The CITGO Petroleum Corporation Flexible Benefits Program for Salaried and Hourly Employees

Summary Plan Description

As in effect January 1, 2013

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PURPOSE

The CITGO Petroleum Corporation Flexible Benefits Program for Salaried and Hourly Employees (the "Plan") offers you a way to save money on premium costs and certain health care and dependent care expenses by paying for these expenses with pre-tax dollars. Through convenient payroll deductions, you may direct part of your salary to pay for your costs of welfare benefit premiums (including premiums for life insurance, health care, prescription, dental and vision benefits) on a pre-tax basis.

You may also direct part of your salary to pay for certain health care expenses which are not covered under the health plan in which you participate, to a so-called Health Care Spending Account ("Health FSA"). The Plan includes two types of Health FSAs – a General Purpose and a Limited Purpose Health FSA –depending on the type of health plan in which you participate.

The Plan permits you to direct part of your salary to pay for certain dependent care expenses, to a so-called Dependent Care Spending Account ("Dependent Care FSA"). The Plan also permits you to direct part of your salary to a Health Savings Account Contribution Option ("HSA Contribution Option"), if you establish a Health Savings Account ("HSA").

In this Summary Plan Description ("SPD"), the Health FSAs and the Dependent Care FSA are sometimes referred to together as "FSAs." The HSA Contribution Option is not an FSA, but permits contributions to be made to an HSA, which is a tax-favored savings account that can be used to pay for certain eligible medical expenses. The Premium Option, the FSAs and the HSA Contribution Option are sometimes referred to in this SPD as the "Options."

> **WELLNESS FLEX CREDITS AGAIN in 2013:** As in 2012, your employer will contribute to your General Purpose Health FSA or your HSA Contribution Account, as the case may be, if you are enrolled in a Company-sponsored medical plan and participate in and earn certain "wellness" benefits. Such employer contributions are referred to in this SPD as "Flex Credits." If your spouse is also enrolled in a Company medical plan, for you to earn Flex Credits, your spouse must also participate in and earn Flex Credits in order for you to be eligible to receive Flex Credits.

The Options and the Flex Credits are described in more detail later in this SPD.

In summary, there are 5 Options under the Plan:

- A Premium Option,
- Two Health FSA Options,
- A Dependent Care FSA Option, and
- An HSA Contribution Option.

If you are eligible and elect to participate in Company-sponsored welfare benefits, ***you will automatically be enrolled in the Premium Option***. You must be eligible for and elect to participate in all other Options.

During the year, as you pay for eligible expenses, you will be reimbursed for those expenses from your FSA accounts or your HSA, as the case may be.

The key is that the portion of your pay you direct to the Premium Option, an FSA and/or HSA is deducted on a pre-tax basis - in other words, before taxes are withheld. By using these funds to pay for eligible expenses, you are saving money by reducing your federal income and Social Security (FICA) taxes, as well as your state and local income taxes, in most cases. Less tax means more net take-home pay.

Certain restrictions and provisions in the current tax laws, such as the "use it or lose it" provision require that you forfeit any unused funds remaining in your FSA accounts by December 31 of the current plan year. Therefore, the FSAs should not be used as a place to save money in case of future need. However, if you are reasonably certain you will be paying for eligible health or dependent care expenses and services during the year, you can save money by using the Plan to pay for these expenses with pre-tax money.

The "use it or lose it" rule does not apply to funds in your HSA, which can be rolled over if they are not used during the year in which the funds are deposited into your HSA. For more information on HSAs, please see the Health Savings Account Reference Guide at www.HR.CITGO.com.

Please see the Definitions at page 56 for the meaning of capitalized terms which are not otherwise defined.

This SPD summarizes the benefits available under the Plan, as well as the Plan's limitations and exclusions. The SPD is not the Plan and in the event that the terms of the Plan document and the SPD conflict, the Plan governs. As a participant in the Plan, 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, as failure to comply may result in a penalty, a reduction in benefits, or even the denial of benefits.

ELIGIBILITY

Who is Eligible

You are eligible to participate in the Plan if you are on the U.S dollar payroll of the Company and:

(1) You are a Regular Full-Time Salaried Employee or a Regular Part-Time Salaried Employee; or

(2) You are a Regular Full-Time Hourly Employee or a Regular Part-Time Hourly Employee.

Who is Not Eligible

However, you are not eligible to participate in this Plan if you meet any of the following conditions:

(1) You are employed on any basis other than as a Regular Full-Time Salaried or Hourly Employee or Regular Part-Time Salaried or Hourly Employee of the Company (for example, a temporary or seasonal employee);

(2) 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;

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

(4) You are a member of a collective bargaining unit which has negotiated for a group medical, dental and prescription drug plan other than Company medical plans for salaried and hourly Employees.

(5) You are an hourly employee under probation who is carried on a temporary payroll of CITGO and covered by a collective bargaining agreement which provides for a probationary period of not more than one year;

(6) You are employed by a related company which has not adopted the Plan; or

(7) 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 Plan upon a final determination of your status as an employee.

Eligible Health Care Dependents

Qualified dependent(s) for the Health Care FSA include:

- Your spouse, if you are not legally separated; and
- Any person(s) you claim as a dependent on your federal income tax return for the year (except in certain cases of divorce or legal separation as explained below).

If you are divorced or legally separated, you may be able to use a Health Care FSA if you have custody of your child(ren) for most of the year – even if you do not claim the child as a dependent on your personal income tax return. In cases of divorce or legal separation, you should consult a competent professional tax advisor.

Eligible Dependents do not have to be enrolled as a dependent under any other Company-sponsored benefit plan in order for their eligible expenses to be paid from a Health Care FSA.

Eligible Dependent Care FSA Dependents

Qualified dependent(s) for the Dependent Care FSA include:

- Dependents eligible to be claimed on your federal income tax return (except in certain cases of divorce or legal separation as explained below); and
- Must be
  - Under age 13; or
  - Age 13 or older *and* physically or mentally incapable of self-care, living in your household at least eight hours each day.

If you are divorced or legally separated, you may be able to use a Dependent Care FSA if you have custody of your child(ren) for most of the year – even if you do not claim the child as a dependent on your personal income tax return. In cases of divorce or legal separation, you should consult a competent professional tax advisor.

PARTICIPATION

Premium Option

If you participate in the Plan, your costs of premiums for Company-sponsored welfare benefits (including life insurance, health, prescription, dental and vision benefits) will be paid on a pre-tax basis without any need to elect the amount of such premiums. Your employer will announce each year which taxable welfare benefits are eligible to be paid on a pre-tax basis through the Premium Option. If you enroll in the Plan, the applicable amount will be deducted from your compensation automatically by your employer and used to pay for such premiums for those welfare benefits in which you elect to participate.

General Purpose Health Care FSA Option

You are eligible to participate in the General Purpose Health Care FSA provided you and your Dependents meet the eligibility guidelines, see "*Eligibility*," page 3, and you do not elect to participate in the Self-Directed Health Plan option for your medical benefits.

Limited Purpose Health Care FSA Option

You are eligible to participate in the Limited Purpose Health Care FSA provided you and your dependents meet the eligibility guidelines, see "*Eligibility*," page 3, and you elect to participate in the Self-Directed Health Plan Option for your medical benefits. If you elect to participate in a Health Care FSA and enroll in the Self-Directed Health Plan, your Health Care FSA election will automatically be converted to a Limited Purpose Health Care FSA.

HSA Contribution Option

If you enroll in the Self-Directed Health Plan for your medical benefits, you may wish to consider electing to make level, payroll-period contributions to a related HSA on a pre-tax basis under the Plan. Neither the HSA nor the HSA Contribution Option is sponsored by your employer and are not a covered by the Federal law known as the Employee Retirement Security Act of 1974, as amended ("ERISA"). However, if you elect the HSA Contribution Option, your employer will contribute pre-tax dollars from your salary directly to your HSA established with your HSA custodian.

Your annual contribution to an HSA must be at least $100, but no less than the annual limits announced by the IRS, which in 2013 are $3,250 for individuals and $6,450 for a family (plus an additional $1,000 if you are age 55 or older). For more information about HSAs and their relationship to the Self-Directed Health Plan, see the Health Savings Account Reference Guide at www.HR.CITGO.com.

Dependent Care FSA Option

To be eligible to participate in the Dependent Care FSA, you and your spouse must meet the following guidelines:

- You pay for day care expenses so that you can work; and
- Your spouse must be:
  - A wage earner, or
  - A full-time student for at least 5 months during a calendar year; or
  - Physically or mentally disabled and unable to provide self-care or care for family members.

Reimbursement for Eligible Expenses

If you are eligible and elect to participate in FSA Options, you can receive reimbursement for eligible expenses according to the following guidelines:

- Reimbursement from a Health Care FSA - for eligible expenses incurred during the portion of the Plan Year in which you are an eligible Active Participant.
- Reimbursement from a Dependent Care FSA - for eligible expenses incurred at any time during the Plan Year after you begin participation (if there are funds available in your account). This applies even if your participation ceased at some time during the Plan Year.

Your FSA elections – including an election not to participate – are in effect for the entire Plan Year and cannot be changed until the next Annual Election Period unless you have an eligible Status Change (page 15) or Change in Family Status (page 16).

ENROLLMENT

Coverage Options

The Plan provides you a way to save money on certain premium, health care and dependent care expenses by setting aside part of your pay on a pre-tax basis. Your Plan options are the:

- Premium Option
- General Health Care FSA Option
- Limited Health Care FSA Option
- Dependent Care FSA Option
- HSA Contribution Option

When to Enroll

Regular Enrollment

You may enroll in the Plan within 31 days of your employment date, or within 31 days of the date you first become eligible for the Plan (if later). You must enroll separately in a Health Care FSA, a Dependent Care FSA, and/or the HSA Contribution Option. You must complete, sign, date and return your enrollment form to your Authorized Company Representative. You can obtain the proper enrollment form from the Benefits HelpLine.

