CITGO Petroleum Corporation
Employee Assistance Program
for Hourly and Salaried Employees

Summary Plan Description
As In Effect January 1, 2013

The Summary Program Description, including announcement letters, brochures and Summaries of Material Modification issued subsequent to the publication date, is the governing Program Document.

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PURPOSE

The Employee Assistance Program ("EAP" or "Program") is intended to ensure that resources are made available to you to address personal or family problems of any nature that may affect your job performance, your physical or mental health or your behavior. This coverage is available to employees and their dependents that meet the eligibility requirements of this Program.

This summary program description describes the benefits available under the Program. As a participant of the Program, you may be asked to comply with certain provisions of this Program, which could affect the benefits you receive.

ELIGIBILITY

Employees

Employees Who Are Eligible

You are eligible to participate in the CITGO Medical Plan you meet **all** of the following requirements:

- You are a Regular Full-Time or Regular Part-Time Employee of the Company;
- You are employed as an Intern or Coop Employee
- You are carried on a U.S. dollar payroll; and
- You are not represented by a labor organization or you are represented by a labor organization that has bargained for and agreed to participate in this Program in lieu of any other Company-sponsored EAP.

Employees Who Are Not Eligible

You are not eligible to participate in the EAP if you meet **any** of the following conditions:

- You are employed on any basis other than as a Regular Full-Time, Regular Part-Time Employee, Intern or Co-op Employee of the Company (for example, a temporary or seasonal employee);
- You are retired
- You provide services to the Company under an independent contract between yourself and the Company or under an independent contract between the Company and a third party;
- You provide services to the Company under a leasing arrangement between the Company and a third party
- You are represented by a labor organization that has not bargained for and agreed to participate in this Program in lieu of any other Company-sponsored EAP.

    - You are employed by a related company which has not adopted the Program; or
    - You are a nonresident alien.

If you are excluded from participation because you provide services under a contract or leasing arrangement and a federal or state court or agency later determines that you should have been classified as an employee, you will still be excluded from participation during the time period you were misclassified and will only become eligible for participation in this Program upon a final determination of your status.

Dependents

Dependents Who Are Eligible

Your eligible Dependents may also participate in the Plan. An eligible Dependent is:

Your Spouse. Spouse is defined as:

- A person of the opposite sex to whom you are legally married at the relevant time and which marriage is effective under the laws of the state in which the marriage was contracted, including a person legally separated but not under a decree of absolute divorce.

- Your Common Law spouse of the opposite sex, if Common Law marriage is recognized in the state of which you are a legal resident. You must submit the applicable paperwork required for your state of residence for review and approval by CITGO legal counsel before coverage will begin.

Effective August 1, 2011, it is officially documented here that it is expressly intended the Plan's definition of Spouse comply with the provisions outlined under Federal law in the Defense of Marriage Act. Individuals who enter into any civil union, domestic partnership, or similar arrangements with an eligible employee are not entitled to benefits under the Plan.

When You and Your Spouse Are Both Employees of CITGO

If you and your Spouse are both covered under the CITGO Company Welfare Benefit Plan, you may each be enrolled as an Employee or be covered as a Dependent of the other person, but not both. Under the same circumstances, a dependent child may only be covered under You or your eligible Spouse.

Disabled Dependent Child Eligibility Guidelines

Your disabled child is eligible for continued medical coverage ***if*** the child is or becomes physically or mentally disabled. These eligibility provisions are applicable for your child of any age who meets all of the following criteria

- is or becomes totally disabled
- is unable to be self-supporting due to a mental or physical disability
- is primarily dependent upon you for support;
- is incapable of self-sustaining employment;
- You must submit to the Plan a completed Disabled Dependent Application with supporting documentation for review and approval. You must submit the application to the Plan Administrator the earlier of 31 days from the date of the disabling event or, if you were not employed within 31 days after you first become eligible for the Plan if the child was disabled prior to your employment.
- The application and any supporting documentation must establish that the child's incapacity occurred prior to the date the child met the limiting age of 26.
- You may include documentation from the attending physician(s) who currently render care for the disabling condition. Coverage will not take effect under the plan if the Child has already exceeded the limiting age of 26 until the Disabled Dependent Application is approved.

Persons Who Are Not Eligible Dependents

- Your former Spouse or former Common Law Spouse
- A Spouse from whom you are legally separated under a court of law (only applies in very few states
- A Spouse or Common Law Spouse who is not of the opposite sex
- Your Child, as defined above, who is over the age 26
- Grandchildren, nieces, and nephews under the limiting age unless they are legally adopted by or in court appointed custody of an eligible Employee or the eligible Spouse of an Employee.
- Brothers, Sisters, Brothers-in-law, sisters-in-law, aunts, uncles, cousins, nieces or nephews
- Dependents actively serving in the armed forces of any country
- A domestic partner

Proof of Dependent Status

Proof of dependent status satisfactory to the Company may be requested for any individual being enrolled or already covered under the Plan as a dependent. Should you be requested to provide proof of dependent status you will have 30 days to submit documentation of eligible dependent status. The request will describe the type of documentation the Company will accept in accordance with the type of dependent the eligibility pertains to.
Under fiduciary obligation, the Company will, from time to time, conduct eligibility audits. Any plan participant who intentionally or knowingly commits fraud against

Dual Company Coverage

If both you and your spouse work for the Company and are eligible for any Company-sponsored health care or EAP plan, you may be covered either as an employee or as a dependent - but not both - under the Plan. If both you and your spouse work for the Company and you have one or more dependent children, only one of you may cover the eligible children.

