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

Summary Plan Description

As in effect January 1, 2015

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PURPOSE

The CITGO Petroleum Corporation Medical, Dental, Vision and Life Insurance Program for Salaried Employees (the "Plan") includes health care benefit programs that are intended to help pay medical, dental and vision expenses incurred by you and your eligible dependents for the diagnosis and treatment of an illness, injury or pregnancy.

This Summary Plan Description (SPD) describes certain benefit programs under the Plan by referring to them as follows:

- Medical Program (provided together with the Prescription Drug Program)
- Dental Program
- Vision Program

They are referred to collectively as the "Programs" and may be referred to individually as "Program," depending on the context.

These Programs under the Plan have been designed so that both you and the Company share their cost. The Programs are intended to pay a portion of your and your eligible dependents' covered expenses, and you are responsible for payment of contributions, annual deductibles, copays, coinsurance, charges in excess of reasonable and customary limits, and services not covered under the Programs.

The medical, dental, and vision benefits each have distinctive terms and conditions, so they are described in separate sections in this SPD. Some provisions, such as eligibility, enrollment and continuation of coverage apply to all of the benefits provided under the Programs (unless otherwise indicated), and are described in the general sections of the SPD.

As a participant in any one of the Programs, you may be asked to comply with certain provisions of the Programs which could affect the benefits you receive. You should acquaint yourself with these provisions, as failure to comply may result in a penalty, delay, reduction or 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 most of these words and phrases are set forth in the section entitled *Definitions* at the end of the SPD, but some are defined in the section to which they mainly apply.

This SPD provides a summary of the main features of the Programs, but does not contain every term or condition of the Programs or the Plan. If you have a question about the Plan terms or governing documents, you can contact the Benefits HelpLine at 1-888-443-5707. Additional resources and contact information can be found on the Contact Information page near the end of this SPD.

ELIGIBILITY

Employees

Employees Who Are Eligible

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

- You are a Regular Full-Time or a Regular Part-Time Employee of the Company;
- You are carried on a U.S. dollar payroll;
- You are not covered under a collective bargaining agreement which provides for coverage under the Plan; and
- You are not listed in the following paragraph which is entitled “Employees Who Are Not Eligible."

Employees Who Are Not Eligible

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

- You are employed on any basis other than as a Regular Full-Time or a Regular Part-Time Employee of the Company (for example, a temporary or seasonal employee);
- You are retired;
- You provide services to the Company as an independent contractor based on a contract between yourself and the Company (or between the Company and a third party);
- You provide services to the Company under a leasing arrangement between the Company and a third party;
- You are in a class of employees covered by a collective bargaining agreement which provides for coverage under the Plan;
- You are employed by a related company which has not adopted the Plan; or
- You are a nonresident alien.

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

Dependents

Dependents Who Are Eligible

Your eligible Dependents may also participate in the Programs. An eligible Dependent is defined by the Plan as your Spouse or your Child.

Spouse Eligibility

“Spouse” is defined as:

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

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

Individuals who enter into any civil union, domestic partnership, same-sex marriage or similar arrangement with an eligible employee are not entitled to benefits under the Programs as a Spouse.

When You and Your Spouse Are Both Employees of CITGO

If you and your Spouse are both covered under the Programs, you may each be enrolled as an employee or be covered as a Dependent of the other person, but not both. Under the same circumstances, a Child may only be covered under you or your Spouse. If an employee's child is also an employee of CITGO, the child should be enrolled as an employee and not as a Dependent.

If divorced birth parents both work for the Company, Children may be covered by either parent.

Child Eligibility Guidelines

"Child" is defined as any one of the following who are under the age of 26 (other than for continuation of coverage for a disabled dependent Child as described below), and who are not excluded under the "Persons Who Are Not Eligible Dependents" section below**:**

- Your biological child;
- Your legally adopted child or a child Placed With You for Adoption;
- Your stepchild; and/or
- A child for whom you or your current Spouse have been awarded legal guardianship or legal custody by a court of law.

Your Child as defined above, is eligible under the Programs, even if he or she is:

- Not enrolled in school,
- Married,
- Not financially dependent on you for the majority of their support**, or**
- Not residing with you in your home.

Disabled Dependent Child Eligibility Guidelines

Your disabled dependent Child is eligible for continued coverage ***if*** the Child is or becomes totally physically or mentally disabled and meets the eligibility provisions. These eligibility provisions are applicable for your Child of any age who meets all of the following criteria prior to the end of the month in which the Child attained age 26:

- is totally disabled;
- is unable to be self-supporting due to a mental or physical disability;
- is primarily dependent upon you for support; and
- is incapable of self-sustaining employment.

You must submit to the Plan Administrator a completed disabled dependent application with supporting documentation for review and approval. You must submit the application to the Plan Administrator within

31 days before the Child attains age 26, or within 31 days after you first become eligible under the Programs, if later. he application and any supporting documentation must establish that the Child's incapacity occurred prior to the date the Child met the limiting age of 26.

You may include documentation from the attending physician(s) who currently renders care for the disabling condition. Coverage will not take effect under the Programs if the Child has already exceeded the limiting age of 26 until the Disabled Dependent Application is approved.

