CITGO Petroleum Corporation
Long Term Disability Program for Salaried Employees

Summary Plan Description
as in effect January 1, 2013

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PURPOSE

The Company's Long Term Disability Program for Salaried Employees ("LTD" or "Plan"), which is underwritten by Metropolitan Life Insurance Company (the "Insurer"), provides you with financial protection if you are unable to work for an extended period of time because of Sickness or injury.

This Summary Plan Description ("SPD") describes the benefits available under the Plan, as well as the Plan's limitations and exclusions. As a participant of 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.

Certain words and phrases in this SPD have special meanings and many, but not all of them are capitalized. The meanings of these words and phrases are set forth in the section entitled *Definitions* at the end of the SPD.

ELIGIBILITY

Your coverage under the Plan is automatic if you meet the eligibility requirements of the Plan.

Who is Eligible

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

- You are a Regular Full-Time Employee compensated on a salaried basis or a Regular Part-Time Employee not covered under a collective bargaining agreement of the Company;
- You have completed six continuous months of Active Work for the Company; and
- You are carried on a U.S. dollar payroll.

If you are not Actively at Work on the date your Plan coverage would become effective, coverage will be effective on the first day on which you resume Active Work.

Who is Not Eligible

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

- You are employed on any basis other than as a salaried Regular Full-Time Employee or Regular Part-Time Employee of the Company (for example, a temporary or seasonal employee);
- You provide services to the Company under an independent contractor agreement between yourself and the Company or under an independent contractor agreement between the Company and a third party;
- You are a non-resident alien;
- You are a non-employee member of the Board of Directors of the Company or a related company;
- You were never Actively at Work;
- You provide services to the Company under a leasing arrangement between the Company and a third party;
- You are in a class of employees represented by a union or covered under a collective bargaining agreement; or
- You are employed by a related company which has not adopted the Plan.

If you are excluded from participation because you provide services under an independent contractor agreement 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.

Benefits for employees who would otherwise be eligible to participate in the Plan, but who became Disabled prior to September 1, 1998, are described in a separate SPD.

DESCRIPTION OF BENEFITS

Subject to certain limitations, after you have been Disabled and satisfy the Elimination Period, the Plan will pay you a monthly benefit equal to 65% of your monthly Pre-Disability Earnings if you are approved for LTD. The maximum monthly benefit is $20,000.

Elimination Period

Your Elimination Period begins on the day you become Disabled. You must be Disabled for 180 days to satisfy your Elimination Period.

Definitions of Disability or Disabled

First Definition of Disability or Disabled: Elimination Period and the Following 12 Months

You are Disabled during your Elimination Period and the following 12-month period, if you are unable to earn more than 80% of your Pre-disability Earnings or Indexed Pre-disability Earnings at your Own Occupation from any employer in your Local Economy. If the Insurer determines you are Disabled under this first definition of Disability, you will be eligible for up to 12 months of benefit payments.

Second Definition of Disability or Disabled: After Elimination Period and the Following 12 Months

After the Elimination Period and the following 12-month period, you are Disabled if you have been found by the Insurer to have a physical or mental condition which would prevent you from earning more than 60% of your Indexed Pre-disability Earnings from any employer in your Local Economy at any gainful occupation for which you are reasonably qualified taking into account your training, education, experience and Pre-disability Earnings. The Insurer's decision as to whether you meet this second definition of Disability will be based on qualified medical evidence and recommendations and any other relevant information. The Insurer reserves the right to request you submit to medical examinations by designated physicians. The Plan will pay for the cost of these examinations.

Maximum Benefit Duration

The duration of your benefit payments depends on whether the Insurer determines that you meet the first or the second definition of Disability, as applicable, as described above, and on your age at the time your Disability begins. This Plan provides monthly benefits according to the following schedule provided you continue to meet the applicable definition of Disability:

Age on Date of Disability	Benefit Period
Less than 60	To age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months

Age on Date of Disability	Benefit Period
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

Benefit Amount

Your benefit amount will be 65% of the first $30,769 of your monthly Pre-Disability Earnings on your date of Disability, reduced by Offsetting Income (see below), subject to the following:

- the minimum monthly LTD benefit will be $50.
- the maximum monthly LTD benefit is $20,000.

The benefit will be payable on a semi-monthly basis and subject to federal, and in some states, state income taxes.

For Regular Part-Time Employees, Pre-Disability Earnings will be based upon your standard hours election (i.e., 20, 24, 28, 32, 36) and your part-time hourly rate. If you do not have regular work hours, the Pre-Disability Earnings are based on the average number of hours you worked per month during the preceding 12 calendar months (or during your period of employment if less than 12 months.) In no event will the number of hours be more than 173 hours per month.

Additional Benefit on Death

If you die while you are Disabled and entitled to receive benefits under the Plan, proof of your death must be sent to the Insurer. On receipt of such proof, the Insurer will be a death benefit equal to three times the lesser of:

- the monthly benefit you received for the calendar month immediately preceding your death;
- the monthly benefit you were entitled to receive for the month you dies, if you die during the first month that benefits are payable under the Plan.

This death benefit will be reduced by the amount of any Overpayment the Insurer is entitled to receive.

Offsetting Income

Income from certain other sources will be taken into account when calculating the amount of your monthly benefit payment. These outside sources of income are known as “offsets’ under the Plan. Your benefit amount is reduced by your Offsetting Income.