If divorced birth parents both work for the Company, dependent children may be covered by each parent.

Effect of Eligibility when age 65

Active Employees Age 65 And Over

Upon retirement, coverage for the EAP will end. Continuation is provided at no cost to plan participants at no cost under the provisions of COBRA Continuation. Therefore, CITGO retirees and their eligible dependents would be granted access to the EAP benefit for a period of 18 months following the retirement date.

DESCRIPTION OF BENEFITS

The EAP provides confidential assessment and referral services for you and your eligible dependents.

At some time in your life you may experience a problem, either your own or that of a dependent, which could affect your physical or mental health, your behavior, or your job performance. You may not even recognize what the problem is or how it is affecting you. It is at times like these when the EAP could be most helpful.

The key to dealing with any problem is early detection and treatment -- catching a problem before it becomes too big to handle and before the damage it can cause is irreparable. The EAP is intended to help you identify the problem, refer you to appropriate treatment, and see that, if called for, you are granted a leave of absence from your job in order to complete any prescribed treatment. In the event any rehabilitative treatment requires time off from work, you will receive the benefits to which you are entitled under the Company's Short-Term Disability Plan (provisions provided in a separate SPD).

Each Program recipient is entitled to five visits with an EAP counselor, per presenting problem, at no cost to the participant.

PROGRAM SERVICES

Resolution for a Variety of Concerns

The EAP utilizes counselors that are trained professionals. These counselors help you identify your problem, understand its implications, and find an appropriate course of treatment.

Services provided by the EAP are provided at no cost to you. Care provided to you or your dependents by a mental health or substance abuse provider, a health care facility, or other provider as a result of a referral by an EAP counselor is not part of the EAP and the cost of the care is your responsibility. The cost of the treatment may be covered if you participate in a medical plan.

The types of problems the EAP can help you with include, but are not limited to:

- Drug and Alcohol Abuse
- Depression
- Anxiety
- Stress Disorders
- Grief Counseling
- Sexual Issues
- Eating Disorders
- Domestic Violence
- Chronic Illness
- Child or Elder Care Concerns
- Emotional Issues
- Behavioral Issues
- Psychological Issues
- Psychiatric Issues
- Marital and Relationship Issues
- Trauma and Phobias
- Gambling
- Legal Issues
- Financial Issues
- Workplace Effectiveness

Log on To: www.liveandworkwell.com

Access Code: 42920

Or call Toll Free 1-888-231-4886 or TDD 1-800-842-9489

ACCESSING YOUR EAP BENEFITS

The Prevention Program

The Prevention Program was designed to help employees, their families and others identify the following conditions, and to make informed decisions about treatment:

- Depression
- Alcohol and Drug Abuse / Addiction
- Attention-Deficit / Hyperactivity Disorder (ADHD)

How To Use This Program

The preventive health program consists of information provided on the www.liveandworkwell.com web site that you can use on your own or by discussing this information with your clinician. The main goal of this information is to help you learn more about depression, Attention Deficit Hyperactivity Disorder, or alcohol and substance abuse and assist you to get professional resources if you believe that you or your child (in the case of ADHD) have one of these conditions.

As with all medical diagnoses, the treatment outcomes for behavioral health issues are generally better the earlier the condition is identified. The information and tools are designed to be helpful if your exploring these conditions for the first time or if you are already in treatment. On the prevention tool site you will find the following information for each center:

- A screening tool to help you decide whether to seek care.
- Articles about behavioral health conditions and how they are treated.
- A list of organizations you can contact if you want more information about a condition and its treatment.
- Contact information for self-help groups if you want to talk with others who can provide support and encouragement.
- Information on how to contact UBH if you have questions or concerns.
- Tools for behavioral health and primary care providers.

Personal Empowerment Tools

Change your thinking and behaviors to support the improvements you want in your life.

Personal Empowerment Programs are your tools to work your wellness and create the life you want. You learn to identify what you want to create and use simple tools to take steps every single day that can help you achieve those goals. Creating the life you want, is really up to you, these tools can help! Programs include:

- *Moving Through Depression*
- *Working Through Stress and Anxiety* *
- *Living in Recovery with Addiction* *

* in development for 2012

Recovery and Resiliency:

- Action Plan for Prevention & Recovery - SAMHSA Tool
- Recovering Your Mental Health - SAMHSA Self-Help Guide
- Recovery & Wellness Lifestyle - SAMHSA Self-Help Guide
- Dealing with the Effects of Trauma - SAMHSA Self-Help Guide

Educational Webinars

United Behavioral Health offers webinars each quarter that you can access at your convenience and at your own pace. Each quarter we will post new featured programs. All it takes is a high-speed internet connection and a web browser to get started.

