically disabled Child of any age (see special rules below); and
- your Domestic Partner and your Domestic Partner's Child(ren) (see special rules below).

Eligibility Rules for 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.

ENROLLING IN THE PLAN

You must enroll yourself in the Plan within 31 days of your employment date, or within 31 days of the date you first become eligible for the Plan (if later).

To complete your Plan election, you'll need to log on to the respective legacy Tesoro or legacy Western benefits enrollment websites:

- choose the Andeavor Voluntary AD&D Insurance Plan & coverage levels; and
- designate your Beneficiaries; and
- submit evidence of insurability, if applicable.

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

Annual Enrollment Period

During an annual enrollment period designated by the Company (normally in October/November of each year for coverage beginning the following January 1), you may make an election to enroll, re-enroll or decline (waive) participation for the coming year. You may change your Plan coverage levels. If you waive coverage (or if you fail to make an initial election), you will not have coverage under the Plan for the following year.

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

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

WHEN COVERAGE BEGINS

If you enroll ...	Coverage for you begins ...
Within 31 days of your eligibility date	On your eligibility date
During the annual enrollment period	On January 1 of the following year
Within 31 days of an eligible status change (see **Changing Your Coverage**)	On the effective date of the status change (unless otherwise prohibited by applicable law)

CHANGING YOUR COVERAGE

After your initial enrollment, you can make changes to your coverage only during the annual enrollment period or as the result of a qualifying status change or other permissible event.

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

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

A qualifying status change allows you to:

- change your level of coverage;
- elect coverage if you previously waived coverage; or
- terminate coverage.

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

Changes in your Plan coverage must be consistent with the status change. For example, you may change your level of coverage to increase the elected benefit if your status changes as a result of the birth of your child during the Plan Year.

Changes to your coverage and any change in your required contributions will take effect as of the date of the event (unless otherwise prohibited by applicable law.)

Changes in Family Status

An eligible change in family status includes:

- marriage;
- divorce or legal separation from your spouse;
- completion of six months in a Domestic Partnership;
- termination of a Domestic Partnership;
- birth, adoption or placement for adoption of a Dependent Child;

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

Changes in Employment Status

An eligible change in employment status includes the following for you, your spouse or your Dependent Child if the change affects the person's eligibility for coverage under the Plan:

- employment or unemployment (i.e., new job or loss of a job); or
- a change in work schedule (i.e., a reduction or increase in hours, a switch between part-time and full-time, strike or lockout, commencement or return from unpaid leave of absence).

COST OF COVERAGE

You pay the entire cost of benefits under the Voluntary AD&D Plan. Your cost is based on the benefit option and level of coverage you choose. The contribution amount for each benefit option and level of coverage is subject to change and is announced in advance.

BENEFITS

A Participant is entitled to benefits under this Voluntary AD&D Plan if the Participant experiences a Covered Loss.

A "Covered Loss" is a loss that is the result, directly and independently of all other causes, of a sudden, unforeseeable external event (a Covered Accident) and which is specified in the Schedule of Covered Losses described in the Certificate. The Covered Loss must be suffered by the Participant within the applicable time period specified in the Schedule of Benefits in the Certificate.

The amount of the benefit payable for a particular Covered Loss is determined as a percentage of the Principal Sum purchased under the Plan.

Employee Benefit

Benefit coverage for employees can be purchased in $10,000 increments, up to the Maximum Employee Benefit. The Maximum Employee Benefit equals the lesser of ten (10) times Base Salary[1], or $1,000,000. Coverage amounts are rounded up to the next higher $10,000 increment.

For Example

If your Base Salary is:	$ 58,385
Ten times that would be:	$583,850
Your Principal Sum would be rounded to:	$600,000

Benefits are paid as a lump sum or through other options as provided in the Schedule of Covered Losses described in the Certificate.

Spouse/Domestic Partner Benefits

Benefit coverage for your Spouse or Domestic Partner can be purchased in $10,000 increments, up to $500,000.

Dependent Child Benefit

Benefit coverage for your Dependent Child can be purchased in $10,000 increments, up to $30,000.