Offsetting Income includes but is not limited to:

- any disability or retirement benefits which you receive or are eligible to receive because of your disability or retirement under:
  - the United States Federal Social Security Act or any state or public employee retirement or disability plan. (This includes primary Social Security benefits to you, the employee, only. Social Security benefits attributable to your dependents will not be offset against your LTD benefits.);
  - the Railroad Retirement Act;
  - any pension of disability plan of any other nation or political subdivision thereof.
- any income received for disability under:
  - group insurance policies where the Company has made a contribution, such as benefits for loss of work time due to disability or installment payments for permanent total disability;
  - a no-fault auto law for loss of income, excluding supplemental disability benefits;
  - a government compulsory benefit plan or program which provides payment for loss of time from your job due to your disability, whether such payment is made directly by the plan or program or through a third party;
  - a self-funded plan or other arrangement if the Company contributes toward it or makes payroll deductions for it;
  - any sick pay, vacation pay or other salary continuation that the Company pays for you;
  - workers compensation or a similar law which provides periodic benefits;
  - occupational disease laws;
  - laws providing for maritime maintenance and cure;
  - unemployment insurance law or program.
- any income you receive from working while Disabled to the extent that such income reduces the amount of your monthly benefit under the Plan as described under "Return to Work Incentives" in the *Special Services* section, below. This includes but is not limited to salary, commissions, overtime pay, bonus or other extra pay arrangements from any source.
- the amount of recovery you receive for loss of income as a result of claims against a third party by judgment, settlement or otherwise, including future earnings.

Your monthly benefit will **not** be reduced to less than the minimum monthly benefit set forth above for or by:

- any reasonable attorney fees included in any award or settlement. If the attorney fees are incurred because of your successful pursuit of Social Security disability benefits, such fees are limited to those approved by the Social Security Administration;
- cost of living adjustments that are paid under any of the sources of Offsetting Income;
- group credit insurance;
- mortgage disability insurance benefits;
- early retirement benefits that have not been voluntarily taken by you;
- veteran's benefits;
- individual disability income insurance policies;

- benefits received from an accelerated death benefit payment; or
- amounts rolled over to a tax qualified plan unless subsequently received by you while you are receiving benefit payments.

If you are paid Offsetting Income in a lump sum payment instead of in monthly payments, you must, within 10 days after receipt of such payment, provide proof satisfactory to the Insurer of:

- the amount of the single sum payment
- the amount to be attributed to income replacement; and
- the period of time covered by the lump sum payment.

The Insurer will pro-rate the lump sum or settlement over this period of time. If you do not provide this information to the Insurer, they may reduce your monthly benefit by an amount equal to the monthly benefit otherwise payable. They will reduce the monthly benefit each month until the lump sum has been exhausted. However, if the Insurer is given proof of the time period and amount attributable to lost income, they will make a retroactive adjustment.

LTD benefits are not subject to inflationary adjustments.

Estimating Social Security

If there is a reasonable basis for you to apply for benefits under the Federal Social Security Act, you are expected to do so. To apply for Social Security benefits means to pursue such benefits until you receive approval from the Social Security Administrator, or a notice of denial of benefits from an administrative law judge.

The Insurer reserves the right to reduce your monthly Plan benefit by estimated Social Security disability benefits you are eligible to receive because of your Disability or retirement. The Insurer will do this after you have received 24 months of monthly benefit payments under the Plan, unless the Insurer has received:

- approval of your claim for Social Security benefits; or
- a notice of denial of such benefits indicated that all levels of appeal have been exhausted.

However, prior to the end of the six month period following the date you became Disabled, you must:

- provide the Insurer with proof that you have applied for Social Security benefits;
- sign the Insurer's reimbursement agreement in which you agree to will repay the Insurer all Overpayments made under the Plan; and
- sign a release that authorizes the Social Security Administration to provide information directly to the Insurer concerning your Social Security benefits eligibility.

If you do not satisfy the above requirements, your Disability benefits will be reduced by your estimated Social Security benefits starting with the first Disability benefit payment under the Plan coincident with the date you were eligible to receive Social Security benefits.

In any case, when you do receive approval or final denial of your claim from the Social Security Administration, you must notify the Insurer immediately. The Insurer will adjust the amount of your monthly

benefit and you must promptly repay the Insurer an amount equal to all Overpayments. If you do not promptly make such a repayment to the Insurer, the Insurer may, at its option, reduce or offset against any future benefits payable to you, including the $50 minimum monthly amount.

Exclusions and Limitations

You are not entitled to receive LTD benefits under this Plan if:

- you are not an eligible employee;
- a limitation due to a pre-existing condition applies (see "Limitations for Pre-Existing Conditions" below);
- you are receiving a combined total of 100% of your regular pay or disability pay;
- you fail to furnish proof of your continued Disability;
- you are not receiving Appropriate Care and Treatment;
- you fail to follow medical instructions; or
- you are receiving LTD benefits under the Plan as in effect prior to September 1, 1998.

Additionally, the Plan does not cover any Disability which results from or is caused by or contributed to:

- war, whether declared or undeclared, or act of war, or participation in an insurrection, rebellion, riot or terrorist act;
- commission of or attempt to commit a felony;
- intentionally self-inflicted injuries or attempted suicide.

Limitations for Pre-existing Conditions

Limitations may apply if you are Disabled due to a pre-existing condition. No benefits are payable under this Plan in connection with that Disability unless your Elimination Period starts after you have been at Actively at Work under this Plan for 12 consecutive months.

A pre-existing condition is an accidental injury or Sickness (including pregnancy) for which, in the three (3) months before you were eligible for the Plan, you:

- received medical treatment, consultation, care or services; or
- took prescription medications or had medications prescribed.