If you choose not to participate in the Plan on the date you first become eligible, you cannot participate in the Plan until the next calendar year, unless you have a mid-year Status Change, page 15, or Change in Family Status, page 16.

Late Enrollment

If you wish to enroll for participation in the Plan:

- More than 31 days after your employment date;
- More than 31 days after first becoming eligible to enroll (if later); or
- If you were enrolled in the Plan, subsequently waived your coverage and wish to re-enroll,

you may enroll:

- Within 31 days after a qualified Status Change (see page 15), or Change in Family Status (see page 16); or
- During the next Annual Election Period.

You are not permitted to enroll at any other time.

Annual Election Period

Each year during a specified time period, you will have the opportunity to elect or decline participation in one or more of the Plan Options and designate the amount of the monthly contribution you wish to be deducted from your paycheck tax-fee. This period is the Annual Election Period. Changes elected during this period will be effective for the following Plan Year (January 1 - December 31).

Each year during the Annual Election Period, you must decide if you want to participate in the Plan for the coming year. If you enroll in the Plan, your enrollment applies only for a single Plan Year. **Therefore, regardless of whether you participated in the Plan for the previous year, you must re-enroll if you want to enjoy the benefits of the Plan in the coming year.** The only exception involves the Premium Option, discussed below.

The Annual Election Period allows you to re-evaluate your and your Dependents' needs for the coming year and adjust the level of your directed salary amounts accordingly. If you are currently a participant in a FSA and/or an HSA Contribution Option and do not submit a completed enrollment form by the end of the Annual Election Period, it will be assumed you do not want to participate in the Plan for the upcoming year. In this case, your Plan participation will end on December 31 and no further FSA contributions would be withheld from your paycheck. Note however, that if you were previously enrolled in the Plan and elected to participate in a taxable welfare plan benefit (such as life insurance, healthcare, prescription, dental or vision benefits) for the next Plan year, your participation in the Plan under the Premium Option will be automatically continued, without your need for any further election. If your Plan participation ends, you cannot participate in the Plan again until the following year.

Effective Date of Participation

If you enroll within 31 days of first becoming eligible (Regular Enrollment), your participation will begin on your date of hire or the date you are transferred to an eligible class of employee. Your contributions will begin on the first day of the month following the effective date. You must be receiving a check from the Company payroll department in a sufficient amount to cover your Plan contributions.

If you elect to participate during the Annual Election period, your participation is generally effective January 1 of the new Plan Year if you are in employment and receiving a check from the Company payroll department in sufficient amount to cover your Plan contributions. If you are not receiving a check from the Company and are on leave of absence or absent due to short-term disability or long-term disability during the Annual Election Period, see "*Absences,*" page 32.

Your participation will end on December 31 of that year, unless you elect to participate in an eligible welfare plan benefit and are automatically enrolled in the Premium Option. Remember, to participate in an FSA or the HSA Contribution Option in the following year, you must complete and return a new enrollment form by the end of the Annual Election Period.

DESCRIPTION OF BENEFITS

Tax Advantages

By participating in the Plan, you can direct a portion of your pay, before taxes are withheld, to one or more Options. Because these amounts are directed to the Options you elect before taxes are withheld, they are not subject to federal income and Social Security (FICA) taxes and, in most cases, are also exempt from state and local income taxes. The nature and extent of the tax-exempt status of the amounts directed to your Options are governed by applicable tax laws.

By directing a portion of your pay to one or more Options, you can use the funds in the appropriate account for pre-tax reimbursement of certain eligible expenses. By paying for these expenses with pre-tax dollars, you may realize several significant advantages over paying for these same expenses on an after-tax basis.

For an estimate of how you may achieve tax-savings by using Plan Options, see the Tax Information Flexible Spending Account at www.HR.CITGO.com.

Health Care Expenses

The current federal tax laws allow you either to pay for certain out-of-pocket health care expenses through the applicable FSA or to claim those expenses as an itemized deductions on your tax return. However, if:

(1) You itemize your deductions in order to claim these expenses on your income tax return, or

(2) Your eligible healthcare expenses are over 7.5% of your adjusted gross income.

then you may not participate in a Health Care FSA.

Since the Company-sponsored medical plans (or other health plan) reimburse you for a portion of your health expenses, most employees never incur enough out-of-pocket expenses to deduct them on their tax return. Remember, you can either itemize your out-of-pocket health care expenses on your tax return or have them reimbursed on a pre-tax basis through a spending account, but not both.

The following example illustrates the financial impact participation in a Health Care FSA may have on your take-home pay.

Example:

Tax Savings Through Use of the Health Care FSA

Let's assume these are two identical employees. Both are married and claim four tax exemptions. The only difference is that one pays for health care expenses on an after-tax basis, the other on a pretax basis through a Health Care FSA.

	Without FSA	With FSA
Annual Base Pay:	$42,000	$42,000
less Pre-tax Health Care Expenses:	- 0	- 3,000
Taxable Wages:	$42,000	$39,000
less Federal Withholding Tax:	- 2,928	- 2,496
less Social Security Withholding:	- 3,213	- 2,984
Gross Take-Home Pay:	$35,859	$33,520
less After-Tax Health Care Expenses:	- 3,000	- 0
Net Take-Home Pay:	$32,859	$33,520
Increase in Take-Home Pay:		$ 661

General Purpose Health Care FSA Option

It's never easy to plan your health care expenses over any given period -- unexpected illnesses, injuries and other events are always possible. However, you probably have some recurring out-of-pocket health care expenses that are not covered in full under your group health plan or other insurance. You should be able to get a good indication of what these recurring expenses are by reviewing your expenses in each of the past two or three years.

In determining the amount you elect, remember that over-the-counter medicines are not eligible for reimbursement through the General Purpose Health Care FSA (see page 10), unless prescribed by a physician. An exception is the cost of insulin, which is an eligible expense.

In addition to looking at past expenses, look to the future and anticipate what expenses you will be incurring during the Plan Year, such as the birth of a baby, new eyeglasses, planned surgical procedures, etc. Because the tax laws mandate that any unused funds in your account by December 31 of the current plan year (see "*Forfeitures*," page

31), you should be conservative when deciding how much you want to direct to the Plan for the General Purpose Health Care FSA.

Limited Purpose Health Care FSA

If you participate in the Company's Self-Directed Health Plan for your medical benefits and also elect to contribute to a Limited Purpose Health FSA, the eligible expenses that can be reimbursed from that account are limited to vision care, dental care and/or preventative care. If you participate in the Self-Directed Health Plan and elect to contribute to a Health Care FSA, you will automatically be enrolled in the Limited Health Care FSA.

As a result, you should base your Limited Health Care FSA Option election on the amount of unreimbursed vision care, dental care and/or preventative care expenses you anticipate that you and your covered dependents will incur during the Plan Year.

Dependent Care FSA Option

Under current tax laws, a federal child and dependent care tax credit may be available to you on your income tax return. The amount of credit available is based on your adjusted gross income. In using the credit for 2013 (under current law), you may claim up to $2,400 in eligible dependent care expenses per year for one dependent, and up to $4,800 per year for two or more dependents.

Expenses reimbursed to you under the Dependent Care FSA may not be claimed for tax credit purposes on your income tax return. In addition, if you are reimbursed for dependent care expenses up to or over the expense limits imposed by the federal tax credit ($2,400 for one dependent), you may not claim the tax credit on your income tax return.

In other words, in most cases you can either pay for eligible dependent care expenses through the Dependent Care FSA or claim them in the federal tax credit on your income tax return, but not both. Under the Dependent Care FSA, the dollar limits are higher - up to $5,000 for eligible expenses, for one dependent. This difference makes it possible, in most cases, for you to save more under the FSA.

Under the current multi-tier federal income tax system, if you fall into a low tax bracket (e.g. 15%), generally you may realize greater savings by using the federal tax credit. Otherwise, you are more likely to realize greater tax savings using the Dependent Care FSA to pay for dependent care expenses.

As a result, you may want to consult with a professional tax advisor to help you determine whether participating in the FSA or claiming the federal tax credit would be best for you.

The following example illustrates the financial impact participation in the Dependent Care FSA may have on your take-home pay.

Example:

Tax Savings Through Use of the Dependent Care FSA to Pay for Eligible Dependent Care Expenses

Let's assume these are two identical employees. Both are married and claim four tax exemptions. The only difference is that one pays for dependent care expenses on an after-tax basis, the other on a pretax basis through the Dependent Care FSA.

	Without FSA	With FSA
Annual Base Pay:	$42,000	$42,000
less Pre-tax Health Care Expenses:	- 0	- 5,000
Taxable Wages:	$42,000	$37,000
less Federal Withholding Tax:	- 2,928	- 2,208
less Social Security Withholding:	- 3,213	- 2,831
Gross Take-Home Pay:	$35,859	$31,961
less After-Tax Health Care Expenses:	- 5,000	- 0
Net Take-Home Pay:	$30,859	$31,961
Increase in Take-Home Pay:		$ 1,102

Note: The employee who paid for dependent care expenses on an after-tax basis may be eligible to claim the federal child and dependent care tax credit, but only for expenses up to $2,400 (in 2013 and under current law) for one dependent.

Evaluating and Planning

Before you decide to take advantage of the tax savings available under the Dependent Care FSA, honest evaluation of your past and current health and dependent care needs and expenses, balanced with careful planning of anticipated expenses is strongly encouraged. These steps are important due to the nature of the Dependent Care FSA (a tax-planning tool) and the conditions imposed upon your participation by the current tax laws.