[1] Base Salary is the salary or wage you would receive as a result of your normal work schedule. Additional components may be included in your Base Salary calculation. Please refer to the Insurance Certificate for additional information.

BENEFICIARY DESIGNATIONS

You may make your beneficiary designations through the legacy Tesoro or legacy Western Benefits enrollment portal. Beneficiary designations may be changed by you at any time through your Benefits enrollment portal, without the consent of the beneficiary.

If you fail to designate a beneficiary, your benefits will be paid to your survivor(s) in the following order:

(1) Your spouse;
(2) Your child or children;
(3) Your mother or father;
(4) Your sisters or brothers;
(5) Your estate.

ADDITIONAL BENEFITS

Accidental Benefits

You may be eligible to receive the following additional benefits:

- Accidental Burn and Disfigurement
- Carjacking Benefit
- Child Care Center Benefit
- Common Accident Benefit
- Common Carrier Benefit
- Exposure and Disappearance Coverage
- Hospital Stay Benefit
- Increased Dependent Child Dismemberment Benefit
- Insurance Continuation Expense Benefit
- Seatbelt and Airbag Benefit
- Special Education Benefit
- Spouse or Domestic Partner Retraining Benefit

For more information on these additional benefits, refer to the Certificate.

EXCLUSIONS

In addition to any benefit-specific exclusions set forth in the Certificate, benefits will not be paid for any loss or injury, which directly or indirectly, in whole or in part, is caused by or results from any of the following <u>unless coverage is specifically provided for by name in the *Description of Benefits* Section of the Certificate:</u>

1. intentionally self-inflicted injury, suicide or any attempt thereat while sane or insane;
2. commission or attempt to commit a felony or an assault;
3. commission of or active participation in a riot or insurrection;
4. bungee jumping; parachuting; skydiving; parasailing; hang-gliding;
5. declared or undeclared war or act of war;
6. flight in, boarding or alighting from an Aircraft or any craft designed to fly above the Earth's surface:
   a. except as a passenger on a regularly scheduled commercial airline;
   b. being flown by the Participant or in which the Participant is a member of the crew;**
   c. being used for:
      i. crop dusting, spraying or seeding, giving and receiving flying instruction, fire fighting, sky writing, sky diving or hang-gliding, pipeline or power line inspection, aerial photography or exploration, racing, endurance tests, stunt or acrobatic flying; or
      ii. any operation that requires a special permit from the FAA, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on);
   d. designed for flight above or beyond the Earth's atmosphere;

e. an ultra-light or glider;
f. being used for the purpose of parachuting or skydiving;
g. being used by any military authority, except an Aircraft used by the Air Mobility Command or its foreign equivalent;

7. sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;
8. travel in any Aircraft owned, leased or controlled by the Andeavor, or any of its subsidiaries or affiliates;**
9. a Covered Accident that occurs while engaged in the activities of active duty service in the military, navy or air force of any country or international organization. Covered Accidents that occur while engaged in Reserve or National Guard training are not excluded until training extends beyond 31 days.
10. operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the Participant has been provided a written warning against operating a vehicle while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Accident occurred;
11. voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
12. in addition, benefits will not be paid for services or treatment rendered by a Physician, Nurse or any other person who is:
    a. employed or retained by Andeavor;
    b. providing homeopathic, aroma-therapeutic or herbal therapeutic services;
    c. living in the Participant's household;
    d. a parent, sibling, spouse or child of the Participant.

*Capitalized terms not defined in this SPD shall have the meaning ascribed in the Certificate.

**Notwithstanding the exclusion listed herein, Participants are eligible for coverage with respect to Covered Accidents and Covered Injuries related to Aircraft owned or leased by Andeavor, including coverage for Andeavor employed pilots. Please refer to the Description of Benefits Section of the Certificate.