Referrals

Self-Referrals

Contact UBH at 1-888-231-4886 to make use of the counseling and referral services provided by the EAP to you or your dependents. UBH is open 7 days a week, 24 hours a day. Just call when you are ready. You will speak with a Masters level EAP Specialist who will assess the situation and give you the name and number of a network provider near you who specializes in your particular issue.

Your call and any subsequent counseling or referral services provided through the EAP will be Confidential. If you are in a safety sensitive position and have an alcohol or drug use problem in which you seek assistance of an alternative source of treatment involving the services of a counselor or provider outside the EAP, you will be obligated to advise your supervisor or the Company Medical or Health Services Department of your actions. Failure to do so will result in disciplinary action up to and including termination.

Continuation of Employment Referrals are required if an employee has a positive drug or alcohol test and the employee is eligible for continued employment. In this case the employee will be referred to the EAP after signing consent forms.

If a minor dependent calls the EAP seeking help for a problem and it is determined that the services of an outside provider are called for in treating this problem, the Program counselor is required, by law, to contact the dependent's parent or legal guardian in order to obtain consent for treatment.

Management Referrals

The EAP is available to all supervisors as a management tool.

Informal Management Referrals

Informal Referrals are useful for supervisors when an employee approaches them with a personal problem and there are no job performance issues at the time. The supervisor can suggest to the employee that the EAP could be helpful to assist with their problems. An employee is under no obligation to follow through on an informal referral to the EAP.

Mandatory Management Referrals

Mandatory Management Referrals are pursuant to the Company Substance Abuse Program, documented job performance decline or witnessed employee behavior on the job that interferes with the employee's ability to satisfactorily perform. The employee will be required to sign a consent form authorizing disclosure of information to/from the EAP and the Company Medical or Health Services Department and/or its representative.

Assessment and Outpatient Short-Term Counseling

When you or an eligible dependent access the EAP, the counselor will ask a number of questions during the telephone consultation in order to evaluate your situation and determine, among other things:

- The type of problem(s) you are experiencing;
- The extent and severity of the problem(s);
- The best course of treatment; and
- The appropriate length of treatment.

This assessment phase is important in determining if the situation can be resolved within the EAP benefit or if referral to medical benefits outside the EAP is required. If the situation can be resolved within the EAP benefit, the individual may receive up to 5 visits per presenting problem. There is no cost to you for this service. Typical issues addressed within the EAP benefit are:

- Personal Issues
- Marriage and family counseling
- Bereavement counseling
- Stress
- Depression
- Eating Disorders; and
- Bullying
- Domestic or Family Violence

Continuation of Clinical and Medical Services under the Company Medical Plan

After you or your eligible dependent have exhausted the five visit maximum for a particular issue, your counselor may recommend an additional course of treatment outside the EAP benefit. Referrals may be made for, but are not limited to, any of the following:

- Outpatient psychotherapy with a social worker, psychologist, psychiatrist, or other appropriate health care professional;

- Behavioral modification treatment; or
- Treatment for alcohol/substance abuse, including:
    - Detoxification;
    - Rehabilitation;
    - Day treatment;
    - Residential treatment;
    - Alcohol and drug abuse support groups (e.g., Alcoholics Anonymous);
    - Traditional 28-day inpatient programs; or
    - Outpatient psychotherapy.
    -

Network and Non-Network Services

If the EAP counselor refers you to a service provider not covered by your medical plan, you will be responsible for paying any applicable costs of goods or services you receive from the provider.

In making a referral for on-going care, your EAP counselor will make every effort to refer you to a provider whose costs are covered under the Company-sponsored medical plan. However, it is the responsibility of the medical plan participant or the applicable guardian of the minor child medical plan participant to verify that the UBH counselor's referral is for services with an in-network provider or facility.

When Services Are Available Under the Major Medical Plan

It must be understood that the proper evaluation and treatment of your issue is the EAP counselor's primary concern. Your medical plan coverage may not cover some or all of the goods and services connected with treatment provided by a treatment program. Therefore, in some cases it may not be possible to refer you to a provider whose services will be covered, in whole or part, by your medical plan coverage.

In order to receive in-network benefits under the Company medical plan the EAP participant must be enrolled in the medical during the time period for which care is received. If you or your eligible dependents are not enrolled in the Company medical plan there will be no coverage available for continuation of services beyond those you receive under the EAP program unless you have medical coverage provided under another program.

Under the following circumstances your EAP counselor may submit a request through UBH Care Coordination for a GAP exception for your benefit to be allowed at the network reimbursement level:

- Facility is full or unwilling to accept the participant
- The level of care is unavailable within a network facility or with a network provider
- The only network facilities available are outside the maximum network radius from the home zip code of the participant

There is no guarantee the request for a GAP Exception will be approved and if approved, there is no guarantee the GAP Exception will continue indefinitely. If you have questions concerning a GAP Exception that has been requested on for you or one of your eligible dependents, please contact UBH authorization

services and coordinate with your referring EAP counselor.

Management Consultations

Management consultations with EAP professionals are available to all supervisors who wish to discuss issues regarding a troubled employee. Trained, masters-level counselors are available 24 hours a day to assist you. These counselors help supervisors clarify personal issues from performance issues.

