CITGO Petroleum Corporation
Fire Fighting Accidental Death and Dismemberment Insurance Plan

Summary Plan Description

January 1, 2018

This Summary Plan Description, including any announcement letters and other communications such as a summary of material modifications issued after the publication date set forth above, the CITGO Petroleum Corporation Fire Fighting Accidental Death and Dismemberment Insurance Plan (the Plan) and the contract for insurance as identified below, including any riders and any certificates of insurance, between the Company and the Insurer (collectively, the Insurance Documents) are the governing Plan documents. Unless the context clearly indicates otherwise, the Insurance Documents will control in the event of a discrepancy between this Summary Plan Description and the Plan, or both, and the Insurance Documents.

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PURPOSE

The CITGO Petroleum Corporation Fire Fighting Accidental Death and Dismemberment Insurance Plan (the Plan) is designed to provide you and your beneficiary(ies) with additional financial security if you die or suffer certain Injuries that occur because of an accident while fighting a fire in the duties of your job with the Company, Any benefits provided by this Plan are in addition to benefits that may be paid under the other Company-sponsored plans.

This Summary Plan Description (the SPD) describes the benefits available under the Plan, as well as the Plan's limitations. As a participant, you may be asked to comply with certain provisions of this Plan, which could affect the benefits you receive. You should acquaint yourself with these provisions. Failing to comply may result in a reduction in or the denial of benefits.

ELIGIBILITY

Who is Eligible

You are eligible to participate in the Plan if you are:

(1) an active employee of the Company; and

(2) carried on the Company's U.S. dollar payroll.

Who is Not Eligible

You are not eligible to participate in the Plan if you:

(1) provide services to the Company under an independent contract between yourself and the Company or a third party and the Company;

(2) provide services to the Company under a leasing arrangement between the Company and a third party; or

(3) are a member of a collective bargaining unit that has negotiated for a fire-fighting accidental death and dismemberment insurance plan other than the Plan.

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 of the Company, you will still be excluded from participation during the period of time you were misclassified and will only become eligible for participation in this Plan upon a final determination of your status as an employee of the Company.

ENROLLMENT

If you are eligible to participate in the Plan, you are automatically enrolled for coverage as of your hire date.

Effective Date of Coverage

Your coverage under the Plan is generally effective starting on your first day of active employment. However, if you are not at work on the day coverage is scheduled to begin, your coverage will start when you are actively at work.

Contributions

The Company pays 100% of the premium payments to the Insurer for the insurance policy that funds benefits provided by this Plan.

DESCRIPTION OF BENEFITS

The Plan is intended to help you and your beneficiary(ies) better manage the financial burdens caused by your death or injury incurred in connection with fighting a fire.

Principal Sum

All benefits payable under this Plan are based on the ***Principal Sum***:

Principal Sum	
Class 1 - All members of the Company's Emergency Response Team (ERT) as defined by the Company, excluding hourly employees located at the CITGO Asphalt Refinery in Paulsboro, NJ.	**$500,000**
Class 2 - All active full-time or part-time Employees of the Company, excluding hourly employees located at the CITGO Asphalt Refinery in Paulsboro, NJ and members of the Company's ERT.	**$500,000**

Except as otherwise provided in the Plan, a Covered Loss must occur within 365 days from the date of the Covered Accident.

Conditions of Coverage, Covered Losses and Benefit Amounts

This Plan will pay benefits, subject to all applicable conditions and exclusions, if you are acting under the Conditions of Coverage and suffer a Covered Loss caused, directly or independently of all other causes, because of a Covered Accident that occurs when responding to an emergency.

As a Condition of Coverage under this Plan, you must be:

(1) designated by the Company as a contact person assigned to respond to emergency calls as part of your specifically assigned job duties;

(2) responding to an emergency call that:

- requires your skills or supervision; and
- requires immediate response to prevent loss or interruption of the Company's business; and

(3) fighting a fire in the performance of your duties on the Premises of the Company and acting at the direction of the Company.

You are covered when you leave the place where you are located when you are notified of an emergency until you return to such place or your place of residence. This is inclusive of a Personal Deviation. A Personal Deviation means an activity that is neither reasonably related nor incidental to the purpose of your travel of no more than one hour that occurs before, during or after an emergency response.