Persons Who Are Not Eligible Dependents

- Your former Spouse or former common law Spouse;
- A spouse or common law spouse who is of the same sex;
- Your Child, who otherwise meets the definition of Child, but is over the age 26 (except for a disabled dependent Child);
- Grandchildren, nieces and nephews under the limiting age unless they are legally adopted by or in court appointed custody of you or your Spouse;
- Brothers, sisters, brothers-in-law, sisters-in-law, aunts, uncles, cousins;
- Dependents in active duty status with the armed forces of any country or a subdivision of any country; and
- A domestic or civil union partner.

Proof of Eligible Dependent Status

Proof of eligible Dependent status satisfactory to the Plan Administrator is required for any individual being enrolled or already covered under the Programs as a Dependent. Should you be requested to provide proof of eligible Dependent status, you will have 31 days to submit documentation of eligible Dependent status. Documentation substantiating eligibility status must be received before coverage becomes effective. The type of documentation that the Plan Administrator will accept is outlined in Appendix II.

The Plan Administrator will, from time to time, conduct eligibility audits. Any participant in the Programs who intentionally or knowingly commits fraud against one or more Programs, along with all members of such participant's family unit, may, in the sole discretion of the Plan Administrator, be prohibited from further participation in the Programs.

Retired Employees

Medical, Dental and Vision Coverage for Eligible Retirees Under Age 65

Under some circumstances, you and/or your Dependents will be eligible to continue medical, dental and vision coverage under the Programs after you retire and before you (or your Spouse) attain age 65 if you have been covered by the Programs, another Company-sponsored health care plan, or a predecessor plan for at least **10 consecutive years** while in active employment **and** you meet at least **one** of the three following conditions:

(1) Your age plus your years of employment total 70 or more at the time you cease employment; **or**

(2) You are age 55 or older and eligible to retire directly from employment with the Company under the provisions of the Retirement Plan of CITGO Petroleum Corporation and Participating Subsidiary

Companies; **or**

(3) You cease employment at age 55 or older and are eligible to receive benefits under the CITGO Petroleum Corporation Salaried Employees' Pension Plan (whether you elect to defer receiving benefits or begin receiving them immediately).

Your coverage after retirement may continue for each of you and your Spouse until either of you attains age 65 unless you choose to waive coverage on the Continuation of Benefits form. In addition to waiving coverage, the Continuation of Benefits form allows you to elect how you will pay any required contributions if you are continuing coverage - you will either be billed monthly or you can elect electronic fund transfer. If you do not complete a Continuation of Benefits form and you have qualifying medical coverage prior to your retirement, coverage for you and any eligible Dependents who are covered as of the date you retire will continue automatically and you will be billed monthly for your contributions.

However, your coverage will end at age 65, the coverage of your Spouse will end at 65, and the coverage of other eligible Dependents will end at the limiting age for such Dependents.

If you waive coverage, you may re-enroll at a later date in accordance with the Late Enrollment provisions. Once you or your Spouse attains age 65, your or your Spouse's retiree medical benefit will be provided under the CITGO Petroleum Corporation Retiree Reimbursement Account (RRA) Plan if you or your spouse select a UnitedHealthcare AARP Medicare product for insurance coverage. See the RRA Plan Summary for more details.

As a retiree, your coverage can be cancelled if you do not pay your share of the cost of coverage and **you will not be eligible to re-enroll at a later date.**

Dependents of Retirees

If you are eligible for retiree coverage under the Programs, you may continue to cover each of your eligible Dependents who are under age 65 or other limiting age after you retire, provided that:

- You are covered under one of the Programs or the RRA Plan as a retiree;
- The Dependent continues to meet the eligibility requirements under the Programs; and
- You pay any required contribution.

You may elect to add new Dependents to your coverage at any subsequent Annual Election Period, or within 31 days after an eligible Qualified Family Status Change. You may continue to cover all your eligible Dependents under the Programs even when you attain age 65. If your addition of a Dependent means that you must change your level of coverage (for example, from "Employee only" to "Employee and Spouse" or from "Employee and Spouse" to "Employee and Family" coverage), then you must change your level of coverage within 31 days after the Qualified Family Status Change. If you do not contact the Benefits HelpLine within 31 days after the change event, the Dependent will not be eligible for coverage under the Programs for the duration of the Plan Year.

If both you and your Spouse are eligible for the Programs at retirement, at any Annual Election Period or eligible Qualified Family Status Change prior to age 65, you may elect to be covered under the Programs **either** as a Dependent **or** as a retiree – but not both.

Effect of Eligibility for Medicare on Medical Coverage

Active Employees Eligible for Medicare

Coverage under the Programs is available to eligible active employees age 65 and over, under the same conditions available to active employees under age 65. If you are covered under the Programs as an employee when you reach age 65, you will continue to be covered with the Programs as your primary coverage while you are an eligible employee unless either:

- you notify the Company in writing that you do not want the coverage to continue (within 31 days after attaining age 65); or
- you otherwise cease to be eligible for coverage under the Programs.

Your coverage under the Programs will be considered primary while you are in active employment with the Company, and Medicare coverage will be secondary. You will continue to be eligible for the same benefits under the Programs as employees who are not eligible for Medicare, however, your enrollment for Medicare benefits while you are still an active employee will prevent you from participating in a health savings account (HSA) available in connection with the Self-Directed Health Plan Option.