Benefits may be payable under this Plan if you cannot satisfy the above limitations and you were eligible under the Company's prior LTD plan that this Plan replaced at the time of the replacement. The Insurer will give consideration towards the continuous time you were eligible under the prior plan and this Plan. If you then satisfy the above limitation, the maximum monthly benefit payable under this Plan will not exceed the lesser of:

- the maximum benefit under this Plan; or
- the maximum benefit under the prior plan.

Limitations for Disabilities Due To Particular Conditions

If you are disabled as a result of any of the following conditions then the amount of coverage under the Plan will be limited as follows:

Mental or Nervous Disorder or Disease: Mental or Nervous Disorder or Disease means a medical condition of that meets the diagnostic criteria established in the current Diagnostic and Statistical Manual of Mental Disorders as of the date of your Disability. A condition may be classified as a Mental or Nervous Disorder or Disease regardless of its cause. You must be receiving Appropriate Care and Treatment for your condition by a Physician.

Monthly benefits are limited to 24 months during your lifetime, or the Maximum Benefit Duration, whichever is less, if you are Disabled due to a Mental or Nervous Disorder or Disease, unless the Disability results from:

- schizophrenia;
- bipolar disorder;
- dementia; or
- organic brain disease.

Alcohol, Drug or Substance Abuse or Dependency: If you are Disabled due to alcohol, drug or substance abuse or addiction, monthly benefits are limited to one period of Disability not to exceed 12 months of Disability during your lifetime. You must be participating in an alcohol, drug or substance abuse or addiction recovery program recommended by a Physician. In no event will monthly benefit payments be made beyond the earliest of:

- the date that 12 monthly Disability benefit payments have been made;
- the date you are no longer participating in the recovery program referred to above;
- the date you refuse to participate in the recovery program referred to above;
- the date you complete such recovery; or
- the Maximum Benefit Duration.

Chronic Fatigue Syndrome and Related Conditions: You are eligible for one period of Disability in your lifetime if you are Disabled due to chronic fatigue syndrome and related conditions for up to 12 months of Disability or the Maximum Benefit Duration, whichever is less.

Concurrent Disability

If a new Disability occurs while monthly LTD benefits are payable under the Plan, it will be treated as part of the same period of Disability. Monthly benefits will continue while you remain Disabled. The monthly Plan benefits will be subject to both of the following:

- the Maximum Benefit Duration; and
- limitations and exclusions that apply to the new cause of Disability.

Temporary Recovery

If you return to Active Work, you will be considered to have recovered from your Disability. In some cases, employees attempting to return to Active Work might experience successive periods of Disability either before or after qualifying for LTD benefits.

During Your Elimination Period

If you return to Active Work before completing your Elimination Period for 30 days or less, and then become Disabled again due to the same or a related Sickness or accidental injury, you will not have to complete a new Elimination Period. Those days worked are counted towards satisfaction of your Elimination Period. However, if you return to Active Work for longer than 30 consecutive days and then become Disabled again, then you will need to satisfy a new Elimination Period. For this purpose, the term Active Work only includes those days you actually work.

After Completing Your Elimination Period

Once your complete your Elimination Period and monthly Disability benefits start, if you return to Active Work for a period of 180 days or less and then become Disabled again due to the same or related Sickness or accidental injury, you will not have to begin a new Elimination Period. During this period of temporary recovery, however you will not qualify for any change in benefit caused by a change in any of the following:

- the rate of earnings during your Elimination Period or your 180 days of Active Work; or
- the terms, provisions, or conditions of this Plan.

If your recovery lasts longer than 180 days, you will have to begin a new Elimination Period when you become Disabled again.

For purposes of this provision, the term Active Work includes all of the continuous days which follow you return to work during which you are not Disabled.

SPECIAL SERVICES

Return to Work Incentives

You are encouraged to work or participate in a Rehabilitation Program during your Elimination Period or while monthly Disability benefits are being paid to you. The Plan provides incentives for you to work or participate in an approved Rehabilitation Program while Disabled.

Work Incentive

If you work while you are Disabled and receiving monthly benefits under the Plan, your monthly LTD benefit will:

- be increased by your Rehabilitation Program Incentive (see below);
- not be reduced by the amount of your earnings for working while Disabled, subject to the limits described below.

***Limits on Work Incentive*:** During the 12-month period following the Elimination Period, you will be able to replace up to 100% of your Pre-Disability Earnings or Indexed Pre-Disability Earnings, when combining Disability benefits and earnings, reduced by Offsetting Income. Your monthly LTD benefit will be reduced if the total amount you receive from the above sources, less any Offsetting Income, exceeds 100% of your Pre-Disability Earnings. In addition, the minimum monthly benefit as described under "Benefit Amount" in the *Description of Benefits* section will not apply.

After the 12-month period described above, your monthly benefit under the Plan will be reduced by 50% of your earnings from working while Disabled and will be further reduced by that portion of your adjusted monthly benefit that exceeds 100% of your Indexed Pre-Disability Earnings.

If your monthly benefit under the Plan is reduced as a result of your receiving earnings from any work or service while Disabled, the minimum monthly benefit of $50 will not apply.

Rehabilitation Incentive

The Plan is designed to encourage and help qualified Disabled employees to participate in a Rehabilitation Program. Selection for participation in Rehabilitative Programs is based on the degree of your Disability and your individual experience, training and education.

While you are participating in a Rehabilitation Program **approved by the Insurer**, your monthly LTD benefit will be increased by 10%, before reduction for Offsetting Income.

Monthly benefit payments will cease on the date you refuse to participate in the Rehabilitation Program in which the Insurer determines you are able to participate.