Schedule of Covered Losses	
Covered Loss	**Benefit Amount**
Life	Principal Sum
Two or more hands or feet	Principal Sum
Quadriplegia	Principal Sum
One hand or one foot plus the sight of one eye	Principal Sum
Sight of both eyes	Principal Sum
Speech and hearing (in both ears)	Principal Sum
Loss of use of two or more hands or feet	Principal Sum
Paraplegia	3/4 Principal Sum
Hemiplegia	1/2 Principal Sum
One hand or one foot and sight of one eye	1/2 Principal Sum
Loss of use of one hand or foot	1/2 Principal Sum
Speech or hearing (in both ears)	1/2 Principal Sum
Thumb and index finger of same hand	1/4 Principal Sum
All four fingers of the same hand	1/4 Principal Sum
Uniplegia	1/4 Principal Sum
All the toes of the same foot	1/5 Principal Sum
Coma	1% Principal Sum

Coma Benefit: A coma benefit equal to 1% of the Principal Sum is payable for 11 months at the end of each month during which you remain comatose. A lump-sum payment equal to the Principal Sum is payable at the beginning of the 12th month during which you remain comatose. If you lose your life because of a Covered Accident, the benefit will be payable to your beneficiary.

If more than one Covered Loss is sustained because of the same Covered Accident, the Plan will pay the benefit for the Covered Loss for which the largest benefit is payable. If a Covered Accident results in your death, the total of all benefits paid by the Plan will not exceed the Principal Sum.

For purposes of a Covered Loss, the following definitions apply.

Covered Loss	Definition
Hand or foot	complete Severance through or above the wrist or ankle joints
Sight, speech or hearing	total and permanent loss which is irrecoverable by natural, surgical or artificial means
Use of hand or foot	total loss of the ability to move the hand or foot, within 60 days of a Covered Accident, that continues for 12 months and is expected to continue for the remainder of your lifetime
Thumb and index finger of the same hand or loss of four fingers of the same hand, index finger or fingers	complete Severance through or above the metacarpophalangeal joints

Toes	compete Severance through the metatarsophalangeal joint
Quadriplegia	total Paralysis of both upper and lower limbs
Hemiplegia	total Paralysis of the upper and lower limbs on one side of the body
Paraplegia	total Paralysis of both lower limbs or both upper limbs
Uniplegia	total Paralysis of one upper or one lower limb
Coma	profound state of unconsciousness from which you are not likely to be aroused through powerful stimulation. The coma must begin within 30 days of the Covered Accident, continue for 60 consecutive days and must be diagnosed and treated regularly by a physician. Coma does not mean any state of unconsciousness intentionally induced during the course of treatment of a Covered Injury unless the state of unconsciousness results from the administration of anesthesia in preparation for surgical treatment of Injuries sustained in that Covered Accident.

Aggregate Limit

No more than $5,000,000 will be paid for all Covered Losses for all participants as the result of any one Covered Accident. If this amount does not allow all participants to be paid the amounts under the Schedule of Benefits, the amount paid will be in the proportion of each participant's Covered Losses to the total of all loses, multiplied by $5,000,000.

Benefit Exclusions

The Plan will not provide benefits for any Covered Injury or Covered Loss that directly or indirectly, in whole or in part, is caused by or results from:

(1) intentionally self-inflicted Injury, suicide or attempted suicide, whether sane or insane;

(2) war or act of war, whether declared or undeclared;

(3) unless a Covered Accident occurs while engaged in Reserve or National Guard training that does not extend beyond 31 days, 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;

(4) traveling in any Aircraft owned, leased or controlled by the Company;

(5) voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless the drug is prescribed or taken under the direction of a physician and taken in accordance with the prescribed dosage;

(6) commission or attempt to commit a felony or an assault;

(7) commission of or active participation in a riot or insurrection;

(8) operating any type of vehicle while under the influence of alcohol, which means being intoxicated as defined by the laws of the state in which a Covered Accident occurs, or any drug, narcotic or other intoxicant including any prescribed drug for which you have been provided a written warning against operating a vehicle while taking it;

(9) Sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment of the same, including exposure, whether or not accidental, to viral, bacterial or chemical agents except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;

(10) flight in, boarding or exiting from an Aircraft except as a fare-paying passenger on a regularly scheduled commercial or charter airline or a passenger in a military Aircraft flown by the Air Mobility Command or its foreign equivalent; or

(11) other exclusions set forth by the Insurer from time to time.

Benefit Limitations

Benefits will not be paid for services or treatment by any person who is:

(1) employed or retained by the Company,

(2) living in the participant's home,

(3) a parent, sibling, spouse or child of the participant and his spouse, or

(4) the participant.