The tax laws are very specific as to how much you and your spouse can direct to a Dependent Care FSA, what types of expenses are considered eligible for reimbursement, and what happens to any unused funds at the end of the Plan Year. Therefore, you should only consider participating in the Dependent Care FSA if you are reasonably certain about the types of expenses you would have (health or dependent care) and how much these eligible expenses will be for the year. You may want to consult with a professional tax advisor.

Dependent Care FSA Option

Usually, evaluating and planning your dependent expenses for a 12-month period is not difficult. Most dependent care situations are structured around a continual need and a regular payment schedule.

When determining how much you would like to contribute to a Dependent Care FSA, remember to take into consideration holidays, vacations, and other situations when dependent care expenses might be lower. Also keep in mind your dependent child's 13th birthday when dependent care expenses are no longer eligible for reimbursement. Again, because of the "use it or lose it" provisions of the current tax laws (see "*Forfeitures*," page 31), it's best to be conservative when deciding on the amount you want to direct to the Dependent Care FSA.

YOUR CONTRIBUTIONS

Your contributions are deducted from your pay before appropriate taxes are withheld. This amount is directed to your applicable Plan Options and then is used to reimburse you for eligible out-of-pocket expenses.

You are not required to pay federal income taxes and, in most cases, state and local taxes on your directed salary amount. If you are earning less than the maximum taxable wage base for Social Security, you will also pay less Social Security taxes.

When you enroll in the Plan, you must be sure to indicate the total amount you want directed to the FSA for the year and how much of that total should be directed to each account. Remember that you have the option of contributing to the applicable Health Care FSA, the Dependent Care FSA, or both. The amount of your pay that can be directed to each account for 2013 is listed below.

Option	Minimum	2013 Maximum
Premium Option	Actual Amount	Actual Amount
General Health Care FSA	$10/month	$208/month (up to $2,500/year)
Limited Health Care FSA	$10/month	$208/month (up to $2,500/year)
Dependent Care FSA (see "*Dual Coverage and Limits"* on page 18)	$10/month	$208/month (up to $2,500/year if married filing a separate return); or $417/month (up to $5,000/year if married filing a joint return or if filing as single head of household)
HSA Contribution Option (under age 55)	$10/month	$271/month (up to $3,250 annually) for an individual; or $538/month (up to $6,450 annually) for a family

Contributions for participation that becomes effective after January 1 of any Plan Year are subject to the Option's *monthly* maximum and minimum, not the annual maximum and minimum.

Payroll Deduction of Contributions

Pre-tax payroll deductions for Plan contributions are divided evenly between your first and second paychecks in each month. Your deductions will begin the first of the month following the date your participation begins. The amount of your pre-tax deductions will then be deposited into your Options.

Employer Flex Credits – AGAIN IN 2013

Your employer may from time to time announce that employer contributions or "Flex Credits" are available to be earned to fund the costs of premium payments or FSAs. For 2012, your employer has established various "wellness" incentives to promote health awareness, known as Healthy Rewards. The terms and conditions of the Healthy Rewards are described in the Healthy Rewards brochure, which is online at www.HR.CITGO.COM under the Healthy

Rewards "tab" and in your open enrollment materials (the terms of which are incorporated into this SPD). You should consider the amount of Healthy Rewards incentives you hope to earn in setting your annual FSA or HSA Contribution election amount.

Employer Flex Credits which you earn are automatically deposited by the employer in your General Health Care FSA or, if you participate in the Self-Directed Health Plan Option and maintain an HSA, into your HSA. If you participate in the Self-Directed Health Plan Option and do not maintain an HSA, you will not receive any Flex Credits. If the maximum amount of your HSA contributions exceeds the annual contribution limit, you will not receive any Flex Credits. It is your responsibility to determine that the amount of the contributions you make to your HSA, together with the amount of Flex Credits you intend to earn, will not exceed the annual contribution limit.

Changes in Your Contributions

The funds in your FSAs are deducted on a pre-tax basis. The Internal Revenue Service places limitations on plans with tax-free deduction provisions and certain limitations apply to changing your election during the Plan Year.

Your applicable Health Care FSA elections cannot be changed during the Plan Year without an eligible Status Change (see below) and in no circumstance may the deductions be decreased below the amount that reimbursements exceed year to date contributions. Your Dependent Care FSA election cannot be changed during the Plan Year without an eligible Change in Family Status (see page 16). Any change in your FSA election must meet three conditions. It must:

- be consistent with the change;
- apply to the specific person or situation affected by the change; and
- be made within 31 days of the date the change event occurs. If you do not change your election within 31 days of the change event, you will not be eligible to make the change.

As an example: Tom has a new baby born into his family on July 1, 2012. He previously elected a Health Care FSA with $100 per month contribution. Between July 1, 2012 and July 31, 2012, Tom may elect to continue at the same level or increase his contribution (due to increased health expenses of a new Dependent), but could not decrease or discontinue the monthly contribution amount.

Status Change for Applicable Health Care FSA

Any of the following conditions will constitute an eligible Status Change that may allow you to make a change to your applicable Health Care FSA during a Plan Year:

- Your marriage;
- Your divorce, legal separation or annulment;
- Death of your spouse or Dependents;
- Birth, adoption or placement for adoption of your Dependents;
- You, your spouse or Dependent begins or ends employment;
- You, your spouse or Dependent changes residence or worksite;
- You, your spouse or Dependent changes work schedule (i.e. reduction in hours,
- You experience an increase in hours, strike or lockout, commencement or return from unpaid leave of absence);

- You, your spouse or Dependent changes from part-time to full-time employment or vice versa;
- You acquire a Dependent that was not eligible for coverage during the Annual Election Period and later becomes eligible during a Plan Year;
- Your spouse or your child is no longer an eligible Dependent under the terms of the Plan (see "*Dependent Eligibility*");
- You or your Dependents lose health coverage from your spouse's employer;
- A court order is issued resulting from a divorce, legal separation, annulment, or change in legal custody that requires health coverage for your Dependent;
- You become entitled or lose entitlement to Medicare/Medicaid; or
- Any event as determined by the Committee which is not inconsistent with laws and regulations applicable to the Plan.

You also may be eligible to make a change in accordance with provisions of the Family and Medical Leave Act (FMLA) or the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Any change in your election must be consistent with the Status Change, must apply to the specific situation affected by the Status Change, and must be made within 31 days of the change event.

Example: *Eligible to Change Election*

During the Annual Election Period, James elects a Health Care FSA. In the following Plan Year, he marries and wishes to increase his coverage. James can increase his Health Care FSA election because his change is consistent with his Status Change. He would not be able to decrease or discontinue his contributions. He must make his change within 31 days of his marriage.

Example: *Not eligible to Change Election*

During the Annual Enrollment Period, Shelly elects a Health Care FSA. During the following year, she wants to cancel her coverage to reduce her expenses. Since this is not an eligible Status Change, she will not be able to change her election.

Change in Family Status for Dependent Care FSA

If you have an eligible Change in Family Status, you can make the following changes to your Dependent Care FSA:

- You can start this account;
- You can increase your contributions to this account;
- You can decrease your contributions to this account; or
- You can cancel all future contributions to this account.

Any of the following conditions will constitute an eligible Change in Family Status that may allow you to make a change to your Dependent Care FSA during a Plan Year:

- Your marriage;
- Your divorce, annulment or legal separation;
- Death of your spouse or Dependent;

- Birth, adoption or placement for adoption of your Dependent;
- Your spouse begins or ends employment;
- You acquire a Dependent who was not eligible for coverage during the previous Annual Enrollment Period but later became eligible during the calendar year;
- Your spouse or your child is no longer an eligible Dependent under the Dependent Care FSA;
- You or your spouse change from part-time to full-time employment or vice-versa;
- You lose coverage from your spouse's employer;
- You change your dependent care service provider or otherwise change the coverage (such as increasing or decreasing the number of hours of work performed by the provider); or
- You experience a significant cost increase imposed by a dependent care provider who is not your relative.

Also, if you have elected to participate in a Dependent Care FSA and the dependent care service provider changes cost of services mid-year or refuses to continue care of your Dependent, you would be allowed to make a change to your election that is consistent with this Change in Family Status.

Special Rules for your HSA Contribution Option

You can prospectively elect, change or revoke your election to make HSA contributions no more than once per month. However, if you become ineligible to contribute to an HSA, you may prospectively revoke your election at any time.

Effective Date of Changes

Changes in your FSA and your HSA Contribution Option will be effective as of the date of the event which made you eligible for the change. The changed level of your contributions will be effective on the next pay period following the date of the election notification (within 31 days of the eligible status change). Any change in your contributions to the Plan resulting from the changing of coverage will be applied as follows:

Notification of Change occurs:	1st day of month	2nd – 15th	From 16th through last day of month
Change in contributions begin	first pay period of the following month	first pay period of the following month	first pay period of following month

Example: *Change Effective Date*

Steve is participating in both a Health Care FSA and a Dependent Care FSA. On March 5, Steve's second child is born. Steve immediately elects to increase his contributions to each FSA by $50 per month. The new deductions will start on April 1. Health care or dependent care expenses incurred for the new baby on or after March 5 will be eligible for reimbursement.

Dual Coverage and Limits

While the Plan places minimum and maximum limits on the amounts you may direct to your FSA accounts, other restrictions also apply.

If both you and your spouse are employees of the Company, you and your spouse may each direct up to $2,500 to the applicable Health Care FSA. However, only one of you may direct an amount up to the $5,000 maximum to the Dependent Care FSA. The maximum amount of your Health Savings Account contribution is announced annually by the IRS and for 2013 is $3,250 for individuals and $6,450 for a family (plus an additional $1,000 if you are age 55 or older).