WorkingSolutions Program

A large part of the Program is concerned with the issue of job performance. Many times, deterioration in your job performance is the first outward sign to your peers or supervisors that you have a personal or family problem. And if your job performance is being affected to the degree where it is noticeable, the odds are that the problem could be adversely affecting your physical or mental health, your relationships with your friends and family, as well as your general well-being.

Depending on the circumstances, you may be referred to an EAP Counselor by your supervisor to receive help for your problem. You may recognize the need for help yourself and wonder what the best way is to get the help you need. In either case, a call to the EAP is in your best interest.

The WorkingSolutions Program is designed to enrich and support you as you experience life changes. Because your needs vary throughout your lifetime, WorkingSolutions offers information, consultation and referrals on a wide variety of subjects. For example:

- Locate an available childcare facility near your home
- Find housing or care giving options for an aging parent
- Answer a legal question or obtain financial advise
- Hire a plumber on short notice
- Locate short-term counseling to manage stress and anxiety
- Get help for a substance abuse program

To access the WorkingSolutions Program

Log on To: www.liveandworkwell.com

Access Code: 42920

Or call Toll Free 1-888-231-4886 or TDD 1-800-842-9489

EVENTS AFFECTING COVERAGE

Status Change

Because your contributions for coverage are taken on a "pre-tax" basis, tax regulations do not allow you to increase or decrease your level of coverage (see page 7), terminate coverage, or change your contribution

during the year, unless you have a Status Change in:

- Your family status; or
- Your or your spouse's employment status,
- To be eligible, the Status Change must affect your (or your family's) eligibility under an Employer's EAP program.

An eligible Status Change in your family status includes:

- Marriage;
- Divorce, annulment or legal separation from your spouse;
- Birth, adoption or placement for adoption of a dependent child;
- Death of a spouse or a dependent child;
- Loss of dependent eligibility;
- Acquiring a dependent who was not eligible for coverage during the previous Annual Election Period and later becomes eligible during a Plan Year;
- You or your dependents lose EAP coverage from your spouse's employer through no action on your or your spouse's part, as a result of an eligible status change under that plan, or as a result of an election made during an annual election period under that plan when that plan has a different period of coverage than the Plan Year (January 1 – December 31);
- Court Order resulting from a divorce, legal separation, annulment, or change in legal custody that requires EAP coverage for a dependent child;
- Beginning or losing eligibility for you, your spouse, or a dependent child under a group EAP insurance plan; or
- Any event as determined by the Plan Administrator which is not inconsistent with laws and regulations applicable to the Plan.

An eligible Status Change in employment status includes:

- A Company authorized transfer requiring a change in your work location or relocation of your residence;
- The employment or unemployment of you, your spouse, or a dependent child;
- You, your spouse or a dependent child changes residence or worksite; or
- You, your spouse or a dependent child changes 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).

In addition to those listed above, losing eligibility for you, your spouse, or a dependent child because of attaining age 65 will be considered an eligible Status Change. An eligible Status Change allows you to make a change in your level of coverage (see page 7). If your change does not meet the Status Change criteria above, you cannot change your level of coverage or terminate your coverage under the Plan for the remainder of the Plan Year. You must wait until the next Annual Election Period.

If you have waived coverage under the Plan and have an eligible Status Change during the Plan Year, you may apply within 31 days of the change event for coverage under the Plan for yourself and your dependent, in accordance with the Status Change rules.

Changes in your benefit coverage on any date other than January 1 will only be permitted if the change is consistent with the Status Change and applies to the specific person or situation affected by the Status Change.

Example: Eligible Status Change
During the Annual Election Period, James, an unmarried employee with two dependent children, elects "Employee and Child(ren)" coverage for himself and his two children. During the following Plan Year,

he marries and decides to add his wife to his coverage. James can change his level of coverage to "Employee and Family" during the Plan Year as long as he makes his change within 31 days of his marriage.

Example: Ineligible Status Change
During the Annual Election Period, Shelly elects "Employee and Family" coverage. During the following year, she wants to cancel her dependent coverage to reduce expenses although she still has eligible dependents. Because this is not an eligible Status Change, Shelly cannot change her election until the next Annual Election Period.

Absences

During any Company-approved absence with full or part pay your EAP coverage will remain in force. You are eligible to continue coverage under the Plan as long as you continue to be an eligible employee and are receiving a check from the Company; or as long as you continue to be an eligible employee and your status falls into one of the categories listed below:

- Approved Leave of Absence
- Absence Due to Disability
- Absence Due to Family Medical Leave (FMLA)
- Absence Due to Military Leave

Your coverage will continue if you make any required contributions within the 30-day grace period unless you qualify for waiver of contributions as explained below. You must notify the Benefits HelpLine at 1-888-443-5707 if you wish to waive coverage.

Absence Due to Family Medical Leave (FMLA), or Military Leave - If coverage is terminated during your leave for any reason and you return to active employment, you will be entitled to reinstate the EAP coverage you had prior to your leave. Any illnesses or injuries deemed by the United States Department of Veterans Affairs to have been connected to service in the armed forces while on military leave will not be covered under the Plan.

Coverage will be effective on the date you return to active employment. You will only be eligible for benefits that you would have had if you had not been absent on a leave. If the Plan has changed during your leave, you will be entitled to the coverage that is applicable.