Family Care Incentive

If you work or participate in a Rehabilitation Program approved by the Insurer while you are Disabled, in addition to the work and rehabilitation incentives described above, you will be reimbursed for up to $400 for

monthly Eligible Family Care Expenses for each of your family members. "Eligible Family Care Expenses" are expenses incurred with respect to a family member to provide:

- care for your or your Spouse's child, legally adopted child or child for whom you or Your Spouse is the legal guardian and who is:
  - living with you as part of your household
  - dependent on you for support; and
  - under age 13.

  The child care must be provided by a licensed child care provider who may not be a member of your immediate family or living in your residence.

- care for your family member who is:
  - living with you as part of your household;
  - chiefly dependent on you for support; and
  - incapable of independent living, regardless of age, due to mental or physical handicap as defined by applicable law.

  care for your family member may not be provided by a member of your immediate family.

Reimbursement for Eligible Family Care Expenses will be made on a monthly starting with the first monthly benefit payment until you have received **24 monthly benefit payments**. Payments will not be made beyond the Maximum Benefit Period. You must send the Insurer Proof that you incurred the expense in order to receive reimbursement.

Eligible Family Care Expenses do not include expenses for which you are eligible for reimbursement under any other source.

Moving Expense Incentive

If you participate in a Rehabilitation Program while you are Disabled, the Insurer may reimburse you for expenses you incur in order to move to a new residence recommended as part of such Rehabilitation Program. Such expenses must be approved by the Insurer in advance. You must send Proof that you have incurred such expenses for moving. Expenses for services provided by a member of your immediate family or someone who is living in your residence will not be reimbursed.

Social Security Assistance Program

If your claim for Disability benefits under the Plan is approved, the Insurer provides you with assistance in applying for Social Security disability benefits.

The Insurer will:

- provide expert assistance up front;
- offer support while you are completing the Social Security forms;
- help guide you through the application process.

Social Security disability benefits may be initially denied, but are often approved following an appeal. If your benefits are denied, a dedicated team of the Insurer's Social Security specialists provide expert assistance on an appeal if your situation warrants continuing the appeal process. These stages may include:

- reconsideration by the Social Security Administration;
- hearing before an administrative law judge;
- review by an Appeals Council established within the Social Security Administration in Washington, D.C.; or
- a civil suit in federal court.

Social Security Attorneys and Vendors

Depending on your individual needs, the Insurer may provide a referral to an attorney or vendor who specializes in Social Security law. The cost for these attorneys, which is capped by Social Security law, is deducted from the amount of any lump sum retroactive Social Security benefit you later receive.

ASSIGNMENT OF BENEFITS

Benefits payable under the LTD Plan may not be assigned other than to the Company, subject to applicable law.

EVENTS AFFECTING COVERAGE

Leave of Absence With or Without Pay

Your coverage will continue during an approved leave of absence.

Family and Medical Leave Act (FMLA)

In the event your approved leave of absence qualifies under FMLA, your overage may be extended for a period agreed to by you and the Company. The extension may not exceed 12 weeks following the date the leave begins.

Military Leave

If you are on military leave, your coverage will end on the date your leave begins. You may resume coverage when you return to Active Work.

Reinstatement of Coverage

If your coverage ends, you may become covered again if you meet the eligibility requirements. Coverage is subject to the following:

- If your coverage ends because you are no longer eligible, and if you become eligible again within 3 months, the Eligibility Waiting Period will be waived.
- If you become covered again as described above, the pre-existing condition limitation provisions described above under “Exclusions and Limitations – Limitations for Pre-existing Conditions” in the *Description of Benefits* section will be applied as if there had been no gap in coverage.

Termination of Coverage

You will cease to be covered on the earliest of the date that:

- you cease to be an employee meeting the eligibility requirements;
- you terminate from employment for any reason;
- you retire;
- you die; or
- the Plan terminates.

Termination of Benefit Payments

If the Insurer determines that you meet the first definition of Disability during the Elimination Period and for the following 12 months, but do not meet the second definition of Disability, your benefit payments will end 12 months from the date you became eligible to receive benefits under the Plan.

If the Insurer determines that you meet the second definition of Disability, your benefit payments will end on the earliest of the following dates:

- the end of the Maximum Benefit Duration;
- the date you are no longer Disabled;
- the date you fail to attend a medical examination(s) requested by the Insurer to determine the current status of your Disability;
- the end of the period specified under *Disability Income Insurance: Limited Disability Benefits*;
- the date you fail to provide the Insurer Proof of Disability;
- the date you cease or refuse to participate in a Rehabilitation Program (see "Return to Work Incentives" in the *Special Services* section, above); or
- your death, except for the benefit paid under "Additional Death Benefit" in the *Description of Benefits* section.

While you are Disabled, your benefits will not be affected by:

- termination of the Plan;
- termination of your coverage; or
- any Plan change effective after the date you became Disabled.

EFFECT ON OTHER COMPANY BENEFIT PLANS

As long as you remain in employment with the Company or receiving or are eligible to receive LTD benefits, your coverage under other Company benefit plans will be continued in accordance with those plans' provisions.

Life Insurance Provisions of the CITGO Petroleum Corporation Medical, Dental, Vision, and Life Insurance Program for Salaried Employees

Life insurance coverage may be continued, but cannot be increased if the applicable life insurance company determines that you are disabled.

Medical and Dental Provisions of the CITGO Petroleum Corporation Medical, Dental, Vision, and Life Insurance Program for Salaried Employees

If the Insurer determines that you are Disabled you may continue your medical and dental coverage under the plan.