In addition, the tax laws place limits on the combined amount you and your spouse may direct to Dependent Care FSAs available at your respective places of employment. If you participate in the Company's Plan and your spouse participates in a Dependent Care FSA at his or her place of employment, the total combined amounts you and your spouse can direct is limited to $5,000 for dependent care expenses.

Example:
Combined Family Limits

Let's assume you and your spouse are employees of the Company and each participates in the FSAs. To take full advantage of the Plan, you may both direct the maximum amount to your respective Health Care FSA, but only one of you may direct an amount (up to $5,000) to the Dependent Care FSA.

	Health Care	Dependent Care	Total
You	$5,000	$5,000	$10,000
Your Spouse	5,000	0	5,000
Total	$10,000	$5,000	$15,000

The tax laws also prohibit you and your spouse from directing amounts to the Dependent Care FSA in excess of the lesser of your or your spouse's pay regardless of which one of you opens the account. For example, if your pay is $35,000 and your spouse's pay is $4,000, the maximum you could direct to the dependent care account would be $4,000.

There are further restrictions under the Internal Revenue Code if your spouse is a full-time student or is unemployed due to a physical or mental disability. To determine the amount you are permitted to direct to the Dependent Care FSA in this case, the law assumes your spouse to have a monthly pay of $250 if you have one dependent child, or $500 if you have two or more dependent children. Therefore, the maximum amount you would be permitted to direct to the Dependent Care FSA would be $3,000 ($250/month x 12 months) if you have one child, or $6,000 ($500 x 12 months) if you have two or more children.

ELIGIBLE EXPENSES

As described earlier in this summary, the Health Care FSAs and the Dependent Care FSA Options are separate from each other in both purpose and function.

At the time you enroll in the Plan, you must indicate how much you wish to direct to the Plan and to each account. The choices you make when you enroll are irrevocable for the year. For example, during the year you may not redirect the amount designated on your enrollment form for the applicable Health Care FSA to the Dependent Care FSA, or vice versa, for any reason.

In addition, funds in your Health Care FSA may not be used to pay for dependent care expenses. Similarly, funds in your Dependent Care FSA cannot be used to pay for health care expenses. If you have excess funds in either account at any time, you may not transfer those funds from one account into the other.

Period for Incurring Expenses

To be eligible for reimbursement from a Health Care FSA, expenses must be incurred – this means that the service must be performed – from January 1st through December 31st, during which you were an Active Participant in the Plan. Payments in advance, even if contractually due, are not eligible for reimbursement until the service is performed (orthodontia expenses are handled differently – see below for details). Services performed prior to the date your participation began are not eligible for reimbursement.

If you began participation in the Health Care FSA on January 1 and terminated from employment May 31, you can submit Withdrawal Requests for eligible expenses incurred from January 1 through May 31. You may be able to continue your participation on an after-tax basis when you terminate from employment if you are eligible to elect COBRA Continuation of Coverage (see page 37).

Health Care FSA

Eligible Health Care Expenses for General Purpose Health Care FSA

By choosing to direct a portion of your pay to a Health Care FSA, you are able to pay for eligible health care expenses with pre-tax dollars.

Only expenses for goods bought or services incurred during the portion of the Plan Year in which you are an Active Participant of the General Purpose Health Care FSA are eligible for reimbursement. You are only reimbursed for the expenses that are not covered or fully paid by the Company's medical, prescription, vision, dental benefits programs or by any other group health care plan that covers you or your dependents. These expenses include your deductibles, co-payments and other out-of-pocket expenses under the health care plans.

The following list contains sample expenses that may be reimbursed under the Health Care FSA Option. The list is not all inclusive:

- Medical, prescription, vision and dental benefit program deductibles and co-payments;
- Routine physicals;
- Over-the-counter medical items are reimbursable only if you receive a written prescription from your physician to treat a specific medical condition. The physician's prescription or letter of medical necessity must cite the specific medical condition being treated and indicate that the over-the-counter drug or medication will treat or alleviate it.
- Insulin (no prescription required)
- Eye examinations, eyeglasses, and contact lenses;
- Hearing examinations and hearing aids; and
- Any eligible medical/dental expenses in excess of any group medical and/or dental limitations or maximums, such as:
    - Dental care
    - Orthodontic services;
    - Treatment for mental and /or nervous conditions;
    - Treatment of substance abuse;
    - Weight reduction programs if medically necessary;
    - Home health care;
    - Skilled nursing;
    - Smoking cessation prescriptions not covered under the Company's medical plan in which you participate; and
- Any other expenses that the Claims Administrator determines are eligible under applicable law and within regulatory guidelines.

Health Care Expenses Not Eligible

The following is a partial list of health care expenses that are not eligible for reimbursement through the General Purpose Health Care FSA. You may not use this account to be reimbursed for:

- Expenses incurred before January 1st of the plan year or after December 31st of that plan year.
- Expenses without proper documentation; or
- Any expenses other than those listed in the section "*Eligible Health Care Expenses*" on page 19. Examples of ineligible expenses include, but are not limited to:
    - Capital improvements to your home that do not have an exclusive health reason, such as a swimming pool or spa;
    - Utilities to run machinery;
    - Air cleaner or duct cleaning for allergies;

- Cost associated with meals and lodging for medical treatment;
- Cosmetic medical or dental surgery or procedures;
- Health club dues;
- Over-the-counter medicine or supplies that is merely beneficial for general health. Examples include:
    - Bath products, cleansers, and soap;
    - Creams, lip balm, lipstick, lotions, and moisturizers;
    - Deodorants / Anti-Perspirants;
    - Feminine Hygiene;
    - Foot Care products;
    - Hair care products;
    - Hair removal products;
    - Medicine dispensers;
    - Powders;
    - Shaving and grooming products;
    - Snoring aids;
    - Stimulants (to stay awake);
    - Sunscreen, sunless tanning and after sun products;
- Insurance premium payments for health care coverage under any health care plan; and
- Legal fees.

Expenses which would otherwise be excluded may be treated as eligible expenses if the Claims Administrator has determined that the expenses are eligible under applicable law and under the most current regulatory guidelines.

Limited Purpose Health Care FSA Option

The eligible expenses that can be reimbursed from your Limited Purpose Health Care FSA Option are limited to vision care, dental care or preventative care. Aside from that limitation, the general rules applicable to eligible expenses under the General Purpose Health FSA also apply to the Limited Purpose Health FSA, e.g., the restriction on no reimbursement of over-the-counter drugs or medicine without a prescription (other than insulin).

Orthodontia Expenses: Orthodontia services are billed differently than other medical expenses and, therefore, are reimbursed from your Health Care FSA differently. Claims for orthodontia services will be reimbursed upon proof of payment, regardless of the actual date of service, as long as it falls within the Plan Year. For example, some orthodontists may offer a discount if the participant pays for services up front, rather than making monthly payments.

Example: *Orthodontia*

Pete's child is diagnosed as needing braces. The total cost of the procedure is $3,200 for 18 months of treatment. The orthodontist will give a 15% discount if the full amount of the cost is paid up-front. Pete pays $2,720 before his child begins treatment in order to receive the discounted price. Pete participates

in the Health Care FSA and can be reimbursed immediately for the full $2,720. (This example assumes NO dental insurance coverage).

Dependent Care Expenses

Eligible Dependent Care Expenses

If you choose to direct a portion of your pay to the Dependent Care FSA, you will be able to pay for eligible child and adult dependent care expenses with pre-tax dollars.

Expenses eligible for reimbursement from your Dependent Care FSA are those expenses for dependent care services which allow both you and your spouse (if you are married) to be gainfully employed and actively at work. If you are married and your spouse does not work, you may not direct amounts to the Dependent Care FSA unless your spouse is either a full-time student for at least five months during the year or is disabled.

Expenses for services incurred at any time during the Plan Year after you begin participation in the Dependent Care FSA are eligible for reimbursement (if there are funds available in your Dependent Care FSA). This applies even if your participation ceased at some time during the Plan Year.

Qualified dependent care expenses do not include those dependent care expenses which are not related to allowing you or your spouse to work; for example, expenses for an evening or weekend baby-sitter (unless business related), or expenses for a baby-sitter while you are on vacation.

To be considered for reimbursement from this account, an expense must be for the care of:

- Your Dependent under age 13, or
- Your spouse or Dependents of any age that you claim on your federal income tax return, who live in your home at least eight hours each day and who are physically or mentally incapable of self-care.

The following expenses may be reimbursed under the Dependent Care FSA:

- Child care, babysitting services, or adult day care inside your home or someone else's home;
- Licensed day care center or nursery school that meets federal and state requirements;
- Before-school and after-school care;
- The costs for household help, if the services are provided primarily for dependent care;
- Summer day camp (not overnight camp) as long as no significant educational services are provided; and
- Any other expenses that the Claims Administrator determines are eligible under applicable law and within regulatory guidelines.

Dependent Care Expenses Not Eligible

Certain expenses are not eligible for reimbursement under the Dependent Care FSA. Such ineligible expenses include, but are not limited to:

- Expenses incurred before the start of the Plan year or after December 31st of the same Plan year;
- Dependent care expenses not related to work;

- Dependent care expenses which you also claim as a tax credit on your federal income tax return;
- Dependent care services provided by your child who is over the age of 13 or by someone you claim as a dependent on your federal income tax return;
- Kindergarten tuition.
- Housekeeping expenses not related to dependent care;
- Food, clothing, or health care expenses for your Dependent(s);
- Transportation expenses between your home and the place your Dependent receives care;
- School costs such as tuition, books, and uniforms;
- Overnight camp; or
- Expenses without proper documentation.

Expenses which would otherwise be excluded may be treated as eligible expenses if the Claims Administrator has determined that the expenses are eligible under applicable law and under the most current regulatory guidelines.