Termination of Coverage

Unless you are eligible to continue coverage as explained under the major heading *Continuation of Coverage* on page 16, your coverage under the Plan will terminate at the end of the month in which the earliest of the following occurs:

- You cease to be an employee meeting the eligibility requirements;
- You terminate employment for any reason and are not eligible to continue coverage as a retiree (see page 4);
- You become eligible for other dental care coverage to which the Company makes contributions on behalf of employees (i.e., the hourly EAP plan);
- You elect to waive coverage during Annual Election or with an eligible Status Change;
- The Plan terminates; or

If you have dependent coverage under the Plan, the coverage for your dependent(s) will terminate at the same time your coverage under the Plan terminates. In addition, your dependent's coverage will terminate at the end of the month in which the dependent no longer meets the eligibility requirements.

If you are rehired, however, then you will be re-enrolled while you are an active employee. When you retire again, EAP coverage as an employee will end.

CONTINUATION OF COVERAGE

Upon Retirement

Upon your retirement you are not eligible for the EAP, you and your dependents' dental coverage will terminate at the end of the month in which you retire. At that time, you can continue coverage under COBRA.

COBRA Continuation Coverage

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (known as "COBRA"), you and your covered dependents may extend your present dental coverage if it is lost due to certain "qualifying events". The following chart describes the COBRA qualifying events for you and your covered dependents:

	Qualifying Event
You, the employee	• Termination of employment, other than for gross misconduct • Reduction in hours resulting in loss of coverage
You, the retiree	• A bankruptcy proceeding in a case under Title 11 of the United States Code with respect to the Company
Eligible dependents	• Termination of your employment, other than for gross misconduct • Reduction in your hours worked that results in loss of coverage • Your death • Your divorce or legal separation • Your dependent child's eligibility for coverage ends • A bankruptcy proceeding in a Title 11 case is commenced with respect to the Company if you are retired

If you and/or your covered dependents lose coverage under the Plan as a result of one of these qualifying events, you and/or your covered dependents will be eligible to continue COBRA continuation coverage for the maximum periods specified by law at no cost to you. In the case the qualifying event is the bankruptcy of the Company, the term "lose coverage" includes any substantial elimination of coverage within one year before or after the date the bankruptcy proceeding commences.

In addition to the qualifying events previously described, you, your spouse or your dependent(s) may have a COBRA qualifying event if all of the following conditions are met:

1. You, your spouse or your dependent is covered under the Plan on the day before the first day of a leave of absence under the Family and Medical Leave Act of 1993 (FMLA leave) or becomes covered under the Plan during the FMLA leave;
2. You do not return to employment with the Company at the end of the FMLA leave; and
3. You, your spouse or your dependent would, in the absence of COBRA continuation coverage, lose coverage under the Plan before the end of what would be the maximum coverage period.

However, meeting the above requirements will not be a qualifying event if the Company eliminated, on or before the last day of your FMLA leave, coverage under the Plan for the class of employees (while

continuing to employ that class of employees) to which you would have belonged if you had not taken FMLA leave.

The maximum coverage period is measured from the last day of the FMLA leave unless coverage is lost at a later date, in which case the maximum coverage period is measured from the date the coverage is actually lost.

Continuation Coverage

Depending on the qualifying event, coverage may continue for up to 18, 29 or 36 months from the date coverage would otherwise end. Continuation coverage will be identical to the coverage provided to active employees. You will have the same rights as an active participant, including the right to enroll eligible dependents. In addition, evidence of insurability is not required in order to continue coverage.

COBRA Qualifying Event	How Long Coverage May Continue	
	You	Dependents
You terminate employment (other than for gross misconduct)	18 months (may be extended an additional 11 months – if you or your dependents are determined under the Social Security Act to be disabled at any time during the first 60 days of continuation coverage and the applicable notice requirements are satisfied - see page 39).	18 months (may be extended an additional 11 months – if you or your dependents are determined under the Social Security Act to be disabled at any time during the first 60 days of continuation coverage and the applicable notice requirements are satisfied - see page 39).
Your hours are reduced, resulting in a loss of coverage	18 months (may be extended an additional 11 months – if you or your dependents are determined under the Social Security Act to be disabled at any time during the first 60 days of continuation coverage and the applicable notice requirements are satisfied - see page 39).	18 months (may be extended an additional 11 months – if you or your dependents are determined under the Social Security Act to be disabled at any time during the first 60 days of continuation coverage and the applicable notice requirements are satisfied - see page 39).
You die	N/A	36 months
You become entitled to Medicare	N/A	36 months (special rules apply)
You and your spouse divorce or legally separate	N/A	36 months
Your child is no longer eligible	N/A	36 months

Secondary Qualifying Events

If you are receiving COBRA continuation coverage as a result of your termination of employment or reduction in hours, your total coverage under COBRA is limited to 36 months from the date of the first qualifying event. However, you may be eligible for an additional period of coverage if a second qualifying event (other than a bankruptcy proceeding with respect to the Company) occurs while you are receiving continued coverage under COBRA. You must notify the Benefits HelpLine at 1-888-443-5707 within 60 days after the second qualifying event.

Other Continuation of Coverage

In addition to the option to extend benefits under the provisions of COBRA, certain extensions of benefits are available due to an employee's or retiree's death.