NAMING YOUR BENEFICIARY

Any Covered Loss will be payable to you unless you die prior to receiving a Covered Loss or your Covered Loss is due to your death. You are encouraged to designate a beneficiary as soon as possible. Beneficiaries include the person or persons you name in writing as your beneficiary on a form satisfactory to the Insurer. You may designate as many Primary and Contingent Beneficiaries as you wish. You can obtain the form from the Benefit Connections site at www.hr.citgo.com.

Your Primary Beneficiary is the person(s) to whom you wish benefits to be paid in the event of your death. Your Contingent Beneficiary receives benefits payable by the Plan if all Primary Beneficiaries die before or at the same time as you. Your beneficiary may be an individual, trust, corporation or other similar entity. To verify that benefits under this Plan are paid in accordance with your wishes, you are encouraged to review your beneficiary designations from time to time to make sure they are current and correct. Just call the Benefits HelpLine at 1-888-443-5707 to obtain current beneficiary information.

If you name more than one beneficiary, proceeds will be shared equally, unless you specify otherwise. Unless you designate otherwise, Contingent Beneficiaries may only receive benefits if there are no living Primary Beneficiaries.

If Your Beneficiary Dies Before You

If any designated beneficiary dies before, or at the same time as you, and you do not designate another, such designated beneficiary's share will be payable equally to the beneficiaries who survive. In the event there is no living, designated beneficiary at the time of your death, or in the event of the absence of a valid beneficiary designation form on file in the Benefits Department, benefits – subject to applicable state laws – will be paid equally to the person or persons who fall into the first class of relatives in the following order:

(1) Your spouse;

(2) your child or children;

(3) your parents;

(4) your siblings; or

(5) your estate.

Changing Your Beneficiary

You may change beneficiaries, without their consent, at any time by completing a beneficiary designation form unless you made your prior designation irrevocable. You can obtain the form from the Benefit Connections site at www.hr.citgo.com.

If you change your beneficiaries, your designation will become effective when the Benefits Department receives a valid form that is properly completed and signed by you.

Additional information can be obtained from the Benefits HelpLine at 1-888-443-5707 or benefits@citgo.com. You should consult with a lawyer or tax professional to better understand the legal and tax consequences of your beneficiary designation.

EVENTS AFFECTING COVERAGE

Absences

If you are absent from work, the insurance will not be effective until you return to work.

Termination of Coverage

Your coverage will terminate upon the earliest of the following events:

- You become ineligible for coverage under this Plan;
- the date you enter into full-time active military duty with the Armed Forces, but active duty does not include Reserve or Nation Guard duty for training;
- you terminate employment for any reason; or
- the Plan is terminated.

CLAIMS PROCEDURES

When and How to File a Claim

The Benefits HelpLine at 1-888-443-5707 must be notified within 31 days after a Covered Loss occurs or as soon as reasonably possible, but in no case any longer than 15 months after the date of loss. The Benefits HelpLine will provide you or your beneficiary with the necessary claim forms. Any release forms required must be signed before any benefits will be paid. The Benefits HelpLine can answer questions about the Plan's benefits and assist you or your beneficiary in filing claims.

Claims should be sent to the Benefits Department (see *Additional Information* on page 15) for processing. A certified death certificate is required for loss of life and must accompany any claim submitted to the Benefits Department in cases where the participant has died. The Plan will, within 90 days of receipt of a claim, do one of the following:

- pay all benefits payable;
- deny the claim in whole or in part;
- request additional information; or
- notify you that there are special circumstances requiring an extension of time of up to 90 additional days.

Claim Denial

The Insurer will review your or your Beneficiary's claim and notify you or your Beneficiary of its decision to approve or deny a claim within a reasonable time, but not longer than 90 days of receipt of a claim unless a longer period is required. If special circumstances require an extension of up to 90 days, you or your Beneficiary will be notified before the initial claims period expires. This notice will indicate the special circumstances requiring an extension of time and the date by which a decision will be rendered.

When a claim is denied, either in whole or in part, the Insurer will explain why the claim has been denied and state the Plan provisions on which the denial is based. The notification will also include a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary. You or your Beneficiary will be provided with a description of the Plan's review procedures and time limits, including a statement of your or your Beneficiary's right to bring a civil action if the claim is denied after an appeal. You, your Beneficiary or a duly authorized representative may appeal the denial and request a final claim review.

Such notification will be provided to you within a reasonable period, not to exceed 90 days from the date the your claim is received, unless you are notified within that period that there are special circumstances requiring an extension of time of up to 90 additional days.