Dependent Care Incurred Expenses

To be eligible for reimbursement from the Dependent Care FSA, expenses must be incurred–this means that the service must be performed–during the applicable Plan Year. Services performed prior to the date your participation began are not eligible for reimbursement.

If you began participation in the Dependent Care FSA on January 1 and terminated from employment April 30, you could submit Withdrawal Requests for eligible expenses incurred from January 1 through December 31. You may be eligible to submit a Withdrawal Request for eligible expenses after participation ends if you and your Dependents continue to meet the eligibility criteria of the Plan (see page 3).

Example: *Incurred Expenses*

Jane's child is attending the Kinder Care Day Care Center. On January 4, Jane paid the provider $100 for taking care of her child the last week of December and $100 for the first week of January. Jane is eligible to file for reimbursement from her Dependent Care FSA for the portion of the payment that covers services performed the first week of January. The portion of the payment that covered the services performed the last week of December was prior to the effective date of Jane's participation in the Dependent Care FSA and, therefore, is not eligible for reimbursement.

Example: *Eligible Dependent Care Expenses*

Chad's children, Jake and Casey, are in Koala Care Preschool so that his spouse, Amy can attend school full time. On April 30, Chad terminates employment with the Company and begins employment with an unrelated company. Day care expenses for Jake and Casey incurred in May will be eligible for reimbursement because they were incurred so that Chad could work and Amy could attend school. Even though the expenses were incurred after Chad's termination of employment, the expenses were eligible because they were incurred in the same plan year.

REIMBURSEMENT/CLAIMS PROCEDURES

Reimbursements

For reimbursement of eligible health care and dependent care expenses, you must submit to the Claims Administrator:

(1) a Withdrawal Request form for reimbursement, in accordance with instructions specified on the form. You can obtain the Withdrawal Request form by calling the Benefits HelpLine, or you can access it online through the CITGO intranet or at http://www.hr.CITGO.com under Forms; and

(2) proper documentation showing proof of the expenses incurred or services rendered (e.g., bill, receipt, invoice, canceled check, or an Explanation of Benefits (EOB) from any medical/vision/dental plan under which you are covered).

If your Withdrawal Request is properly completed and your expenses are eligible, you will receive reimbursement. Only expenses incurred during the Plan Year in which you participate are eligible for reimbursement; however, requests for reimbursement will be accepted and processed through March 15 of the following Plan Year, regardless of whether you elect to participate in the Plan in the following year.

Minimum Reimbursement

The amount of your reimbursement must total $25 or more. The $25 minimum reimbursement rule is waived during the filing period from January 1 through March 15 following the Plan Year, in order to clear your account.

Automatic Rollover

UnitedHealthcare is the Claims Administrator of the General Purpose Health Care FSA and is also the claims administrator for the Company medical and vision plan. Under Automatic Rollover, when a provider or participant files a medical or vision claim with UnitedHealthcare Vision for reimbursement or with CIGNA for dental, the unpaid portion of the allowable charges is forwarded to the Claims Administrator's FSA Department for reimbursement. The unpaid portion includes your out-of-pocket vision, dental or medical expenses including prescription drug costs. The participant will receive the applicable amount from their General Health Care FSA without having to file a Withdrawal Request for the reimbursement. The Automatic Rollover feature is beneficial to you if you are covered by the Company's medical, prescription, dental, vision benefit programs and no other group health care plan.

Example: *Automatic Rollover*

Jim goes to the Emergency Room and pays his $100 co-payment. The provider files the claim with UnitedHealthcare for reimbursement. UnitedHealthcare applies the contract amount to the claim and reimburses the provider the contracted amount less Jim's $100 co-pay. UnitedHealthcare then applies the claim against Jim's General Purpose Health Care FSA. Jim is automatically issued a check for $100 to reimburse him for his co-pay.

You will be automatically enrolled in the Automatic Rollover provision when you enroll in the General Purpose Health Care FSA.

If you do not want to participate in the Automatic Rollover, then you must call UnitedHealthcare at 1-866-317-6359, after you become eligible or after January 1 of each year to turn off this feature. If you or your dependents are covered under any other group health care plan, you should not use the Automatic Rollover option. If this is the case, please call UnitedHealthcare and make sure you turn off this feature.

Direct Deposit

You may elect to have your FSA reimbursements directly deposited to your bank account by enrolling in direct deposit online at http://www.myuhc.com. This will give you easier access to your money. You can also update or change your bank account information or cancel direct deposit at http://www.myuhc.com.

Health Care Reimbursements

To qualify for reimbursement of an eligible health care expense under a Health Care FSA, the expense must be for you, your spouse or an eligible Dependent and must meet all conditions in the current tax laws. The expense must also be for goods purchased or services provided during the portion of the plan year in which you were an Active Participant.

Under both Health Care FSAs, you can be reimbursed for eligible health care expenses up to the amount you set aside for the plan year less any amounts already reimbursed. This means that the full amount of contributions you elected to set aside to this account is available for your use at any time during the year, regardless of whether the actual balance in your account can cover the expense provided your monthly contributions have not been stopped.

Example: General Purpose Health Care FSA Reimbursement		
Let's assume the following:	FSA Participation Date:	January 1
	FSA Annual Contribution:	$ 600

FSA Monthly Contribution	$ 50
Suppose you submit a request form for reimbursement of eligible health care expenses of $200 on March 1. You would be reimbursed the $200, even though your account balance was $100.	
Health Care FSA Balance: ($50/month for January and February)	$ 100
March Request for Reimbursement:	$ 200
Amount paid to Employee:	$ 200
In April of the same year you submit a second request for reimbursement for a $500 eligible expense. You would be reimbursed $400, which is the $600 annual contribution you elected less the $200 previously reimbursed.	
April Request for Reimbursement:	$ 500
Amount Paid to Employee:	$ 400
After this second reimbursement you would not be able to receive a reimbursement for any additional eligible expenses for the same year because you have reached the $600 amount of your annual contributions. The $50 monthly contributions would continue to be withheld from your pay for the remainder of the year.	

The process to request reimbursement from the General Purpose Health Care FSA varies depending on whether the expense is eligible to be paid through the Company's medical plan and/or another group health plan. Below are reimbursement procedures for some possible scenarios. These scenarios involve the General Purpose Health Care FSA. Remember that eligible health care expenses for reimbursement from a Limited Purpose Health Care FSA are limited to dental care expenses, vision care expenses, and preventative care only.

The eligible covered expense is for you or a family member who is covered only by a Company medical benefits option.

You or your provider must first submit your medical claim to the claims administrator for processing. You will receive an Explanation of Benefits (EOB) form that shows the amount not reimbursed by the Plan (i.e., deductibles, co-payments, etc.). This is the amount that you are out-of-pocket and is eligible for reimbursement through your General Purpose Health Care FSA. The out-of-pocket amount will automatically rollover and will be applied towards your spending account. If you called UnitedHealthcare to turn off the Automatic Rollover feature, you will need to submit the EOB form along with a completed FSA Withdrawal Request.

The eligible covered expense is not covered by any group health plan.

Submit the itemized invoice and proof of payment along with a completed FSA Withdrawal Request. An Explanation of Benefits (EOB) is not required for eligible expenses, such as eyeglasses, if not covered by any group health plan.

The eligible covered expense is for your 30% cost from the retail participant pharmacy or the co-payment from the mail order program and you are covered by a Company medical plan.

The amount that you paid out-of-pocket for your prescription will Automatically Rollover and will be applied towards your spending account. If you called UnitedHealthcare to turn off the Automatic Rollover feature, submit the receipt from the participating pharmacy showing proof of payment along with a completed Withdrawal Request. (An EOB is not required for eligible expenses from the retail pharmacy.)

The expense is for eligible orthodontic services for you or a family member who is only covered by a CITGO Dental Plan.

If you or the family member is covered by a Company dental benefits program, the General Purpose Health Care FSA will reimburse your out-of-pocket portion of eligible expenses. Thus, you can receive reimbursement equal to the difference between the amount you pay and any benefits paid under a Company dental benefits program, regardless of the actual date of service. Reimbursements can be submitted upon proof of payment. You must submit a copy of the orthodontic contract or agreement with a copy of your check or other proof of payment for the portion you are obligated to pay under the orthodontic contract or agreement. The General Purpose Health Care FSA will reimburse the difference between the contract amount and the portion paid by the insurance company.

The eligible covered expense is for you or a family member who is covered only by a Company dental benefits program.

You or your provider must first submit your dental claim to the claims administrator for processing. You will receive an Explanation of Benefits (EOB) form that shows the amount not reimbursed by the Plan. This is the amount that you are out-of-pocket and is eligible for reimbursement through your General Purpose Health Care FSA. If you have Automatic Rollover, you will not need to submit the EOB form or a completed Withdrawal Request.

The eligible covered expense is for you or a family member who is not covered by a Company medical or dental benefits program, but is covered by another group health plan.

You must first submit your medical and or dental claim to the other group health plan for processing. You will receive an EOB or other comparable form that shows the amount not reimbursed by the plan. This is the amount that you are out-of-pocket and is eligible for reimbursement. You will need to submit this form along with the itemized invoice from the provider and a completed Withdrawal Request.

The eligible covered expense is for you or a family member who is covered by both a Company medical benefits program and another group health plan.

Submit the claim to the primary carrier first; then submit the claim to the secondary carrier for coordination of benefits. If remaining expenses are not reimbursed (such as deductibles), submit EOB or comparable forms from both plans along with a completed Withdrawal Request.

The expense is for eligible orthodontic services for you or a family member who is covered by both a Company dental benefits program and another group dental plan.