Covered Dependents of Active Employees

Coverage is available to active employees' Dependents who are eligible for Medicare by reason of age or disability. This includes Spouses age 65 and over. If you are an active employee and your Spouse who is covered under the Programs reaches age 65 or a Dependent becomes eligible for Medicare, he or she will continue to be covered by the Programs until:

- The employee notifies the Company within 31 days after the Spouse's 65th birthday or during the Annual Election Period that he or she does not want the Spouse's coverage to continue;
- The Spouse otherwise ceases to be eligible for coverage for a reason that would also make a Spouse under age 65 ineligible for coverage;
- The employee notifies the Company within 31 days after the Dependent becomes eligible for Medicare or during the Annual Election Period that he or she does not want the Dependent's coverage to continue; or
- The Dependent otherwise ceases to be eligible for coverage under the Programs.

As long as you are actively employed, coverage under the Programs will be considered primary and Medicare coverage will be secondary for your Dependents who are eligible for Medicare.

Retirees Under Age 65 Eligible for Medicare

After you cease active employment with the Company and if you become eligible for Medicare by reason of disability, your coverage can be continued under the Programs, but Medicare will become your Primary Payor for Medical Program benefits. You remain an eligible participant as a disabled employee as long as you:

- are under the age of 65;
- are totally and permanently disabled; and
- are receiving long-term disability benefits under the CITGO Petroleum Corporation Long Term Disability Insurance Program for Salaried Employees or the Retirement Plan of CITGO Petroleum Corporation and Participating Subsidiary Companies.

You and your Dependents will no longer be eligible for Network benefits; however you and your eligible Dependents will be enrolled in the Non-Network Option. While on disability, if you become eligible to begin your Medicare benefits, you must enroll and call the Benefits HelpLine for the effective date of your Non-Network Option benefits.

Covered Dependents

If you are retired, under age 65 and you have a Dependent eligible for Medicare by reason of disability, the Medical Program will be your Primary Payor and Medicare generally will be the Primary Payor for your Dependent's Medical Program benefits. If your Spouse attains age 65, his or her coverage will be available from United Healthcare with a subsidy under the CITGO RRA Plan as described below.

When Medicare is Your Primary Payor

When Medicare becomes your Primary Plan, Medicare Parts A and B must be elected because any medical benefits payable under the Medical Program will be offset or reduced by any amount that you receive, or would be eligible to receive, under Medicare even if you are not enrolled in Medicare. This means that the Medicare benefits will be "carved out" of the Medical Program benefits so that the total benefit from Medicare and the Medical Program will always be at least as much as the Non-Network Option would have paid in the absence of Medicare. You are not eligible to continue in the Medical Program if you elect supplemental Medicare Part D (prescription drug) coverage.

Retirees and Spouses Age 65 And Above Eligible for Medicare

If you are an eligible post 65 retiree (or a post 65 Spouse of such a retiree), you may purchase a new health care plan from UnitedHealthcare® Medicare Solutions.

UnitedHealthcare insures AARP® Medicare Supplement Insurance Plans. In addition, they offer Medicare Advantage and Part D prescription drug plans.

The Company currently partially subsidizes your Medicare and related coverage through a "Retirement Reimbursement Account" (RRA). An RRA is a tax-advantaged notional account that is currently credited monthly by CITGO. Your RRA can be used to reimburse your Medicare Part B, Part D and Medicare healthcare plan premiums. RRA credited amounts can also be used for out-of-pocket expenses such as co-pays or deductibles.

See the separate RRA Plan Summary for more details.

CONTRIBUTIONS AND COST OF COVERAGE

You and the Company share in the cost of your medical, dental and vision benefits. As an eligible employee, you pay your contributions with "pre-tax dollars" under the Company's Flexible Benefits Program for Salaried and Hourly Employees through payroll deduction. Eligible Retirees pay with "after-tax" dollars. If you enroll in one of the Vision Program options, you contribute 100% of the cost of coverage.

The amount of your contribution depends on your coverage category. Contributions are deducted from your paychecks throughout the year.

Company Contributions

The Company currently contributes to the Programs each month for eligible participants. The Company's contribution will be reviewed periodically.

Participant Contributions – Employees

All participants in the Programs are required to share in the cost of the Plan. Contribution rates are published annually during the Annual Election Period.

For active employees, your monthly contributions will be equally divided and deducted on a pre-tax basis from your normal semi-monthly pay.

As an active employee, your contributions will be paid on a "pre-tax basis," which means:

- your contributions are deducted from your pay before taxes are withheld; and
- you are not required to pay federal income tax and, in most cases, state and local taxes on the amount of this deduction.

If you are on a leave of absence without pay, or otherwise not receiving payroll compensation from the Company, please see Leaves and Other Events Affecting Coverage.

Participant Contributions - Retirees

Participating retirees are billed monthly for their contribution amount. Retiree contributions are paid on an after-tax basis.

No Contribution Refunds

If you drop any Dependent's coverage within 31 days after the Dependent's loss of eligibility and this changes your level of coverage and monthly contribution amount, you may be entitled to a refund for a portion of the most recent contribution.

If you fail to drop coverage for your Dependent within 31 days after the loss of eligibility, you will not be entitled to a refund of contributions.