CITGO Salaried Employees' Pension Plan (the "Pension Plan")

You will continue to accrue benefit credit service while you are receiving LTD benefits unless you elect to retire under the Pension Plan. If you elect to retire under the Pension Plan, your LTD benefits will be offset by the amount you receive as a pension benefit.

CITGO Petroleum Corporation Retirement and Savings Plan

You are no longer eligible to make or receive contributions unless you are receiving short term disability.

If you are not receiving LTD benefits at the time of your retirement, coverage under the Company benefit plans may be continued in accordance with the provisions of those plans.

CLAIMS PROCEDURES

Filing Your Claim

If it appears that your Disability will exceed six months (Elimination Period), you should file a claim for Plan benefits. You should file the claim as soon as you are able.

You may obtain the claim forms and assistance in filing the claim by calling the Benefits Helpline at 1-888-443-5707. If, due to your disability, you are unable to complete the necessary paperwork, a friend or family member may initiate a claim on your behalf.

Claims should be sent to the Insurer for processing. Claim forms must be submitted in accordance with the instructions on the claim form.

The Insurer will require written statements from your physician establishing that you are Disabled and may further require you to be examined by an Insurer-appointed physician. You will be asked to submit periodic Proof of Disability to the Insurer that you are still Disabled.

Documentation

When submitting a claim for benefits, you must provide, at your expense, documented Proof of Disability. Proof of Disability includes, but is not limited to:

- the date your Disability started;
- the cause of your Disability;
- the prognosis of your Disability;
- The continuity of Your Disability and
- Documentation that you are under Appropriate Care and Treatment throughout your Disability.

You will be required to provide signed authorization for the Insurer to obtain and release medical and financial information, and any other items that may be reasonably required in support of your Disability. These will include but are not limited to:

- Proof of Disability continuation;
- Proof that you have applied for, or are not eligible, for Offsetting Income. If you do not provide written proof you have applied for Offsetting Income, the Insurer may reduce your monthly benefit. The reduction will be based on the Insurer's estimate of what you would be eligible to receive through proper and timely pursuit;
- Proof that you applied for Social Security disability benefits until denied at the Administrative Law Judge level; and
- Proof you have applied for Worker's Compensation benefits or benefits under a similar law. If you do not provide proof that you have applied for these benefits, the Insurer may reduce your monthly benefit. The reduction will be based on the Insurer's estimate of what you would be eligible to receive through proper and timely pursuit.

- Any and all medical information, including but not limited to:
  - x-ray films; and
  - photocopies of medical records, including histories; physical, mental or diagnostic examinations; and treatment notes.
- The names and addresses of all:
  - physicians and medical practitioners who have provided you with diagnosis, treatment or consultation;
  - hospitals or other medical facilities which have provided you with diagnosis, treatment or consultation; and
  - pharmacies which have filled your prescriptions within the past three years.

Initial Claim Determination

After you submit a claim for Disability benefits to the Insurer, the Insurer will review your claim and notify you of its decision to approve or deny your claim.

Such notification will be provided to you within a reasonable period, not to exceed 45 days from the date you submitted your claim, except for situations requiring an extension of time because of matters beyond the control of the Plan, in which case the Insurer may have up to two (2) additional extensions of 30 days each to provide you such notification.

If the Insurer needs an extension, it will notify you prior to the expiration of the initial 45 day period (or prior to the expiration of the first 30 day extension period if a second 30 day extension period is needed), state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information or filed an incomplete claim, the time from the date of the Insurer's notice requesting further information and an extension until the Insurer receives the requested information does not count toward the time period the Insurer is allowed to notify you as to its claim decision. You will have 45 days to provide the requested information from the date you receive the extension notice requesting further information from the Insurer.

Claim Appeal

If a claim for benefits is wholly or partly denied, you will be furnished with written notification of the decision. This written notification will:

- give the specific reason(s) for the denial;
- make specific reference to the Plan provisions on which the denial is based;
- provide a description of any additional information necessary, if applicable, to prepare an appeal and an explanation of why it is necessary;
- provide an explanation of the review procedure; and
- state the rule, protocol, guideline or other criterion, if any, relied upon in making the denial and that you may request a copy free of charge.

On any denied claim, you or your representative will have 180 days to appeal to the Insurer for a full and fair review. If an appeal is not made to the Insurer within 180 days of the original decision, the denial will be considered final, conclusive and binding. You may:

- request a review upon written application within 180 days of the claim denial;
- request to review and to receive copies, free of charge, of pertinent documents; and
- submit any additional information and documents in writing.

Include your name, name of the Plan and reference the initial decision. Also explain why you are appealing the initial decision.

After the Insurer receives your written request appealing the initial determination, the Insurer will conduct a full and fair review of your claim. Deference will not be given to the initial denial, and the Insurer's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny your claim. If the initial denial is based in whole or in part on a medical judgment, the Insurer will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

The Insurer will notify you in writing of its final decision (whether your appeal is approved or denied) within a reasonable period of time, but no later than 45 days after the Insurer's receipt of your written request for review, except that under special circumstances the Insurer may have up to an additional 45 days to provide written notification of the final decision. If such an extension is required, the Insurer will notify you prior to the expiration of the initial 45 day period, state the reason(s) why such an extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information, the time period from the Insurer's notice to you of the need for an extension to when the Insurer receives the requested information does not count toward the time the Insurer is allowed to notify you of its final decision. You will have 45 days to provide the requested information from the date you receive the notice from the Insurer.