The General Purpose Health Care FSA will reimburse your out-of-pocket portion of eligible expenses. Thus, you can receive reimbursement equal to the difference between the amount of your contractual obligation to the orthodontist and any benefits paid under any group dental plan(s). Reimbursements can be submitted upon proof of payment, regardless of the actual dates of service. You may submit a copy of the orthodontic contract or agreement with your first FSA Withdrawal Request for orthodontic expenses.

If you are covered under two dental plans, you must submit an EOB or comparable form from each plan. You must also submit a copy of your check or other proof of payment for the portion you are obligated to pay under the orthodontic contract or agreement. The Health Care FSA will reimburse the difference between the contract amount and the portion paid by the insurance company(s).

If the expense is not covered under any group dental plan(s), you must submit a copy of your check or other proof of payment with a completed Withdrawal Request. The Health Care FSA will reimburse the amount you pay the orthodontist (up to the contractual obligation). With your first request ***only***, you must also provide an EOB or comparable form documenting that no benefits are payable under any dental plan(s).

Dependent Care Reimbursements

To qualify for reimbursement under the Dependent Care FSA, a dependent care expense must be for the care of an eligible dependent that allows you and your spouse (if applicable) to work.

Unlike the Health Care FSA, reimbursements for eligible expenses under the Dependent Care Spending Account can only be made up to the amount of money actually in your account at the time reimbursement is made. If your Withdrawal Request is greater than your current Dependent Care FSA balance, your reimbursement will equal the current amount in your account. The remaining balance of your Withdrawal Request will be held until additional funds permit all or part of the remaining balance to be paid to you.

Also unlike the Health Care FSA, eligible expenses incurred at any time during the Plan Year after you begin participation in the Dependent Care FSA are eligible for reimbursement (if there are funds available in your account). This applies even if your participation ceased at some time during the Plan Year. Thus, if you began participation in the Dependent Care FSA on March 1, 2012 and terminated from employment May 31, 2012, you could submit Withdrawal Requests for eligible expenses incurred from March 1, 2012 through December 31, 2012.

Example: Dependent Care FSA Reimbursement		
Let's assume the following:	FSA Participation Date:	January 1
	FSA Annual Contribution:	$ 3,600
	FSA Monthly Contribution	$ 300
Suppose a participant in the Dependent Care FSA submits a request form for reimbursement of eligible dependent care expenses of $700 on March 1, covering January and February dependent care services. It's the employee's first claim for benefits under the Dependent Care FSA this year. This employee would be reimbursed in the following manner:		
Dependent Care FSA Balance: ($300/month for January and February)		$ 600
Request for Reimbursement:		$ 700
Amount paid to Employee: Dependent Care FSA Balance: Balance Due Employee:		$ 600 $ 0 $ 100
Because the employee did not have enough funds in his Dependent Care FSA to cover the expense, the reimbursement request would be held until additional funds are credited to his account. The balance due the employee would then be paid to the extent that the additional funds covered it.		
Dependent Care Spending Account Balance: March Contribution		$ 0 $ 300
Dependent Care FSA Balance: Pending Balance Due Employee:		$ 300 $ 100
Dependent Care FSA Balance:		$ 200
Amount Paid to Employee:		$ 100

Reimbursement Claims Procedure

All eligible expenses must be incurred for services performed during the plan year. To obtain reimbursement for eligible expenses, you must submit a completed Withdrawal Request with the proper documentation to the Claims Administrator by March 15 after the end of the plan year.

Within 10 days after receiving a Withdrawal Request, the Claims Administrator will either:

- Reimburse eligible expenses;
- Deny the Withdrawal Request in whole or in part; or
- Request additional information.

You can review your reimbursements by logging onto www.myuhc.com. If you have any questions about your Withdrawal Request, please call UnitedHealthcare Customer Service Center at 1-866317-6359.

Withdrawal Request Denial

If your Withdrawal Request is denied, you will receive an Explanation of Benefits (EOB) with the reason why the claim was denied. The explanation may request additional information for a resubmission. If you have questions about the denial you can call Customer Service. The Customer Service representative will review the claim. If they uphold the denial and you disagree, you have the right to appeal the decision to the Claims Administrator, in writing within 180 days of receiving the initial claim determination.

The Claims Administrator will send you written notification of its decision within 30 days of the receipt of your request for review of the denial. If the Claims Administrator denies your appeal and you are still not satisfied with this decision, you have the right to take your appeal to the Committee.

Final Review

If your appeal to the Claims Administrator is denied, you may review pertinent documents, and then submit to the Plan Administrator a written request for a review of the denial.

You will have 60 days from the date of the denial to make a written request for review by the Plan Administrator. If you do not appeal the denial within 60 days to the Plan Administrator, the denial will be considered final, conclusive and binding.

Your request to the Plan Administrator must state the reasons why you believe the reimbursement was improperly denied and submit any written comments, documents, records or other information you deem appropriate.

The Plan Administrator will review the facts of the case and will have the discretionary authority to make a final and conclusive determination of the claim. The Plan Administrator has the exclusive right to interpret and administer the Plan, and these decisions are conclusive and binding. The Plan Administrator's determination will be issued in writing within 30 days after receipt of your second and final written appeal.

Legal Actions

You may not pursue your claim in federal or state court until first exhausting the claims procedures under the Plan. You may not sue after two (2) years from the date the expense was incurred.

FORFEITURES

In accordance with IRS rules, if, as of March 15th after the end of the Plan Year, you have not submitted Withdrawal Requests for eligible expenses incurred during the previous Plan Year, you will forfeit any unused funds remaining in your FSAs. Forfeitures, if any, will be used by the Company to offset administrative costs of the FSAs or for any other expense permitted by applicable law.

To help you better manage your accounts and understand your current funding situation, you will receive quarterly statements that show your FSA activity and current balance(s).

Any amounts remaining in any of your FSAs as of March 15 after the end of the Plan Year will be forfeited if you have not submitted Withdrawal Requests for eligible expenses in accordance with the guidelines of the Plan. This means "*use it or lose it*" for the FSA balances.

EVENTS AFFECTING COVERAGE

Absences

During any Company-approved absence with full or part pay, you are eligible to continue coverage under your Options as long as you continue to be an eligible employee and are receiving a check from the Company payroll department in a sufficient amount to cover the contributions for your Options. You may continue participation in an FSA in the following situations:

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

This discussion does not apply to your HSA Contribution Option, if any. You can decide whether to continue or cease deferrals into your HSA as described above under Changes in Status, see page 15.

Duration of Coverage

If you are on Leave of Absence, Short-term or Long-term Disability Leave, Family Medical Leave (FMLA), or Military Leave, the duration of coverage is as follows:

Premium Options and Health Care FSAs – If you are receiving pay from the Company payroll department in an amount sufficient to cover your contribution, your coverage will continue at the same amount of coverage as on your last day of active employment until you return to active employment or terminate employment with the Company. You also may elect to stop participation during your leave and reinstate coverage upon your return as described under "*Reinstatement of Coverage*", page 33.

Dependent Care FSA – If you are receiving pay from the Company payroll department in an amount sufficient to cover your contribution, your coverage will continue at the same amount of coverage as on your last day of active employment until you return to active employment or terminate employment with the Company. If you are not receiving pay, your contributions **will not** continue while you are on leave. If you are not receiving a check while on leave, your participation is canceled until you return to work with the Company (see "*Reinstatement of Coverage*", on page 33). You are not allowed to make after-tax contributions to this account.

In order to continue coverage under a Premium Option or a Health Care FSA if you are not receiving pay or your pay is not sufficient to cover your contributions:

- Notify the Benefits Helpline at 1-888-443-5707 that you wish to continue coverage (or the Benefits Helpline will contact you for your decision); and
- Make any required contributions within a 30-day grace period.

If you do not return to active employment when the leave expires, your coverage ceases on the last day of the month in which the leave expires.

Payment of Contributions During Leave from Employment

In order to continue your participation in the Premium Option or a Health Care FSA you must continue your regular monthly contributions to the account on an after-tax basis. You should contact the Benefits Helpline to arrange payment procedures. If you continue to make regular contributions while absent and you later return to work with the Company during the same Plan Year, your pre-tax payroll deductions for your Premium Option and/or Health Care FSA will be resumed.

If contributions are not made within a 30-day grace period, coverage may be terminated once final written notice has been given. You will be notified in writing at least 15 days before the date the coverage will terminate.

Also, if you do not return to employment when your leave of absence expires, your coverage will terminate on the last day of the month in which the leave expires, provided the required contributions have been made. The Company has reserved the right to recover any contributions not paid by you for continuation of coverage upon your return to work from the leave. If you do not return to active employment, the Company may recover amounts due from any pay due and owing to you.

If you terminate from employment with the Company, see "*If You Leave Employment*," page 35.

Reinstatement of Coverage

If your Premium Option and/or Health Care FSA coverage is terminated during your leave (either because you elected to stop participation or you failed to make any required contributions) and you return to active employment, you will be entitled to reinstate the Premium Option and/or Health Care FSA. You must contact the Benefits HelpLine to resume your participation. Upon reinstatement, you may resume coverage either at the same annual election amount (which will result in an increased monthly contribution) or resume coverage at the same monthly contribution amount as in effect prior to your leave (which will result in a lesser annual election amount). Your contribution election cannot be less than the amount of reimbursements that have exceeded year to date contributions. Your return from leave also will be considered a Status Change, which may allow you to change the amount of your election. (See "*Status Change for Applicable Health Care FSA*" on page 15)

You may resume coverage in your Dependent Care FSA when you return to work. You must contact the Benefits Helpline to resume your participation which will normally be at the same monthly contribution amount as in effect prior to your leave unless you elect otherwise. You may also have had a Change in Family Status that would allow you to change the amount of your election. (See "*Change in Family Status for Dependent Care FSA*" on page 16).