EVENTS AFFECTING COVERAGE

Disability

If you become Disabled while covered under this Voluntary AD&D Insurance Plan, the coverage that was in effect at the time your Disability began can be continued, subject to your payment of premiums, until the earlier of the following dates:

- The date you are no longer Disabled;
- The later of the date you are Disabled for 12 months or attainment of Social Security Normal Retirement Age; and
- The date the policy is terminated.

For these purposes "Disability"/"Disabled" means because of Injury or Sickness you are unable to perform all the material duties of your Regular Occupation; or are receiving disability benefits under a long-term disability plan to which your Employer contributes. "Regular Occupation" means the occupation you routinely perform at the time the Disability begins.

Leave of Absence

You will remain eligible for coverage under the Plan during a Company-approved, paid leave of absence. If you are on a Company approved unpaid leave of absence, you may continue the coverage you had when active employment ceased up to a maximum of twenty-four (24) months, provided you continue to pay the required premiums. Your cost for this coverage will be the same as for an active employee. You must make arrangements with the Benefits Department to pay any required contributions for the entire period of the leave, prior to going on leave.

Such coverage may also be continued for a leave of absence taken under the Family and Medical Leave Act of 1993 (as amended) for the period of the FMLA leave or, if later, the period required by the laws of the state in which you are employed.

Labor Dispute

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

TERMINATION OF COVERAGE

Except as otherwise provided in the prior section, your coverage under the Plan will end upon the earliest to occur of the following:

- The date your employment is terminated, other than by reason of your death (including as a result of a layoff or your failure to return to regular, full-time employment following expiration of a FMLA or USERRA leave of absence),
- The date your regularly scheduled hours are reduced to less than 30 hours per week, other than by reason of your death,
- The date you fail to pay the required premiums/contributions toward coverage under the Plan,
- The date you no longer meet the eligibility requirements under the Plan, other than by reason of your death, and
- The date the Company discontinues the Plan.

CONVERSION PRIVILEGE

If your coverage terminates for any reason (other than a failure to pay premiums), you have the option to convert your existing Voluntary AD&D Plan coverage to an individual AD&D insurance policy through the Plan Insurer within thirty-one (31) days after the date coverage ends. Contact Life Insurance Company of North America at 1-800-547-5515 for additional information or to request coverage conversion.

GENERAL CLAIMS PROCEDURE

Filing Claim for Benefits

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

Life Insurance Company of North America
1601 Chestnut Street,
Philadelphia, PA 19192-2235

To constitute a claim for purposes of this Plan, the claim must identify: (1) you and (2) your date of your Covered Loss (or, if applicable, death). Additional evidence of your Covered Loss (or, if applicable, death) may be required to be submitted upon request of the insurance carrier.

When to Submit Claims

Within 31 days of your Covered Loss (or, if applicable, death), you (or your representative) should complete your application for Plan benefits. Your supervisor or HR Business Partner/Manager can help initiate the process by contacting the Corporate Benefits Department. You will receive a letter from the Plan Insurer with instructions and the forms you will need to complete to file your claim.

If your claim is approved, the appropriate benefit will be paid to you, if living. Payment of benefits due for loss of life will be paid according to the beneficiary designation in effect at the time of your death.

Authorized Representative

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

Notice of Decision

Non-Disability Claims

The Plan Insurer 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 ninety (90) days after receipt of the claim, unless special circumstances require an extension of time for processing such request for review.

The Plan Insurer may extend this period for up to ninety (90) days; provided that the Plan Insurer: (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 90-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If any such extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the standards on which entitlement to benefits is based, the unresolved issues that prevent a decision from being made and the additional information required. You will be given at least forty-five (45) days from receipt of such notice to provide the specified information. If such extension is necessary in order for you submit additional information necessary to decide the claim, the period for making the claim determination shall be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Written notice of the adverse benefit determination shall be written in a manner that is intended to be understood by you, shall be delivered 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 from you and an explanation of why the material or information is needed; and
- An explanation of the review procedures and the time limits that apply, including a statement of your right to sue under Section 502(a) of ERISA following an adverse benefit determination on review.