If the Insurer denies the claim on appeal, the Insurer will send you a final written decision that states the reason(s) why the claim you appealed is being denied and references any specific Plan provision(s) on which the denial is based. The final decision will also include, if applicable, a statement of the rule, protocol, guideline or other criteria relied upon in making the denial, of which you may request a copy free of charge. Upon written request, the Insurer will provide you free of charge with copies of documents, records and other information relevant to your claim.

Payment of Benefits

If your claim for Disability benefits is approved, payment of benefits will be made on the next semi-monthly cycle. Subsequent payments will be made on a semi-monthly basis thereafter. Each month's payment is based on the number of days you are Disabled during each one-month period.

For example, if your Pre-Disability Earnings are $3,000 per month and you are Disabled the entire month, then your monthly LTD benefit would be $1,950 (65% of $3,000) minus Offsetting Income.

Your monthly benefit payment will not be less than the minimum monthly amount payable of $50 under the Plan (except in the case of an Overpayment (see below) or while receiving work related earnings).

Overpayments

The Insurer has the right to recover from you any amount that it determines to be an Overpayment. You have the obligation to refund to the Insurer any such amount. The Insurer's rights and your obligations in this regard are also set forth in the reimbursement agreement you are required to sign when you become eligible for benefits under the Plan. This agreement confirms that you will repay all Overpayments and authorizes the Insurer to obtain any information relating to Offsetting Income.

An Overpayment occurs when the Insurer determines that the total amount paid on your claim is more than the total of the benefits due under the Plan. This includes any Overpayment resulting from:

- retroactive awards received from sources shown in the list of Offsetting Income;
- fraud; or
- any error made in processing your claim.

The Overpayment equals the amount paid in excess of the amount that should have been paid under the Plan. In the case of a recovery from a source other than the Plan, the Overpayment recovery will not be more than the amount of the recovery.

An Overpayment also occurs when payment is made by the Insurer that should have been made under another group plan. In that case, the Insurer may recover the payment from one or more of the following:

- any other insurance company;
- any other organization; or
- any person to or for whom payment was made.

The Insurer, at its option, may recover the Overpayment by:

- reducing or offsetting against any future benefits payable to you or your survivors;
- stopping future benefit payments (including the minimum monthly benefit of $50) which would otherwise be due under the Plan. Payments may continue when the Overpayment has been recovered;
- demanding an immediate refund of the Overpayment from you; or
- taking legal action.

Final Claim Review

If the Insurer denies your claim and appeal, you or your duly authorized representative will have 60 days to appeal to the Committee for a full and fair review. If an appeal is not made to the Committee within 60 days of the Insurer's final decision, the denial will be considered final, conclusive and binding. You may:

- request a review upon written application within 60 days of the appeal denial;

- request to review all information used by the Insurer; and
- submit any additional information and documentation in writing.

After the Committee receives your written request appealing the denial, the Committee will conduct a full and fair review of your claim. Deference will not be given to the Insurer's denial, and the Committee's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination or Insurer appeal. The individuals who will review your appeal will not be the same persons as those who made the initial decision to deny your claim or the Insurer appeal. In addition, the individuals who are reviewing the final appeal will not be subordinate to the persons who made the initial decision to deny your claim or the Insurer appeal. If the initial denial and Insurer appeal are based in whole or in part on a medical judgment, the Committee will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not have consulted on the initial determination or appeal, and will not be a subordinate of any person who was consulted on the initial determination or appeal.

The Committee will notify you in writing of its final decision within a reasonable period of time, but no later than 45 days after the Committee's receipt of your written request for review, except that under special circumstances the Committee may have up to an additional 45 days to provide written notification of the final decision. If such an extension is required, the Committee will notify you prior to the expiration of the initial 45 day period, state the reason(s) why such an extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information, the time period from the Committee's notice to you of the need for an extension to when the Committee receives the requested information does not count toward the time the Committee is allowed to notify you of its final decision. You will have 45 days to provide the requested information from the date you receive the notice from the Committee.

If the Committee denies the claim on final appeal, the Committee will send you a final written decision that states the reason(s) why the claim you appealed is being denied and references any specific Plan provision(s) on which the denial is based. The Committee's final decision will also include, if applicable, the internal rule, protocol, guideline or other criteria relied upon in making the denial, which you may request a copy free of charge. Upon written request, the Committee will provide you with copies of documents, records and other information relevant to your claim.

Legal or Administrative Action

No equitable action, suit of law, or administrative action may be brought by any person for benefits under the Plan until all remedies available under this claim and appeal procedure have been exhausted. No legal action of any kind may be filed:

- within the 60 days after Proof of Disability has been given; or
- more than three years after Proof of Disability has been given to the Insurer. This will not apply if the law in the area where you live allows a longer period of time to file Proof of Disability.

If you, as a participant under this Plan:

- suffer a Disability because of the act or omission of a third party;
- become entitled to and are paid benefits under a group insurance policy in compensation for lost wages; and
- do not initiate legal action for the recovery of such benefits from the third party in a reasonable period of time;

then the Insurer will be subrogated to any rights you may have against the third party and may, at its option, bring legal action to recover any payments made by it in connection with the Disability.

ADMINISTRATIVE INFORMATION

The Committee, on behalf of the Plan, has contracted with the Insurer to provide coverage under the Plan. The provisions of this Plan are subject to the terms and conditions of the Long-Term Disability Insurance Contract between the Company and the Insurer. The Insurer makes all payment of benefits under the terms of the Plan.

The Claims Administrator/Insurer is responsible for individual claim determinations and has final discretionary authority to interpret the Plan's provisions, to resolve any ambiguities in the Plan and to determine all questions related to the Plan, including eligibility for benefits. Except for individual claim determinations, the Committee is responsible for the administration of this Plan. Respectively, the decisions of the Claims Administrator and Committee will be final, conclusive and binding on all persons, with respect to all issues and questions relating to the Plan, except those specifically governed by the Long-Term Disability Insurance Contract.