Coverage reinstated following an absence due to a leave will be effective on the date you return to active employment. You will only be eligible for benefits that you would have participated in if you had not been absent on a leave. If the Plan terms have changed during your leave, you will be entitled to the coverage that is applicable for your class of employees.

Expenses Incurred During Leave from Employment

If, during your leave, you incur expenses that would normally be eligible for reimbursement under an FSA, those expenses will only be eligible if you elect to continue participation and make timely payment of any required contributions. If you choose to stop participation in the FSA, or fail to make any required contributions during your leave, those expenses incurred during the period you were not an Active Participant will not be eligible for reimbursement.

Expenses excluded from payment under the FSAs because participation was not continued during the leave will not become eligible for payment after your return to work whether or not you decide to reinstate coverage.

Annual Election Period While Absent

If you are on leave and eligible to participate in an Option, during the Annual Election Period, you may make a new election if you wish to participate in an Option, for the next Plan Year. If you do not enroll during the Annual Election Period, you will only be eligible to enroll during the Plan Year if you have an eligible Status Change or Change in Family Status.

Premium Option and Health Care FSA: During the Annual Election Period, you may enroll in the Health Care FSA for the next Plan Year. You also may elect to make your contributions on an after-tax basis until you return to work or elect to have participation commence on your return. Your contributions will be on a pre-tax basis once you return to work.

In determining the amount of your annual election, remember that you will not be able to submit any Withdrawal Requests for those periods in which you did not contribute to the Health FSA. Please refer above to "*Expenses Incurred During Leave from Employment*".

Dependent Care FSA: You may enroll in the Dependent Care FSA for the next Plan Year, but your participation will not be effective until you return to work. Your contributions will be on a pre-tax basis once you return to work.

Termination of Coverage

Your participation will automatically cease at the end of each Plan Year (December 31). If you are currently a Participant this year and do not wish to participate in the Plan the following year, you don't have to do anything. By not filing a new enrollment form during Annual Election, your participation will end on December 31 of the current Plan Year.

If You Leave Employment

If you retire, die, or otherwise terminate employment with the Company during a Plan Year, neither you nor your beneficiary(ies) can add any more pre-tax dollars to either of the FSAs. The following rules apply:

Premium Option: Your participation in the Premium Option ceases at the end of the month following the date your active employment terminates.

Health Care FSA: Your participation in a Health Care FSA ceases at the end of the month following the date your active employment with the Company terminates. However, Withdrawal Requests for eligible expenses for services performed ***while you were an Active Participant*** may be filed until March 15 after the end of the Plan Year. You or your dependents may be able to continue your Health Care FSA under the Consolidated Omnibus Budget Reconciliation Act (COBRA) by making the after-tax contributions and paying an administrative fee (see "*COBRA Continuation of Coverage*", page 37).

Dependent Care FSA: Your participation in the Dependent Care FSA ceases at the end of the month following the date your active employment with the Company terminates. However, if you and your spouse continue to meet the eligibility requirements (see page 3) you may submit eligible expenses along with a completed Withdrawal Request for services performed during the plan year. All eligible expenses must be filed by March 15 after the end of the Plan Year. COBRA Continuation of Coverage is not available.

Failure to Make Required Contributions

If you fail to make the required after-tax contributions to your Health Care FSA as provided under "*Payment of Contributions During Leave from Employment*" (page 33), your participation will be canceled and COBRA Continuation of Coverage (see page 37) will not be available to you. However, withdrawal requests for eligible expenses for services performed ***while you were an Active Participant*** (from the date your participation begins through the end of the month in which your participation is canceled) may be filed until March 15 after the end of the plan year. Since you cannot continue participation in the Dependent Care FSA on an after-tax basis, this provision does not apply to that account.

Termination of the Plan

The Company reserves the right to determine whether to terminate the Plan or not to offer the Plan each year. If the Company does not offer the Plan, your participation will be canceled.

Cancellation of the Dependent Care FSA

If you are employed but are not receiving a check from the Company payroll department, your participation in the Dependent Care FSA will stop (see "*Duration of Coverage*" page 32) until you return to work.

Transfer to Class of Ineligible Employees

Your participation in a Health Care FSA and/or the Dependent Care FSA ceases if you transfer to a class of ineligible employees (see page 3).

Health Care FSA: Only those eligible expenses incurred during that part of the Plan Year in which you were an Active Participant in the Health Care FSA are eligible for reimbursement. Expenses incurred during that part of the year in which you were not an Active Participant are not eligible for reimbursement. Thus, if you began participation in the Health Care FSA on January 1, 2012 and transferred to a class of ineligible employees in May 2012, you could submit Withdrawal Requests for eligible expenses incurred from January 1, 2012 through May 31, 2012.

Dependent Care FSA: Eligible expenses incurred at any time during the Plan Year after you began participation in the Dependent Care FSA are eligible for reimbursement, if there are funds available in your account. This applies even if your participation ceased at some time during the Plan Year. Thus, if you began participation in the Dependent Care FSA on March 1, 2012 and transferred to a class of ineligible employees in May 2012, you could submit Withdrawal Requests for eligible expenses incurred from March 1, 2012 through December 31, 2012.

COBRA CONTINUATION OF COVERAGE

Your participation in the Health Care FSA ceases at the end of the month following the date your active employment with the Company terminates. However, you or your dependents may be able to continue your Health Care FSA under the Consolidated Omnibus Budget Reconciliation Act (COBRA) by making after-tax contributions and paying an administrative fee. COBRA Continuation of Coverage is not available for the Dependent Care FSA.

General Information

COBRA requires that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "COBRA Continuation of Coverage") in certain instances where coverage would otherwise end. The events discussed below entitle you to COBRA Continuation of Coverage and will sometimes be referred to as "qualifying events" in this SPD. This information summarizes your rights and obligations under COBRA Continuation of Coverage as the coverage relates to the Health Care Spending Account. Both you and your spouse should take the time to read this information about COBRA Continuation of Coverage carefully.

In order to ensure compliance with this law, all changes in marital and dependent status as well as any change in address for you or your spouse must be submitted to an Authorized Company Representative. Failure to promptly provide these changes may delay or cancel the offer of COBRA Continuation of Coverage.

If you have any questions about your COBRA Continuation of Coverage for the Health Care FSA, you should contact the Benefits HelpLine at 1-888-443-5707.

Eligibility

	Qualifying Event
You, the employee	Termination of employment, except for gross misconduct Reduction in hours resulting in loss of coverage
Your spouse and Dependents	Termination of your employment, except for gross misconduct Reduction in your hours worked that results in loss of coverage Your death Your divorce or legal separation

In addition to the qualifying events previously described, an employee (or the employee's spouse in the case of the spouse's eligibility) may have a COBRA qualifying event if all of the following conditions are met:

- The employee (or employee's spouse) is covered 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;
- The employee (or employee's spouse) does not return to employment with the Company at the end of the FMLA leave; and

- The employee (or employee's spouse) would, in the absence of COBRA Continuation of Coverage, lose coverage under the Plan and cease to be covered under the same terms and conditions for similarly-situated active employees before the end of what would be the maximum coverage period.

Meeting these requirements will not be a qualifying event if the Company eliminated, on or before the last day of the employee's FMLA leave, coverage under the Plan for the class of employees (while continuing to employ that class of employees) to which the employee would have belonged if the employee 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.

Notice Requirements

The employee or a family member has the responsibility to inform the Benefits HelpLine of a divorce or legal separation in writing within 60 days of that qualifying event. If the notice is sent to the Benefits HelpLine more than 60 days after the later of ***either*** the date of one of the qualifying events described above ***or*** the date the employee ceases to be an Active Participant in a Health Care FSA because of the qualifying event, you may not be entitled to elect COBRA Continuation of Coverage.

Enrollment

You must notify the Benefits HelpLine that you want COBRA Continuation of Coverage no more than 60 days after the later of either:

- The date that the employee ceases to be an Active Participant in the Health Care Spending Account due to one of the qualifying events described above; or
- The date you are notified of your continuation rights.

If you do not choose COBRA Continuation of Coverage, your active participation in or coverage under the Health Care Spending Account will end.

Eligibility for Reservists Called to Active Duty

In the event that a covered employee who is a reservist in the Armed Forces of the United States is called up to active duty and coverage of the reservist and his family is not otherwise continued under a Health Care FSA, a qualifying event will occur and COBRA Continuation of Coverage will be available for the reservist and his family. You should contact the Benefits Department or the Committee if you have any questions concerning this situation.

Choosing COBRA Continuation of Coverage

During the 60-day election period for electing COBRA Continuation of Coverage described above, you may either elect or revoke the COBRA Continuation of Coverage.

If you elect continuation coverage for the remainder of the Plan Year in which your participation would otherwise have ceased, you must continue making the monthly contribution to your Health Care FSA that was in effect at the time your active participation ceased. In that Plan Year, the maximum you can be reimbursed from your Health Care FSA is the amount of your annual election less any amounts already reimbursed. Only those expenses eligible for reimbursement under the Health Care FSA (see page 20) will be considered for reimbursement.

During the 60-day election period for choosing COBRA Continuation of Coverage, your Withdrawal Requests for eligible expenses incurred during the 60 day election period will be suspended until you elect COBRA Continuation of

Coverage and make the required contributions. Additionally, no reimbursement will be made for any expense incurred during a period for which the required contribution has not been paid. If you waive COBRA Continuation of Coverage, expenses incurred during the 60-day election period will not be eligible for reimbursement. However, Withdrawal Requests for eligible expenses incurred while an Active Participant in the Health Care FSA can be submitted until March 15 after the end of that Plan Year.

Period of COBRA Continuation of Coverage

Generally, the law requires that you or your eligible dependent be afforded the opportunity to maintain COBRA Continuation of Coverage for the remainder of the Plan Year in which the qualifying event occurs. In certain cases, the period of continuation coverage may be different. If any exception applies to you, the Company will inform you about the length of continuation coverage.