The Claims Administrator will require reimbursement for any benefits paid after the retroactive loss of coverage date.

ENROLLMENT

To enroll in the Programs, you will need to:

- choose from the options available to you; and
- decide which of your eligible Dependents you wish to cover, if any.

You cannot enroll only your Dependents in medical, dental, and vision coverage. You must also be enrolled in order to enroll your Dependents in any one of the Programs. Elections for each Program are independent of any other. For example, you may enroll in dental without enrolling in medical or vision coverage.

Level of Coverage

The coverage levels available under the Medical Program (with Prescription Drug Program), Dental Program and Vision Program options are:

- Employee Only;
- Employee and Spouse;
- Employee and Child(ren); or
- Employee and Family.

Your enrollment materials will contain information to help you make your enrollment elections. Contact the Benefits HelpLine if you need more information.

When to Enroll

Regular Enrollment

You may enroll yourself and your eligible Dependents in the Programs within 31 days after your employment date, or within 31 days after the date you first become eligible for the Programs (if later). You must complete, sign, date and return your enrollment forms to the CITGO Benefits Department.

Late Enrollment

If you wish to enroll for coverage in the Programs:

- more than 31 days after your employment date;
- more than 31 days after first becoming eligible to enroll (if later); or
- after you first enrolled and then subsequently waived coverage;

then you may enroll:

- within 31 days after an eligible status change (for details, see Changing Your Coverage); or
- during the next Annual Election Period.

You are not permitted to enroll at any other time.

When Coverage Begins

Your coverage under any Program begins as follows:

If you enroll….	Coverage for you and your enrolled Dependents begins …..
Within 31 days after employment	On the first day you are actively at work
Within 31 days after your initial eligibility date	On your eligibility date
During the Annual Election Period	On January 1 of the following year
Within 31 days after an eligible status change (see Changing Your Coverage)	On the effective date of the status change

Changing Your Coverage

Annual Election Period

Once each year there is a specific time during which you may make new elections or coverage changes for the next Plan Year (January 1 - December 31). This period is the Annual Election Period.

During the Annual Election Period, you can:

- change your coverage from one option to another option (for example, from the EPO Option to the SDHP Option);
- change your coverage level (for example from "Employee Only" to "Employee and Spouse" coverage);
- add or drop Dependents from your coverage;
- elect coverage if you had previously waived coverage; or
- drop coverage.

Coverage changes elected during the Annual Election Period are effective on January 1 of the following year.

During this period, you may be required to make an affirmative election rather than have your current elections continue in the following year. You will be notified if this applies to you. If you are required to make an election, you must complete your election through the SAP Employee Self Service Portal or by calling the Benefits HelpLine within the specified time limits.

If you do not complete the required election within the specified time limits, you and your eligible Dependents, if applicable, will have the same benefits as you did in the prior Plan Year and will not be permitted to make any changes in coverage unless you have an eligible status change.

Note:

- If you are not required to make an election during the Annual Election Period, your current coverage will continue for the following Plan Year unless you choose otherwise. **Although your current coverage will continue in this case, your flexible spending account (FSA) or health savings account (HSA) elections will NOT automatically continue in the following Plan Year. You must make a new FSA or HSA election each year if you wish to participate in those programs.**

- If your available Medical Program options change and your current option is NOT available for the following Plan Year, you should make a new election during the Annual Election Period. If you do not make a new election, your option will be automatically changed to an available option designated by the Plan Administrator in its discretion.

Special Enrollment Period

Loss of Other Coverage

If you experience a loss of coverage from another plan, you may be entitled to a special enrollment period under the Programs. A special enrollment period is available when all of these things happen:

- You are an eligible Employee and you (or your eligible Dependents) lose coverage under another group health plan after first becoming eligible under this Program;
- The other group health plan coverage was either:
  - COBRA continuation coverage for which the continuation period ended, or
  - Other group health care coverage that ended either because employer contributions toward the cost of coverage were terminated, or because eligibility ended (including due to legal separation, divorce, death, termination of employment or reduction in work hours);
- The other group health plan coverage was not terminated for cause (such as making a fraudulent claim or an intentional misrepresentation) or for nonpayment of contributions; and
- You file a completed enrollment form with the Plan Administrator during the special enrollment period.

The special enrollment period for persons who have lost other group health coverage is the 31-day period starting on the date the COBRA coverage is exhausted, the date the employer contributions are terminated, or the date eligibility for the other group coverage is lost. This means that you have 31 days after one of these events to file the completed enrollment form with the Plan Administrator.

New Eligible Dependents

A special enrollment period is available to certain new eligible Dependents. If a person becomes your eligible Dependent through marriage, birth, adoption or placement for adoption, that person may be eligible for a special enrollment period. The following rules apply to the special enrollment period for new eligible Dependents:

- You cannot enroll a new eligible Dependent unless you are already enrolled, or you enroll yourself, during this special enrollment period.
- You can enroll your un-enrolled Spouse during this special enrollment period if there is a birth or adoption and your Spouse is otherwise an eligible Dependent.

The special enrollment period for new eligible Dependents is the 31-day period starting on the date of the marriage, birth, adoption or placement for adoption. This means that you have 31 days after one of these events to file with the Plan Administrator the completed enrollment form and supporting documentation.