The Committee may delegate to other persons the responsibilities for performing the ministerial duties in accordance with the terms of the Plan and may rely on information, data, statistics or analysis provided by these persons. The Company's determination will be conclusive regarding rates of pay, periods of absence with or without full or part pay, length and continuity of service, and termination of employment.

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

Payment of Benefits

No employee contributions are required or permitted. Benefits payable under the Plan are funded in part through the CITGO Employees' Benefit Trust (Trust) and in part by the purchase of long term disability insurance from the Insurer.

Assets of the Plan, which are held in the Trust, consist of actuarially determined employer contributions for benefits covering employees who became Disabled prior to September 1, 1998. The Insurer provides administrative services for these benefits but does not insure or guarantee these benefits. Benefits under the Plan for employees who become Disabled after September 1, 1998 are insured under a contract with the Insurer. Employer contributions for premium payments, to the extent not paid directly to the Insurer, may be deposited in the Trust to be used for payment of premiums.

Agent for Service of Legal Process

If you feel you have cause for legal action, you may present petition for service of legal process to the Secretary of the Benefit Plans Committee at the address listed for the Plan Administrator (see *Additional Information* on page 24). Service of legal process may also be made upon the Plan Administrator or any other trustee of the Plan.

CITGO Employees' Benefit Trust

Assets of the Plan consist of actuarially determined contributions. Employer contributions to the Plan are held in the CITGO Employees' Benefit Trust. Premiums for long term disability insurance benefits payable

under the Plan are paid from the assets of the Trust to the Insurer. The current trustee is Bank of Texas. Trustees are subject to change.

In the event of the termination of the Plan, assets of the Plan will be used to pay Plan benefits, premiums, and administrative expenses. Any remaining assets will be used for the payment of similar benefits or distribution in accordance with the CITGO Employees' Benefit Trust Agreement and applicable law.

Contributions and Funding

Plan benefits are made available under the provisions of the CITGO Petroleum Corporation Long Term Disability Insurance Program for Salaried Employees. The cost of the Plan benefits provided are funded in part through the CITGO Employees' Benefit Trust and in part by the purchase of long term disability insurance from the Insurer. The Trust is irrevocable; the funds in the Trust cannot be returned to the Company; and must be used for claims and/or premiums.

Future of the Plan

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

ADDITIONAL INFORMATION

As a participant or beneficiary under this Plan you have certain rights and protections as more fully described within the Statement of ERISA Rights page 26. Other important information about the Plan is provided below:

Name of Plan:	CITGO Petroleum Corporation Long-Term Disability Program for Salaried Employees
Type of Plan:	Insured Welfare Benefit Plan
Plan Sponsor:	CITGO Petroleum Corporation 1293 Eldridge Parkway Houston, TX 77077
Plan Sponsor's Employer Identification Number	73-1173881
Plan Administrator:	CITGO Petroleum Corporation Benefit Plans Committee - Secretary C/O Benefits – HR Total Rewards Houston, TX 77077
Trustee	Bank of Texas 5956 Sherry Lane, Suite 701 Dallas, TX 75225
Plan Number:	516
Plan's Initial Effective Date:	September 1, 1998
Plan Year:	January 1 - December 31
Funding Method:	Funded through an insurance policy purchased with employer contributions held in the CITGO Petroleum Corporation Employees' Benefit Trust which are used to pay policy premiums.
Insurer / Claims Administrator:	MetLife – Life Insurance Unit 2300 Lakeview Pkwy, Suite 400 Alpharetta, GA 30004 1-800-635-6707
The Benefits Department: **By Phone:** **By Email:**	CITGO Benefits Helpline 1-888-443-5707 benefits@citgo.com

By Mail:

CITGO Petroleum Corporation
Attn: Benefits – HR Total Rewards
1293 Eldridge Parkway, N5063
Houston, TX 77077

Statement of ERISA Rights

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

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, 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 copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administer may make a reasonable charge for the copies.

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is

denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order of medical child support order, you may file suit in Federal court. If it should happen that Plan Fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

DEFINITIONS

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

"Actively at Work" or "Active Work" means you are an employee working for the Company doing all the material duties of your occupation at either at one of the Company's usual places of business, at an alternative place approved by the Company, or at some location to which Company business required you to travel. If you are absent from work solely due to approved vacation days, holidays, scheduled days off or approved leaves of absence not due to disability, you will be considered to be Actively at Work if you were Actively at Work on the last schedules work day preceding such time off.

"Appropriate Care and Treatment" means medical care and treatment that meet all of the following:

- It is received from a Physician, who is not related to you or your Spouse, with medical training and clinical experience suitable to treat your Disability; necessary to meet your basic health needs and is of demonstrable medical value;
- It is consistent with the Physician's diagnosis of your Disability;
- It is consistent in type, frequency and duration of treatment with relevant guidelines of nation medical research, health care coverage organizations and governmental agencies; and
- It is intended to maximize your medical and functional improvement.

"Benefit Plans Committee" or "Committee" means the committee appointed by the Company to act as the Plan Administrator. The Committee has the authority to control and manage the operation and administration of the Plan, including discretionary authority to establish and implement rules for the operation and administration of the Plan; to construe and interpret the provisions of the Plan; and to make factual determinations under the Plan. This includes the power to determine the rights or eligibility of any person to benefits under the Plan and the amounts of their benefits..