Eligible Dependents of Deceased Active Employees not Eligible for Retiree Coverage

If you die as an active employee and you are not eligible for retiree coverage under the Plan, your dependents may continue coverage under the Plan **until the earlier of:**

- Six months following the end of the month in which your death occurred if your death is not the result of an on-the-job accident;
- The end of the month following the date that your spouse remarries;
- The end of the month following the date that your dependent loses eligibility under the Plan; or
- The end of the month following the date coverage under the Plan terminates due to failure to make required contributions in a timely manner.

The above continuation of coverage will be offset with COBRA continuation coverage (see page 35).

Eligible Dependents of Deceased Active Employees Eligible for Retiree Coverage or Deceased Retired Employees

If you die as an active employee and you are eligible for retiree coverage under the Plan or you die as an eligible retiree, your dependents may continue coverage under the Plan **until the earlier of:**

- The end of the month following the date that your spouse remarries;
- The end of the month following the date that your dependent loses eligibility under the Plan; or
- The end of the month following the date coverage under the Plan terminates due to failure to make required contributions in a timely manner.

Qualified Medical Child Support Orders (QMCSO's)

If you are getting divorced or legally separated, coverage for your dependent children may be continued as long as they otherwise satisfy the eligibility requirements as eligible dependents. However, there may be a domestic relations order that *requires* you to provide EAP coverage for your eligible children, regardless of whether:

- They are currently covered under the Plan,
- They are dependent on you for financial support, or
- You have legal custody of the children.

A medical child support order is any judgment, decree, order, or court-approved settlement agreement that:

1. Provides for child support or EAP benefit coverage with respect to a child, is issued pursuant to a state domestic relations law, and relates to benefits under a group EAP plan; or
2. Is issued pursuant to a law relating to EAP child support with respect to a group EAP plan.
3.

However, the Plan Administrator is not required to comply with the order unless the order is a *Qualified Medical Child Support Order* (QMCSO).

A QMCSO is a medical child support order that creates or recognizes the right of a child (alternate recipient) to be covered under your Company-sponsored group EAP care plan to the extent he or she would otherwise be eligible for participation under the provisions of the Plan. If the child is not already covered under the Plan, you will be allowed to enroll the child in the Plan as directed under the QMCSO,

and the Plan's late enrollment provisions will not apply. Enrollment of this type is considered an eligible Status Change.

A QMCSO must meet specific legal requirements, as outlined in the Plan's written procedures for QMCSO's. A copy of these procedures is available upon request from the Benefits HelpLine free of charge.

If you are going through a divorce or separation, you should ask your attorney to obtain a copy of the Plan's QMCSO procedures, which can be helpful in drafting the order. Your attorney should also send a draft of your proposed medical child support order to the Plan Administrator for review, before it is approved by the state court. This way, you will know in advance whether the order meets the requirements for a QMCSO and will avoid having to go back to the court later to amend the order.

Don't forget to send a final copy of the court-approved QMCSO to the Plan Administrator. Coverage for the child will begin as soon as administratively possible after request and approval of the QMCSO. Coverage cannot be retroactive to the receipt of the QMCSO.

Once the Plan Administrator determines that an order is qualified, the Plan Administrator will take whatever actions are required to comply with the QMCSO.

Under current law, a QMCSO cannot require the Plan to pay a greater benefit than the benefit that would otherwise be paid from the Plan if no QMCSO existed. However, current law requires benefits to be paid directly to the child or the child's custodial parent or legal guardian, instead of to the Plan participant (you), who normally is the only family member entitled to payment of Plan benefits.

ADMINISTRATIVE INFORMATION

The Plan Administrator is responsible for the administration of the Program. The Program Administrator has contracted with United Behavioral Health to manage the services under the Program. The Plan Administrator has final discretionary authority to interpret the Program's provisions, to resolve any ambiguities in the Program, and to determine all questions relating to the Program, including eligibility for benefits. The decisions of the Plan Administrator with respect to all issues and questions will be final, conclusive, and binding on all persons. The Plan Administrator may delegate to other persons the responsibilities for performing ministerial duties in accordance with the terms of the Program and may rely on information, data, statistics or analysis provided by these persons.

This Program is voluntary on the part of the Company. The Company reserves the right to amend, modify, or terminate the Program at any time, with or without advance notice, prospectively as well as retroactively, subject to applicable law.

ASSIGNMENT OF BENEFITS

Benefits payable under the EAP program may not be assigned, other than to a service provider or the Company, subject to applicable law.

CONTRIBUTIONS AND FUNDING

CITGO pays the entire cost of the EAP program and no contribution is required from plan participants.