Gaining or Losing Health Coverage State Assistance

You may be able to enroll yourself and your Dependents in the Programs later than your initial enrollment period if:

- you or a Dependent loses coverage under Medicaid or a state child health insurance program; or

- you or a Dependent become eligible for group health plan premium assistance under Medicaid or a state child health insurance program.

You must request enrollment in the Programs and file a completed enrollment form within 60 days after losing such other coverage or gaining premium assistance eligibility. To request special enrollment contact the Benefits HelpLine at 1-888-443-5707.

Qualified Family Status Change

In order for you to make mid-year election and contribution changes for health and life benefits after payroll deductions have begun for the current Plan Year, you must experience a Qualified Family Status Change. Qualified Family Status Changes include certain changes in family or work status, such as marriage, divorce and a child losing eligibility at age 26. See the Flexible Benefits Program for Salaried and Hourly Employees SPD for details about all Qualified Family Status Changes, and certain restrictions on those changes.

Transfer from Salaried to Hourly or Hourly to Salaried

If you are an hourly employee enrolled in the Company's health care programs available to hourly employees and you are transferred to salaried status (or vice versa):

- You have the option of changing your coverage in a manner consistent with your eligibility change as provided under the Flexible Benefits Program.
- If you do not change your coverage, you will automatically be enrolled in an option and coverage level in the newly available health care programs based upon your enrollment choice in the previous programs (for example, if you had "Employee Only" coverage under the EPO Option as an hourly employee, you will automatically be enrolled for "Employee Only" coverage in the EPO Option available to salaried employees under the Medical Program).
- Any deductibles, coinsurance or other payments you made under the previous programs during the Plan Year in which you transfer will be credited to you under the newly available programs; and
- Any benefits paid or used under the previous programs during the Plan Year in which you transfer will be applied to any annual maximum benefits provided under the newly available programs.
- Your health coverage will not change.

MEDICAL PROGRAM - OVERVIEW

Overview of Medical Program Options

CITGO offers a variety of Medical Program options administered by UnitedHealthcare. Options vary depending on whether or not your home zip code falls within an area covered by the UnitedHealthcare network.

The Medical Program options are as follows:

- Exclusive Provider Option - EPO
- Preferred Provider Option - PPO
- Non-Network Option
- Self Directed Health Plan Option – SDHP
- No Coverage

Healthy Rewards Program for Active Employees

If you are an active employee and select one of the coverage options listed above (other than No Coverage), you have the opportunity to try to improve your health and also gain financial rewards. You are eligible to receive incentive dollars during the current Plan Year that can help you pay for medical expenses not covered by the Medical Program you select. The incentive dollars are paid to your health care flexible spending account (FSA) or to your health care savings account (HSA), if you participate in the SDHP Option. See the Healthy Rewards Program description at:
https://www.hr.citgo.com//DOC/HealthyRewards/HealthyRewardsProgramOverview.pdf

You are not eligible to participate in the Healthy Rewards Program if you are covered as a retiree, as a disabled employee, or you elect the No Coverage option under the Medical Program.

Each Option Has Something To Offer

There are important features that are the same in all of your Medical Program options, and overall they are similar in how each option pays benefits.

- Each option covers In-network Preventive Care at 100%, which means the deductible and coinsurance do not apply. Certain preventive prescription drugs are also covered at 100%.

- Each option offers you a choice on the amount of your annual deductible before any of the options begin paying benefits and how much you will have to meet. However, the prescription drug benefits in the Self Directed Health Plan require that you must meet a deductible.

- After you meet the deductible, all of the options feature coinsurance or cost-sharing between you and the Medical Program.

- Once the amount you pay meets the out-of-pocket maximum, each option pays 100% for eligible covered expenses.

The differences among the Medical Program options have to do with:

- The amount of your monthly contribution.
- The amount of the deductible.
- The annual out-of-pocket maximum.
- Your access to a special account for qualified health care expenses, and the features of that account. For example, the Medical Program option you are enrolled in determines the amount of your maximum contributions and whether or not the funds roll over from year to year.
- Your prescription drug coverage.

When you select a Medical Program option, that option applies to you and all of your covered Dependents, even if your covered Dependents live outside of the network area.

The UnitedHealthcare Choice Network

The EPO, PPO and SDHP options utilize the Choice Network, the preferred provider network offered by UnitedHealthcare. This network provides access to a large, nationwide network of physicians who have agreed to discount their services as part of their contract agreement to be a provider in the UnitedHealthcare network.

Information about participating providers in the UnitedHealthcare Choice Network may be obtained through:

- UnitedHealthcare's website for CITGO participants at www.myuhc.com/groups/citgo;
- the UnitedHealthcare Customer Service Center at 1-866-317-6359; or
- the Benefits HelpLine at 1-888-443-5707.

If you are enrolled in the EPO, PPO, or SDHP option and you want to receive in-network benefits, it is your responsibility to ensure that a physician or other type of provider such as a diagnostic laboratory or a surgical facility is a participating network provider.

Be sure to present your ID card and identify yourself as a Choice Network member every time you visit a provider.

Authorization for Out-of-Network Services: If there is not a network specialist in your network area, you must call the UnitedHealthcare Customer Service Center at 1-866-317-6359 to request an authorization to obtain services from an out-of-network provider at the in-network level of benefits.