Disability Claims

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

The Plan Insurer may extend this period for up to thirty (30) days; provided that the Plan Insurer: (1) determines that such an extension is necessary due to matters beyond the control of the Plan and (2) notifies you before the end of the initial 45-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. The Plan Insurer may extend the period an additional thirty (30) days, if due to matters beyond the control of the Plan Insurer, a decision cannot be rendered within the initial 30-day extension period and the Plan Insurer notifies you before the end of the initial 30-day extension period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If any such extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the standards on which entitlement to benefits is based, the unresolved issues that prevent a decision from being made and the additional information required. You will be given at least forty-five (45) days from receipt of such notice to provide the specified information. If such extension is necessary in order for you submit additional information necessary to decide the claim, the period for making the claim determination shall be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Written notice of the adverse benefit determination shall be written in a manner that is intended to be understood by you, shall be delivered to you by certified or registered mail to your last known address, and shall contain the following:

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

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

Internal Appeals

A participant (or beneficiary) who feels he or she is being denied any benefit or right provided under the Plan shall have the right to file an appeal with the Plan Insurer within 60 days after receipt of notice of an adverse benefit determination as provided above. Such claim may be filed directly by you or your authorized representative. All such appeals shall be submitted in the form and manner prescribed by the Plan Insurer, and shall be considered filed on the date the claim is received by the Plan Insurer.

Appeal Standards

The Plan Insurer shall provide you the opportunity to submit written comments, documents, records, and other information related to the claim. The Plan Insurer will provide you, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim. In conducting its review, the Plan Insurer shall consider all comments, documents, records and other information submitted by you in support of the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

Notice on Appeal

Within a reasonable period of time, but not more than 60 days, after receipt by the Plan Insurer of a written request for review of the claim, the Plan Insurer shall notify you of its decision on appeal. The Plan Insurer may extend this period, one time, for a period of up to 60 days; provided that the Plan Insurer: (1) determines that such an extension is necessary due to special circumstances and (2) notifies you before the end of the initial 60-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

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

- The specific reason or reasons for the denial of benefits;
- A specific reference to the pertinent provisions of the Plan upon which the denial is based;
- A statement that you may receive, upon request and free of charge, copies of all documents and other information relevant to the claim; and

- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about these procedures, as well as a statement of your right to sue under Section 502(a) of ERISA.

Exhaustion of Claims Procedures

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

You must exhaust the internal claims procedures provided hereunder prior to pursuing any other legal or equitable remedy.

No legal action may be brought after 3 years from the date satisfactory proof of loss is required to be furnished to the Plan Insurer.

ADDITIONAL INFORMATION

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

Plan Name	The Andeavor Voluntary Accidental Death & Dismemberment Insurance Plan is a Constituent Benefit Program of the Andeavor Omnibus Group Welfare Benefits Plan.
Type of Plan	Welfare benefit plan
Plan Sponsor	Andeavor, 19100 Ridgewood Parkway San Antonio, TX 78259 (210) 828-8484
Plan Sponsor's Employer Identification Number	95-0862768
Plan Administrator	Andeavor Employee Benefits Committee 19100 Ridgewood Parkway San Antonio, TX 78259 (866) 688-5465, press options 3, then option 5
Plan Number	501
Plan Year	January 1 – December 31
Plan Funding	The Plan is funded through an insurance contract. The cost of coverage is paid for solely by employee contributions.
Type of Administration	Insurer
Plan Insurer	Life Insurance Company of North America 1601 Chestnut Street, Philadelphia, PA 19192-2235
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.

Other Employers Whose Employees Are Covered By the Plan

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

CONTACTS

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

Benefits Administrator

Legacy Tesoro Employees:

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

Legacy Western Employees:

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

Andeavor Benefits Department

Legacy Tesoro Employees:

Corporate Benefits Department
(866) 688-5465
SatBenefits@andeavor.com

Legacy Western Employees:

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

ERISA

As a participant in this 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 employee benefits described in this section, but reserves the right to amend or discontinue any or all parts at any time and for any reason. In no event will you become entitled to any vested rights under this Plan.

INTERPRETATION OF THE PLAN

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