ADMINISTRATIVE INFORMATION

Important information about the Program is provided below:

Name of Program:	The CITGO Petroleum Corporation Medical, Dental, Vision and Life Insurance Program for Salaried Employees; and The CITGO Petroleum Corporation Medical, Dental, Vision and Life Insurance Program for Hourly Employees
Type of Program:	Employee Assistance Program
Program Sponsor:	CITGO Petroleum Corporation 1293 Eldridge Parkway Houston, TX 77077
Program Sponsor's Employer Identification Number:	73-1173881
Plan Administrator:	Benefit Plans Committee – Secretary CITGO Petroleum Corporation 1293 Eldridge Parkway, N5072 Houston, TX 77077
Plan Number:	515 and 518
Program's Initial Effective Date:	January 1, 2002
Plan Year:	January 1 – December 31
Funding Method:	Funded by Company contributions under a fully-insured arrangement with the provider
EAP Provider:	United Behavioral Health 1-888-231-4886
Website:	www.liveandworkwell.com Group Number 42920
The Benefits Department:	CITGO Benefits Helpline
By Phone:	1-888-443-5707
By Email:	benefits@citgo.com
By Mail:	CITGO Petroleum Corporation Attn: Benefits – HR Total Rewards P.O. Box 4689 Houston, TX 77210-4689

STATEMENT OF ERISA RIGHTS

Under the Employee Retirement Income Security Act of 1974, as amended, (ERISA), the Company is required to provide you with the following statement of ERISA rights to fully inform you of your rights as a participant under those benefit plans subject to ERISA.

As a participant in the Program, you are entitled to certain rights and protections under ERISA. ERISA provides that all Program participants shall be entitled to:

Receive Information about Your Program and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Program, including insurance contracts, and a copy of the latest annual report (form 5500 Services) filed by the Program with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Program, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary program description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Program's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Program as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary program description and the documents governing the Program on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Program Fiduciaries

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

Enforce Your Rights

If your claim for a welfare 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 Program documents or the latest annual report from the Program 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 Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Program's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Program Fiduciaries misuse the Program'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 the Program, 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 at 1-866-444-3272.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

This section incorporates the requirements of the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA) and the regulations issued thereunder as set forth in 45 C.F.R. Parts 160, 162 and 164, as amended (HIPAA Regulations).

Definitions

For purposes of this section, words and phrases not otherwise defined herein which are defined in the HIPAA Regulations shall have the meanings assigned therein when used herein. In the event of a conflict between the meaning of a word or phrase used herein with the definition given elsewhere in the Program, the meaning given in this section shall control.

The Use and Disclosure of Protected Health Information

Effective April 14, 2003, the Program will 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 the following uses and disclosures:

1. Health care payment: For this purpose, health care payment includes activities undertaken by the Program to obtain premiums or determine or fulfill its responsibility for coverage and provision of benefits under the Program or to obtain or to provide reimbursement for the provisions of health care that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

    a. determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of benefit claims;

    b. risk adjusting amounts due based on enrollee health status and demographic characteristics;

    c. billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss coverage), and related health care data processing;

    d. review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;

    e. utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and

    f. disclosures to consumer reporting agencies of any of the following protected health information relating to collection or premiums or reimbursement: name and address, date of birth, social security number, payment history, account number, and name and address of health care provider and/or health plan.

2. Health care operations: For this purpose, health care operations include, but are not limited to, the following activities:

   a. conducting quality assessment and improvement activities, including outcomes and evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities;

   b. conducting population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions that do not include treatment;

   c. reviewing the competence or qualifications of health care professionals, evaluation practitioner and provider performance, health plan performance, conducting training programs which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-healthcare professionals, accreditation, certification, licensing, or credentialing activities;

   d. underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance) provided certain requirements are met if applicable;

   e. conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance review programs;

   f. business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Program, including formulary development and administration, development or improvement of payment methods or coverage policies; and

   g. business management and general administrative activities of the Program, including, but not limited to:

      (i) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements;

      (ii) customer service, including the provision of data analyses for policyholders, program sponsors or other customers, provided the protected health information is not disclosed to such policy holder, program sponsor, or customer;

      (iii) resolution of internal grievances;

      (iv) the sale, transfer, merger or consolidation of all or part of the Program with another program, or an entity that following such activity will become a covered entity and due diligence related to such activity; and/or transfer of assets to a potential successor in interest; and

(v) consistent with the applicable requirements of 45 C.F.R. § 164.514, creating de-identified health information or a limited data set, and fundraising for the benefit of the Program.

3. Treatment: For this purpose, treatment means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

Disclosure to the Program Sponsor

The Program will disclose protected health information to the Program Sponsor only upon receipt of a certification from the Program Sponsor that the Program documents have been amended to incorporate the requirements listed under the headings "Additional Agreements of Program Sponsor" and "Adequate Separation Between the Program and the Program Sponsor" below. The Program has received this certification from the Program Sponsor. However, the Program may disclose summary health information to the Program Sponsor if the Program Sponsor requests the summary health information for the purpose of obtaining premium bids from health plans for providing health insurance coverage under the Program or modifying, amending or terminating the Program. In addition, the Program may disclose to the Program Sponsor information on whether the individual is participating in the Program, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Program.

The Program participates in an organized health care arrangement with the following plans sponsored by the Program Sponsor:

1. The CITGO Petroleum Corporation Medical, Dental, Vision, and Life Insurance Program for Hourly Employees

2. The CITGO Petroleum Corporation Medical, Dental, Vision, and Life Insurance Program for Salaried Employees

Accordingly, the Plans may exchange protected health information for treatment, payment and health care operations purposes of such organized health care arrangement.