Transition of Care

Certain temporary "transition" provisions may be available for participants who are in the second or third trimester of pregnancy, who are undergoing treatment for long-term serious illnesses at the time that network options become effective in their area, or they first become eligible for coverage. These provisions are not automatic. Contact UnitedHealthcare Customer Service at 1-866-317-6359 if you think they may apply to you.

EPO Option

Under the EPO Option, you **must** receive all services from a network provider. The EPO Option uses the UnitedHealthcare Choice Network, which provides you access to a large, nationwide network of physicians.

Following are some highlights of this option:

- The EPO Option is best suited for individuals who are always willing to obtain their care from network providers.
- The EPO Option does not offer out-of-network benefits, except:
  - in the case of a life threatening emergency; or
  - if you obtain authorization to see a non-network specialist based on clinical need because there are no contracted providers within the specialty available in your geographic area as defined by the Claims Administrator.
- The Prescription Drug Program is automatically included (see Prescription Drug Program).
- You do not need to designate a Primary Care Physician (PCP); however, you are encouraged to use an in-network PCP for all non-specialty care. PCPs include family practitioners, general practitioners, internists and pediatricians.
- You can choose to see an in-network specialist anytime, without a referral.

If you are in the EPO Option and there is no network specialist in a certain field in your area, you must call the UnitedHealthcare Customer Service Center at 1-866-317-6359 to request authorization before obtaining services from an out-of-network provider at the in-network level. Such approvals are based on clinical and medical need of the patient.

PPO Option

Under PPO Option, you may receive benefits from a network provider or an out-of-network provider — but you will pay less when you use network providers. The PPO Option uses the UnitedHealthcare Choice Network, which provides you access to a large, nationwide network of physicians. Following are some highlights of this option:

- The PPO Option is best suited for individuals who want freedom of choice and the ability to use out-of-network providers.
- The PPO Option provides benefits for in-network and out-of-network services.
- Each time you need medical care, you are free to visit any provider you want; however, the choice you make determines how much you pay.
- If you choose an in-network doctor or hospital, you will pay less because in-network providers provide services at pre-negotiated rates so the Medical Program covers more of the cost.
- If you go to an out-of-network provider, your fees will be higher and the Medical Program will cover less of the cost.
- The Prescription Drug Program is automatically included (see Prescription Drug Program).
- You do not need to designate a Primary Care Physician (PCP); however, you are encouraged to use an in-network PCP for all non-specialty care. PCPs include family practitioners, general practitioners, internists and pediatricians.
- You can choose to see a specialist anytime, without a referral.

- Out-of-network providers are providers who are not part of the Choice Network and have not agreed to accept negotiated and discounted rates. If you are in the PPO Option and you obtain any services — other than emergency care — from an out-of-network provider or facility, you will receive the out-of-network benefit.

Non-Network Option

The Non-Network Option provides coverage for people who live in an area that does not have reasonable access to Choice Network providers and who do not want to travel to a network area to receive care. It is a traditional medical option with most Covered Health Services subject to an annual deductible and coinsurance. Following are some highlights of this option:

- Once you have met your deductible, the Medical Program will pay 80% of eligible expenses; you pay the other 20% (your coinsurance) until you meet your out-of-pocket maximum.
- The Prescription Drug Program is automatically included when you elect Medical Program coverage (see Prescription Drug Program).
- Under the Non-Network Option, if the physician or facility you use is a member of the network, you will continue to receive benefits under the Non-Network Option design, but your charges will be based on the lower, discounted network fee.

Self-Directed Health Plan (SDHP) Option

The Self-Directed Health Plan (SDHP) Option is essentially a high-deductible health plan. The SDHP is best suited for individuals who do not expect to need much medical care in the coming year but want to have basic protection for unexpected events, or for individuals who wish to participate in a tax-favored Health Savings Account.

Following are some highlights of this option:

- The Prescription Drug Program is automatically included. Unlike the other Medical Program options, the SDHP Option does not begin paying benefits for prescription drugs until after the annual deductible has been met, except for certain prescription drugs that are deemed to be preventive, and thus, covered at 100%.
- All non-preventive care is subject to an annual deductible and coinsurance, rather than co-pays.
- Instead of a single and a family deductible, SDHP deductibles are determined by the coverage level in which you are enrolled.
- Participants enrolled in the SDHP can elect to use UnitedHealthcare Choice Network providers or Out-of-Network providers.

The SDHP gives you an opportunity to participate in a tax-favored Health Savings Account (HSA).

- An HSA is a trust or custodial account established exclusively to receive tax-favored contributions (much like an IRA) on behalf of eligible individuals and their spouses and dependents who are enrolled in a SDHP.
- Amounts contributed to an HSA accumulate on a tax-free basis and are not subject to tax if they are used to pay for eligible medical expenses.
- Eligible medical expenses include COBRA, Medicare and retiree group medical premiums.

- Contributions can be rolled over from year to year, which means contributions made in one year and not used to pay eligible medical expenses in that year may be used to pay eligible medical expenses later.

To be eligible to participate in an HSA, you must:

- be enrolled in an eligible SDHP;
- not be enrolled at the same time in a non-SDHP Medical Program; and
- not be entitled to benefits under Medicare.