Claim Appeal

Within a period of 60 days after the denial is received, the denial may be appealed, in writing, to the Insurer. If the Insurer's initial determination is being appealed, a request for review of appeal and all supporting documentation should be submitted in writing to the Insurer's office that processed the claim.

The request must state the reason or reasons why you believe or your Beneficiary believes the claim was improperly denied and may include any written comments, documents, records or other information you deem or your Beneficiary deems appropriate. Upon request and free of charge, you or your Beneficiary will be provided with reasonable access to, and copies of, all documents, records and other information relevant to the claim.

During the appeal all the information will be re-evaluated. The review will be conducted in a full and fair manner that takes into account all comments, documents, records and other information submitted by you or your Beneficiary relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When a claim is denied, either in whole or in part, the Insurer will explain why the claim has been denied and state the Plan provisions on which the denial is based. You will be reminded that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim. You or your Beneficiary will be provided with a description of the Plan's review procedures and time limits, including a statement of your or your Beneficiary's right to bring a civil action if the claim is denied after an appeal. You, your Beneficiary or a duly authorized representative may appeal the denial and request a final claim review if the Insurer denies you or your Beneficiary's claim, in whole or part.

You or your beneficiary will receive a notification of the determination on appeal within a reasonable period of time, but no later than 60 days after receipt of the written appeal (or within 120 days if special circumstances require an extension of time for processing). If an extension of time is required for the review, you or your Beneficiary will be notified before the extension period begins. If an appeal is not made within the 60-day period, the denial will be considered final, conclusive and binding.

The Insurer has the right, at its own expense, to examine you when and as often as they may reasonably request while the claim is pending. It can have an autopsy made unless forbidden by law.

Final Claim Review

If an appeal adjudicated by the Insurer cannot be satisfactorily resolved with the Insurer, you or your Beneficiary may appeal the claim within 60 days of the Insurer's final denial of the claim, to the Plan Administrator for review. If you do or your Beneficiary does not appeal the denial within 60 days to the Plan Administrator, the Insurer's denial will be considered final, conclusive and binding.

The written request to the Plan Administrator must state the reasons why you believe or your Beneficiary believes the claim was improperly denied and submit any written comments, documents, records or other information they deem appropriate.

During the appeal all the information will be re-evaluated. The Plan Administrator will review the facts of the case with the Insurer and will have the discretionary authority to make a final and conclusive determination of the claim. The review will be conducted in a full and fair manner that takes into account all comments,

documents, records and other information submitted by you or your Beneficiary relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When a claim is denied, either in whole or in part, the Plan Administrator will explain why the claim has been denied and state the Plan provisions on which the denial is based. You or your Beneficiary will be entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim. You or your Beneficiary will be provided with a description of the Plan's review procedures and time limits, including a statement of your or your Beneficiary's right to bring a civil action if the claim is denied after an appeal.

You or your beneficiary will receive a notification of the determination on appeal within a reasonable period of time, but no later than 60 days after receipt of the written appeal (or within 120 days if special circumstances require an extension of time for processing). If an extension of time is required for the review, you or your Beneficiary will be notified before the extension period begins.

Legal Actions

You or your beneficiary(ies) may not pursue the claim in federal or state court until first exhausting the claims procedures under the Plan. You or your beneficiary may not sue after the expiration of the applicable limitations period.

ADMINISTRATION

The Plan Administrator, on behalf of the Plan, has contracted with the Life Insurance Company of North America to provide coverage as the Insurer under the Plan. You may obtain a certificate of coverage for your review from the Insurer by making a request to the Benefits HelpLine at 1-888-443-5707.

The provisions of this Plan are subject to the terms and conditions of the insurance that funds benefits payable by the Plan between the Company and the Insurer. The Insurer makes all payment of benefits under the terms of the Plan.

The Plan Administrator has delegated certain duties and obligations with respect to administering this Plan to the Insurer. As a fiduciary, the Insurer has discretionary authority to interpret the Plan's provisions, to resolve any ambiguities in the Plan and to determine all questions related to the payment of benefits provided by the Plan. The decisions of the Insurer will be final, conclusive and binding on all persons with respect to all issues and questions relating to the Plan.

The Plan Administrator is responsible for the administration of this Plan and has final discretionary authority to interpret the Plan's provisions, to resolve any ambiguities in the Plan and to determine all questions related to the Plan, including eligibility for benefits. The decisions of the Plan Administrator will be final, conclusive and binding on all persons with respect to all issues and questions relating to the Plan, except those specifically governed by the insurance contract between the Company and the Insurer.