Additional Agreements of Program Sponsor

With respect to protected health information, the Program Sponsor further agrees to:

1. not use or further disclose the information other than as permitted or required by the program document or as required by law;

2. ensure that any agents, including a subcontractor, to whom the Program Sponsor provides protected health information received from the Program agree to the same restrictions and conditions that apply to the Program Sponsor with respect to such information;

3. not use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plans of the Program Sponsor unless authorized by an individual;

4. report to the Program any protected health information use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;

5. make available protected health information to an individual in accordance with HIPAA's access requirements and 45 C.F.R. § 164.524;

6. make available protected health information for amendment and incorporate any amendments to protected health information in accordance with HIPAA and 45 C.F.R. § 164.526;

7. make available the information required to provide an accounting of disclosures in accordance with HIPAA and 45 C.F.R. § 164.528;

8. make its internal practices, books and records relating to the use and disclosure of protected health information received from Program available to the Secretary of the Department of Health and Human Services for the purposes of determining the Program's compliance with HIPAA;

9. if feasible, return or destroy all protected health information received from the Program that the program sponsor still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction not feasible; and

10. ensure that adequate separation between the Program and Program Sponsor (as described below) is established.

11. Effective April 20,2005, implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives, maintains or transmits on behalf of the Program (except with respect to enrollment and disenrollment information, summary health information and protected health information disclosed pursuant to an authorization under 45 C.F.R. § 164.508) and shall ensure that any agents (including subcontractors) to whom it provides such electronic protected health information agree to implement reasonable and appropriate security measures to protect such information;

12. Effective April 20, 2005, report to the Program any security incident of which it becomes aware and

13. Effective February 17, 2010 follow Incident Security Response Procedures for handling security breaches which involve HIPAA protected information including those applicable for Business Associate breach incidents

Adequate Separation between the Program and the Program Sponsor

In accordance with HIPAA and the HIPAA Regulations, only the following employees or classes of employees or other persons may be given access to protected health information to be disclosed:

1. The Plan Administrator
2. Human Resources employees within the Benefits Planning and Administration Department;
3. Human Resources employees with responsibility for investigating appeals and recommending decisions to the Plan Administrator
4. Human Resources employees with access to the data which is stored electronically
5. Employees within the Information Technology ("IT") Group which maintain the servers on which some protected health information may be stored or those IT employees who have access to systems such as email and voicemail
6. Employees in the area of Benefits Accounting
7. Employees in the Internal Audit Department, and
8. In-house legal counsel

The persons identified in this sub-section may only have access to and use and disclose protected health information for Program administration functions that the Program Sponsor performs for the Program. If the persons identified in this section do not comply with the restrictions set forth in this Program document and otherwise under HIPAA and the HIPAA Regulations, the Program Sponsor shall respond to such noncompliance in accordance with the requirements of applicable law and the Program Sponsor's policies, including as appropriate, the imposition of disciplinary sanctions. The program sponsor will ensure that the provisions of this Section are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic protected health information.

Consistency with HIPAA and HIPAA Regulation

In the event any amendment of HIPAA or the HIPAA Regulations is adopted which renders any provision of this section inconsistent therewith, this section shall be deemed amended to be consistent therewith.

Other Uses and Disclosures of Health Information

In addition to the above uses and disclosures, the Program Sponsor may use and disclose protected health information to the fullest extent permitted under HIPAA or the HIPAA Regulations.

Notice of Privacy Practices

The HIPAA Regulations require the Program to provide you with a notice describing the Program'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 Program enrollees. In addition, an updated notice will be provided to all Program participants within 60 days of any material revision of the notice. Copies of the notice are available at all times on the CITGO intranet, at http://www.hr.CITGO.com or by calling the Benefits HelpLine.

DEFINITIONS

This Program description has been written in a simplified manner that is intended to help explain this Program as clearly as possible. The following definitions specifically apply to the EAP:

"Benefits HelpLine" is a resource you may contact for assistance with any benefits related issues. The Benefits HelpLine is available toll free at 1-888-443-5707 or by email to Benefits@citgo.com.

"Company" means CITGO Petroleum Corporation and any of its subsidiaries or affiliated companies that participate in this Program.

"Confidential" means all information is held in confidence except in the following instances: If there is neglect/abuse of a child, the elderly, mentally retarded, danger to self or others, required by a law or regulation requiring disclosure, Company policies regarding required disclosure of information, or in auditing the EAP for fiduciary and clinical due diligence.

"Management Referral" means a referral pursuant to the Company's Substance Abuse Program or a mandatory referral by a manager or supervisor because of an employee's performance or other problems.

"Regular Full-Time Employee" means an employee who is regularly scheduled to work at least 40 hours per week or an individual that is on Long-Term disability.

"Regular Part-Time Employee" means an employee who is scheduled to work less than 40 hours per week.

"Self Referral" means an employee's voluntary use of the Employee Assistance Program for help in resolving personal or family problems, including those involving alcohol or drug use.

"You" or "Your" (even though not capitalized) means you, the employee, and does not mean your dependents or any other person, institution, or other entity.

These meanings will apply whenever these words are used, unless a different meaning is clearly indicated in the text. There may be places where other words are used that also have important and specific meanings, and these words and their definitions are identified in the text of the description.