Termination of COBRA Continuation of Coverage

The law also provides that your COBRA Continuation of Coverage might be cut short for any of the following reasons:

- The Company no longer offers the Health Care FSA or the Plan; or
- The required contribution for your COBRA Continuation of Coverage is not paid in a timely manner.

Payment of Contributions

If you choose COBRA Continuation of Coverage, the required contribution must be paid on a timely basis. Generally, payments are timely if they are paid within 30 days after the due date. However, no payment of contributions may be required until 45 days after the date of your election of COBRA Continuation of Coverage. The first payment made is generally applied to the COBRA Continuation of Coverage period beginning immediately after the date your active participation in the Health Care FSA ceased *or* the period beginning with the effective date of your COBRA Continuation of Coverage, if later.

Cost of COBRA Continuation of Coverage

The required monthly contribution for COBRA Continuation of Coverage will be equal to your monthly contribution plus a 2% administrative fee.

ACCOUNT STATEMENTS

Each time you receive a Health FSA or Dependent Care FSA reimbursement from the Plan, you will receive an Explanation of Benefits (EOB) statement from the Claims Administrator, which will include your year-to-date balances so you can track your accounts. Also, you will receive quarterly statements from the Claims Administrator and you can access your account at any time at www.myuhc.com.

EFFECT ON OTHER BENEFITS

By participating in the Plan and having a portion of your pay directed to the Plan on a pretax basis, you will not affect your participation or the level of benefits you enjoy under any of the other Company-sponsored benefit plans, including any Company retirement plan.

Your monthly additions to the Premium Option, the FSAs and the HSA Contribution Account are deducted from your pay on a pretax basis, which means you will not be paying Social Security (FICA) taxes on these amounts. If your taxable pay (the amount of pay after your directed salary amount HSA been deducted) is greater than the Social Security Wage Base for that year, your participation in the Plan will have no effect on your future Social Security benefits.

If your taxable pay is less than the applicable taxable wage base for Social Security, you will be paying less in Social Security taxes. Therefore, your participation in the Plan might have an impact on the amount of any future Social Security benefits. Because the amount of any Social Security benefits for which you may be eligible is based upon your individual employment and pay history, it is not possible to state with any accuracy how participation in the Plan may affect these benefits. The impact on your Social Security benefits, if any, will depend entirely on the amount you direct to the Plan and the number of years you participate in the Plan.

REPORTING REQUIREMENTS

You have several responsibilities under the conditions of participation in the Plan. It is your responsibility to:

- Make sure the expenses you submit for reimbursement under the FSAs are eligible and meet all conditions of current tax law;
- Maintain detailed and accurate records of these expenses; and
- Make sure that all persons claimed as Dependents under the FSAs are also claimed as Dependents on your personal tax return. (Special rules may apply in certain cases of divorce or legal separation.)

If the Internal Revenue Service (IRS) questions the eligibility, the type or amount of any expense reimbursed to you under the FSA or an HSA, it is your responsibility, not that of the Company, to furnish the IRS with the necessary documentation to provide proof.

Whether you are taking advantage of the Dependent Care FSA or claiming the Federal Dependent Care Tax Credit, the IRS requires you to identify the service provider on your federal income tax return. Therefore, if you are reimbursed for dependent care expenses under this Plan or a similar plan offered by your spouse's employer, or even if you intend to use the federal tax credit, you are required to provide the name, address, and tax identification number (or Social Security Number, in the case of an individual) of the organization or person providing the services on your federal tax return. If this information is not provided, your expenses will be deemed ineligible under both the FSA and the federal tax credit. This does not apply if the provider is a charitable organization under Section 501(c)(3) of the Internal Revenue Code.

As required by the tax laws, the amount of your FSA dependent care contributions will be reported on your Form W-2, but they will not appear as part of your taxable income.

ADMINISTRATION

The Plan Administrator is responsible for the administration of the Plan and has final discretionary authority to interpret the Plan's provisions, to resolve ambiguities in the Plan and to determine all questions relating to the Plan, including eligibility for benefits. The decisions of the Plan Administrator with respect to all issues and questions relating to the Plan 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 Plan and may rely on information, data, statistics or analysis provided by these persons. The Company has entered into an Administrative Services Only (ASO) Contract with UnitedHealthCare, the Claims Administrator under the Plan. The Claims Administrator makes all payments of benefits under the terms of the Plan.

GENERAL INFORMATION

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

The Options are offered under the Plan. The Health Care FSAs under the Plan are also part of 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.

The Options are intended to provide non-taxable benefits to all eligible persons. If, for any reason, the Internal Revenue Service should determine that benefits provided under any Option are taxable, any individual who accepts a benefit under such Option agrees to be liable for any tax which the Internal Revenue Service may levy.

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

Plan:	The CITGO Petroleum Corporation Flexible Benefits Program for Salaried and Hourly Employees. The Health Care FSAs under the Plan are also part of 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 Plan:	Cafeteria Plan – Pre-Tax Premium Option; Health Care and Dependent Care FSAs; HSA Contribution Option; Flex Credits
Plan Sponsor:	CITGO Petroleum Corporation 1293 Eldridge Parkway Houston, TX 77077
Plan Sponsor's Employer Identification No.:	73-1173881
Plan Administrator:	Benefit Plans Committee 1293 Eldridge Parkway Houston, TX 77077
Plan Number:	549
Plan's Effective Date:	January 1, 1992
Plan Year:	January 1 – December 31
Funding Method:	Employee Contributions
Claims Administrator:	Flexible Spending United HealthCare Duluth Service Center P.O. Box 981178 El Paso, TX 79998-1178

United Healthcare Member Services
Phone: 1-866-317-6359 or 1-877-311-7849
Fax: (915) 781-1085

www.myuhc.com
Group Number: 197621

Benefits HelpLine: 1-888-443-5707

Email: Benefits@citgo.com

Benefits Department: The Benefits Department can be contacted as follows: Telephone: 1-888-443-5707

HIPAA

HIPAA is a federal law that requires health plans to protect the confidentiality of your private health information. The Plan and the Plan Sponsor will not use or further disclose individually identifiable health information transmitted or maintained by the Plan that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. For some disclosure purposes, you will be given an opportunity to consent to the release of information, but other specified types of disclosures do not require your consent. For all disclosures not specifically permitted by HIPAA, your written authorization will be required before such information is released. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor. As required by law, the Plan has required its business associates to also observe HIPAA's privacy rules.

Under HIPAA, you and your personal representative have certain rights with respect to your protected health information, including certain rights to see and copy the information, request restrictions on the uses and disclosures of health information, receive an accounting of certain disclosures of the information and, under certain circumstance, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

HIPAA also requires protection of any protected health information that is electronically stored or transmitted ("electronic protected health information") The Plan's Security Officer is required, among other things, to oversee the security of electronic protected health information. HIPAA also contains certain notification requirements in the event a breach of electronic protected health information occurs.

A more detailed description of your rights under HIPAA can be found in the Notice of Privacy Practices for the Plan, which was distributed to you upon enrollment. If you have questions about the privacy of your health information or wish to file a complaint under HIPAA, please contact the Privacy Officer, the Security Officer or the Plan Administrator.

PARTICIPANTS' RIGHTS UNDER ERISA

For purposes of this ERISA rights statement only, the term "Plan" refers collectively to the Health Care FSAs only.

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 (for hourly employees), 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 (for hourly employees), 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.

Continue Group Health Plan Coverage

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

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 (for hourly employees), 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 specifically apply to the Plan. Other definitions are included earlier in this SPD.

"Active Participant" is an eligible participant actively making contributions to a Spending Account.

"Annual Election Period" is a period during which you may elect or make changes to your benefits under the Plan.

"Authorized Company Representative" includes your Human Resources or Personnel representative as well as appropriate members of the CITGO Benefits Planning and Administration Department.

"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.

"Collective Bargaining Agreement" is a contract or agreement between the employer and a labor organization which has been certified by the National Labor relations Board (NLRB) as the representative of a particular group of employees, for example, an agreement between CITGO Petroleum Corporation and a labor union.

"Committee" is the Benefit Plans Committee which the Company has appointed as the Plan Administrator. The Committee has the authority to control and manage the operation and administration of the Plan.

"Company" means CITGO Petroleum Corporation and any of its subsidiaries or affiliated companies, as the context indicates.

"Dependent" means an eligible dependent covered under the applicable Company medical plan (or other employer health plan) with respect to the Premium Option and the Health Care FSAs. With respect to the Dependent Care FSA, a Dependent means (i) a tax dependent of the Participant as defined in Code section 125, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B thereof and who has the same principal place of abode as the Participant for more than one-half of such taxable year, (ii) a Participant's child, as defined in Code section 152(f)(1), until the end of the month in which such child attains 13, and (iii) the spouse of the Participant, if the spouse is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as the Participant for more than one-half of such taxable year.

"Regular Full-Time Employee" means an Eligible Employee compensated on a salaried basis who is not covered under a collective bargaining agreement and who is regularly scheduled to work at least 40 hours per week.

"Regular Part-Time Employee" means an Eligible Employee who is (a) a part-time employee not covered under a collective bargaining agreement; (b) an employee who is compensated on an hourly basis and who is normally scheduled to work at least 20 hours per week but less than 40 hours per week [and six months per year]; or (c) a part-time employee who is a member of a collective bargaining unit which has negotiated for the Plan and completes 1,000 hour of service during either a calendar year or a twelve-month period starting on the first day of employment.

"Withdrawal Request" means a form that you must submit along with proper documentation to the Claims Administrator in order to receive reimbursement from your spending account.

"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.

DEFINITIONS

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.