CITGO has partnered with Fidelity Investments to provide HSA accounts for eligible participants. While eligible participants may have an HSA with any HSA banking provider, CITGO will only sponsor payroll deductions for the Fidelity HSAs. Also, any wellness incentives you may earn will only be deposited into a Fidelity HSA account.

The Fidelity Health Savings Account (HSA) Features

- Your Fidelity Health Savings Account (HSA) is a tax-advantaged medical savings account available to you and your eligible covered dependents who are enrolled in a Self-Directed Health Plan (SDHP).
- Unlike a Flexible Spending Account (FSA), your HSA funds roll over and accumulate year to year, if not spent.
- HSAs are owned by you and not CITGO.
- Each participant will receive a debit card to use for qualified medical expenses.
- Triple tax advantage:
  - Deposits/contributions are tax deductible.
  - Interest on your savings accumulates tax deferred.
  - Funds withdrawn are tax-free when used for qualified medical expenses.
- You will have sound Fidelity Investment choices to grow your HSA funds if you choose to do so.

How An HSA Works

- An HSA works much like a medical Flexible Spending Account (FSA), but if you do not use any or all of your HSA dollars, they rollover to the next year and can accumulate over time for greater protection.
- Both you and CITGO can contribute to the HSA.
- Since your SDHP Option will not begin paying benefits, other than your preventive care, until your deductible is met, you can use your HSA to pay for your health care expenses
- You may use HSA funds to pay for:
  - Expenses that must be met before your deductible.
  - Pay for services not covered by your Medical Program such as alternative therapies or your portion of out-of-network care.
- If you leave employment with CITGO, your HSA account remains yours. Therefore, it can be used to cover qualified medical expenses during periods of unemployment.

Your Contributions To Your HSA

Contributions may be made via:

- The convenience of payroll deduction on a pre-tax basis; or
- Direct to your Fidelity HSA by check or bank debit. Cash contributions made to your HSA account are 100% deductible from your federal gross income (within legal limits).

When calculating your contributions to your HSA, it is very important to include the amount of Healthy Rewards Incentives you plan to earn in your calculations.

IRS HSA Maximums

- The Internal Revenue Service adjusts the maximum contribution limit to HSAs annually.
- If you are age 55 and older, "catch-up" contributions of $1,000 per year are available above these limits. CITGO will only consider the age of the employee in increasing the statutory limit for catch up contributions.
- You may make changes to the amount you contribute via payroll deduction by contacting the Benefits HelpLine at 1-888-443-5707 or benefits@citgo.com. Changes become effective within 1-2 pay periods.
- HSA deductions are taken from all pay periods up to the lesser of the maximum IRS limit or the maximum amount you have elected to contribute.

Eligible HSA Expenses

- Funds you withdraw from your HSA are tax-free when used to pay for qualified medical expenses as described in Section 213(d) of the Internal Revenue Code. In general, the expenses must be to alleviate or prevent a physical or mental defect or illness, including dental and vision. A list of qualified expenses is available on the IRS website, www.irs.gov in IRS Publication 502, "Medical & Dental Expenses".
- Funds also can be used to pay for:
  - Future Medicare Premiums
  - COBRA Premiums
  - Long Term Care Premiums
- Your HSA funds can be withdrawn by debit card, check or a withdrawal request.
- Checks and debits do not have to be made payable to the provider.
- Funds can be withdrawn for any reason, but withdrawals that are not for documented qualified medical expenses are subject to income taxes and a 20% penalty.
- The 20% tax penalty is waived for persons who have reached the age of 65 or have become disabled at the time of the withdrawal.

Setting Up Your Fidelity HSA

If you elect to enroll in the SDHP, you are eligible to establish a Fidelity HSA® (Health Savings Account). To open your Fidelity HSA, please:

- Go to NetBenefits or www.401k.com.
- After you log on, click the "Open" link next to your Health Savings Account.
- Complete and submit the Fidelity HSA online application so Fidelity can open your account and accept contributions. **Fidelity cannot accept contributions to your HSA until you have opened your account.**

You may also request a Fidelity HSA debit card with your application. After your Fidelity HSA is open, you

may transfer assets from other Health Savings Accounts to your Fidelity HSA by submitting a Transfer of Assets request to Fidelity. If you don't have Internet access, or if you have further questions, simply call 1-800-544-3716 for personal assistance in setting up your Fidelity HSA. It is important to remember that you may set up your HSA with your own HSA provider. However, **Fidelity is the only HSA provider where CITGO will sponsor the monthly administrative fee**, deposit payroll deductions, and transmit any wellness incentives you have earned.

More information about qualified Health Savings Account expenditures can be found by accessing:

- IRS Publication 502 located on the web at: http://www.irs.gov/pub/irs-pdf/p502.pdf.
- IRS Publication 969 located on the web at: http://www.irs.gov/pub/irs-pdf/p969.pdf.

Consult a tax advisor should you require specific tax advice about your HSA account, qualified expenses, or other information pertaining to your individual HSA account.

MEDICAL PROGRAM - IMPORTANT FEATURES

Definition of Covered Medical Services

Medical Program benefits apply only to eligible expenses for Covered Health Services, which are defined as those health services, including services, supplies, or pharmaceutical products, which are all of the following:

- Medically Necessary (defined below);
- Described as Covered Health Services in this Summary Plan Description; and
- Not otherwise excluded in this Summary Plan Description under the Medical Exclusions and Limitations.