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

"Diagnostic and Statistical Manual of Mental Disorders" is a comprehensive classification of officially recognized psychiatric disorders, for use by mental health professionals to ensure uniformity of diagnosis.

"Disability" or "Disabled" (even when not capitalized) means that, due to Sickness or as a direct result of accidental injury, you are receiving Appropriate Care and Treatment from a Physician on a continuing basis and complying with the requirements of such treatment, and during the Elimination Period, and for the next 12 months of Sickness or accidental injury, you are unable to earn more than 80% of your Pre-Disability Earnings at your Own Occupation from any employer in your Local Economy. After that, you must be unable to earn more than 60% of your Indexed Pre-Disability Earnings from any employer in your Local Economy at any gainful occupation for which you are reasonably qualified taking into account your training, education, and experience.

For purposes of determining whether a Disability is the direct result of an accidental injury, the Disability must have occurred within 90 days of the accidental injury and result from such injury independent of other causes. Your failure to pass a physical examination required to maintain a license to perform the duties of

your occupation does not alone mean that you are Disabled. If your occupation requires a license, the fact that you lose your license for any reason will not, in itself, constitute a Disability.

"Eligibility Waiting Period" means the period of continuous membership in an eligible class that you must wait before you become eligible for coverage under the Plan. The period begins on the date you enter an eligible class and ends on the date you complete six months of continuous membership in an eligible class.

"Elimination Period" means the period of time beginning with the onset of a covered Disability and continuing for the next 180 days that you are Disabled. No benefits are payable during this period of time.

If you return to Active Work for a period of 30 days or less during the Elimination Period, and then subsequently become Disabled again due to the same or related condition, you will not have to begin a new Elimination Period. If you return to Active work for a period of more than 30 days, and then become Disabled again, you will have to complete a new Elimination Period. For this purpose, the term Active Work only includes those days you actually work.

"Indexed Pre-Disability Earnings" is used by the Insurer to determine if you continue to be Disabled each year after you have received Disability benefits under the Plan for 12 months. This has no effect on the amount of your monthly Plan benefit. The Insurer takes your Pre-Disability Earnings, increases it by 7% each year then takes 60% of this amount to determine your Indexed Pre-Disability Earnings. The first increase will take place on the date the 13th monthly benefit is payable. Subsequent increases will take effect on each anniversary of the first increase.

"Local Economy" means the geographic area within which you reside and which offers suitable employment opportunities within a reasonable travel distance. If you move on or after you become Disabled, the Insurer may consider both former and current residence to be your Local Economy.

"Maximum Benefit Duration" means the maximum period of time during which benefits under the Plan may be continued as described under "Maximum Benefit Duration" in the *Description of Benefits* section.

"**Offsetting Income**" means income that is deducted from your monthly LTD benefit as described under "Offsetting Benefits" in the *Description of Benefits* section.

"Own Occupation" means the essential functions that you regularly perform and that provide your primary source of earned income. It is not limited to the specific position you hold with the Company. It may be similar activity that could be performed with the Company or any other employer.

"Overpayment" means any amount paid to you by the Insurer that is more than you are entitled to receive under the Plan as described under "Overpayments" in the *Claims Procedures* section.

"Physician" means a person who: (i) is legally licensed to practice medicine in the jurisdiction where services are performed; or (ii) any other person whose services, according to applicable law, must be treated as a Physician's services for purposes of the Plan's insurance policy. Each such person must be licensed in the jurisdiction where he performs the services and must act within the scope of that license. He must also be certified and/or registered if required by such jurisdiction. The term Physician does not include:

- you;

- your Spouse; or
- any member or your immediate family, including your and/or your Spouse's parents, children (natural, step or adopted), siblings, grandparents; or grandchildren.

"Pre-Disability Earnings" means gross salary or wages from the Company as of your last day of Active Work before the Disability began. This is calculated on a monthly basis. Pre-Disability Earnings include contributions you were making through a salary reduction agreement with the Company to:

- any Company-sponsored Internal Revenue Code section 401(k) plan;
- an executive non-qualified deferred compensation arrangement; and
- any fringe benefits under the Company's Internal Revenue Code section 125 plan.

Pre-Disability Earnings do not include:

- awards, commissions and /or bonuses;
- overtime pay;
- the Company's contributions on your behalf to any deferred compensation arrangement or pension plan;
- the grant, award, sale, conversion and/or exercise of shares of stock or stock options; or
- Any other compensation from the Company.

"Proof" or **"Proof of Disability"** means written evidence satisfactory to the Insurer that a person has satisfied the conditions and requirements to receive a benefit under the Plan. When a claim is made for a benefit under the Plan, Proof must establish:

- the nature and extent of the loss or condition;
- the Insurer's obligation to pay the claim;
- your right to receive payment of benefits.

"Regular Full-Time Employee" means an employee who is regularly scheduled to work at least 40 hours per week.

"Regular Part-Time Employee" means an employee who is regularly scheduled to work at least 20, but less than 40 hours per week.

"Rehabilitation Program" means a program that has been approved by the Insurer for purposes of helping you return to work. It may include, but is not limited to, your participation in one or more of the following activities:

- return to work on a modified basis with a goal of resuming employment for which you are reasonably qualified by training, education, experience and past earnings;
- on-site job analysis;
- job modification/accommodation;
- training to improve job-seeking skills;

- vocational assessment;
- short-term skills enhancement;
- vocational training; or
- restorative therapies to improve functional capacity to return to work.

"Sickness" means illness, disease or pregnancy, including complications of pregnancy.

"**Spouse**" means your lawful spouse.

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

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