The Plan Administrator may delegate to other persons the responsibilities for performing the ministerial duties in accordance with the terms of the Plan and may rely on information, data, statistics or analysis provided by these persons. The Company's determination will be conclusive regarding rates of pay and termination of employment.

Agent for Service of Legal Process

If you feel you have cause for legal action, you may present petition for service of legal process to the Secretary of the Benefit Plans Committee at the address listed for the Plan Administrator (see *Additional Information* on page 15).

Future of the Plan

It is the Company's intention to continue to provide these benefits to participants of this Plan. However, the Company reserves the right to amend, modify, or terminate this Plan, in whole or in part, at any time and for any reason. Such actions will be effective as of any date designated by the Company.

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

As a participant or beneficiary under this Plan, you have certain rights and protections as more fully described within the Statement of ERISA Rights on page 16. Other important information about the Plan is provided below.

ADDITIONAL INFORMATION

Name of the Plan:	The CITGO Petroleum Corporation Fire Fighting Accidental Death and Dismemberment Insurance Plan
Type of Plan:	Insured Welfare Plan
Plan Sponsor:	CITGO Petroleum Corporation 1293 Eldridge Parkway Houston, Texas 77077
Plan Sponsor's Employer Identification Number:	73-1173881
Plan Administrator:	Benefit Plans Committee – Secretary Attn: Benefits CITGO Petroleum Corporation 1293 Eldridge Parkway, N5063 1-888-443-5707
Plan Number:	544
Plan Initial Effective Date:	October 4, 1984
Plan Year:	January 1 – December 31
Funding:	The Plan benefits are provided by an insurance policy and the premiums paid to the Insurer are paid by the Company. Employees are not required to contribute to the cost of the plan
Insurer:	Life Insurance Company of North America 1601 Chestnut Street Philadelphia, Pennsylvania 19192-2235
Contract / Policy Number:	ABL 960804
Benefits HelpLine Phone:	1-888-443-5707
Email:	Benefits@citgo.com
Benefits Department:	CITGO Petroleum Corporation 1293 Eldridge Parkway Houston, Texas 77077 Telephone: 1-888-443-5707

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 Plan, you are entitled to certain rights and protections under 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 a copy of the latest annual report (form 5500 Services) filed by the Plan 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 Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administer 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 plan. 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 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 Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in 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 Plan's decision or lack thereof concerning the qualified status of a domestic relations order of medical child support order, 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 the 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.

DEFINITIONS

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

"Aircraft" means a vehicle that has a valid certificate of airworthiness and is being flown by a pilot with a valid license to operate the aircraft. For purposes determining whether an aircraft is "controlled" by the Company, the Company will be deemed to control an aircraft if the aircraft may be used as the Company wishes for more than 10 consecutive days or 15 days in any year.

"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.

"Conditions of Coverage" has the meaning set forth on page 4.

"Contingent Beneficiary" is the person(s) to whom a benefit will be paid in the event of your death if all Primary Beneficiaries die before or at the same time as you.

"Covered Accident" means a sudden, unforeseeable, external event that results, directly and independently of all other causes, in a Covered Injury or Covered Loss and occurs while the participant is covered by this Plan, occurs under one of the Conditions of Coverage, is not contributed to by disease, Sickness or mental or bodily infirmity and is not otherwise excluded under the terms of the Plan, including the Insurance that funds benefits provided by the Plan.

"Covered Injury" means any bodily harm that results, directly and independently of all other causes, from a Covered Accident.

"Covered Loss" means a loss or Injury listed in the *Schedule of Covered Losses* on page 5.

"Injury" means bodily harm that results, directly and independently of all other causes, from a Covered Accident.

"Insurer" means the insurance company who underwrites and issues the insurance policy the Company has purchased to fund the Plan. The insurance company may be changed from time to time.

"Plan" means the CITGO Petroleum Corporation Fire Fighting Accidental Death and Dismemberment Insurance Plan.

"Paralysis" means total loss of use. A physician must determine the loss of use to be complete and not reversible at the time the claim is submitted.

"Premises" means real estate owned, leased, controlled or under the management of the Company for the purpose of conducting its business.

"Primary Beneficiary" is the person(s) to whom a benefit will be paid in the event of your death.

"Severance" is the complete separation and dismemberment of the part from the body.

"Sickness" means a physical or mental illness, including pregnancy.

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.