Definition of Medically Necessary

- Health care services provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, mental illness, substance use disorder, condition, disease or its symptoms that are in accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance use disorder, disease or its symptom(s).
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic result as to the diagnosis or treatment of your Sickness, Injury, disease or symptom(s).

Generally Accepted Standards of Medical Practice

UnitedHealthcare administers the claims on behalf of the Medical Program in accordance with Generally Accepted Standards of Medical Practice, scientific evidence, prevailing medical standards and clinical guidelines supporting determinations regarding specific services. The clinical guidelines are revised from time to time and are available to Medical Program participants on www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card. They are also available to Physicians and other health care professionals at www.unitedhealthcareonline.com.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research.

Covered health services must be provided:

- while the Medical Program is in effect;
- prior to the effective date of any of the termination conditions set forth in this SPD or under the Plan; and
- only when the person who receives services meets the eligibility requirements for coverage under the

Programs.

Reasonable and Customary (R&C) Charges

If you choose to see an out-of-network provider, the Medical Program will reimburse a portion of covered expenses up to the lesser of:

- the amount billed for the services; or
- an amount determined by UnitedHealthcare to be reasonable and customary (R&C) for that service.

The R&C charge is the lower of the provider's usual charge or the prevailing charge in the geographic area where it is furnished — as determined by UnitedHealthcare. To determine the R&C charge, UnitedHealthcare takes into account the:

- complexity of the service;
- degree of skill needed;
- type or specialty of the provider;
- range of services provided by a facility; and
- prevailing charge in the area in which services are performed.

If you incur a covered expense that is above the R&C limit, you are responsible for paying the excess amount (R&C Excess). You have the right to have UnitedHealthcare review your claim if you or your physician believes that there are special circumstances that justify the charge over the R&C limit.

Pre-Determination of Medical Benefits

If you have a question about whether a particular treatment is covered or how much is payable under the Medical Program, you may:

- call the UnitedHealthcare Customer Service Center at 1-866-317-6359; or
- submit a written description of the proposed medical treatment and its cost to the Claims Administrator.

If you choose to submit a written description of your proposed treatment, the description must be completed by a Physician. Written notification of benefits may take up to 30 days.

Any notification you receive from the Claims Administrator is not a guarantee of payment of the estimated benefits.

Therapeutic vs. Maintenance Care

The Medical Program covers rehabilitation services (physical, occupational, speech and hearing therapy) and chiropractic care and spinal treatment as long as they are considered therapeutic. If these services are administered to instead "maintain" a level of functioning, they are not covered under the Medical Program. Rehabilitation services and chiropractic care have annual limits, so you should encourage your provider to submit these claims for reimbursement as soon as possible.

Care Coordination

The Care Coordination program is designed to encourage an efficient system of care for you and your covered Dependents by identifying and addressing possible covered health care needs that are not met.

This may include:

- hospital pre-admission review;
- admissions counseling;
- inpatient care advocacy; and
- certain discharge planning and disease management activities.

Care Coordination can be called anytime you need more information before proceeding with medical care. They can be of valuable assistance to you in reaching important health care decisions. **You can reach UnitedHealthcare Care Coordination at 1-866-317-6359.**

Notification Requirements

One of the most important services of Care Coordination is pre-admission and concurrent review of hospital or other inpatient care as well as review of certain other services. You, a family member or friend, or your provider is **required** to notify Care Coordination if you or any of your covered Dependents receive the following services:

- ambulance transfer — non-emergency air (pre-notification required);
- Clinical Trials (pre-notification required);
- Congenital heart disease surgery (pre-notification required);
- Durable Medical Equipment or prosthetic device if the purchase price or accumulated rental cost is more than $1,000, including diabetes equipment for the management and treatment of diabetes (pre-notification required);
- Genetic Testing – BRCA (pre-notification required);
- Home Health Care (pre-notification required);
- Hospice care – impatient (72 hours before receiving services);
- Inpatient hospital stay (72 hours before an elective admission or within two business days after an emergency or non-elective admission);
- Inpatient mental health or substance abuse treatment stay (72 hours before a non-emergency admission or within 48 hours of an emergency or non-elective admission);
- Lab, x-ray and major diagnostics – CT, PET scans, MRI, MRA and Nuclear Medicine, including diagnostic catheterization and electrophysiology implants;
- Maternity/newborn inpatient hospital stay that is more than 48 hours following a normal vaginal delivery or 96 hours following a cesarean delivery (as soon as reasonably possible);
- Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility). Intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management (pre-notification required);
- Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders - inpatient services (including Partial Hospitalization/Day treatment and services at a Residential Treatment Facility). Intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management (pre-notification required);
- Obesity surgery (pre-notification required);

- Outpatient sleep studies (notification 5 business days before scheduled services is required);
- Private duty nursing (72 hours before receiving services);
- Prosthetic Devices for items that will cost more than $1,000 to purchase or rent (pre-notification required);
- Reconstructive procedures, including breast reconstruction surgery following mastectomy and breast reduction surgery (72 hours before receiving services);
- Skilled nursing/extended care facility or impatient rehabilitation facility services (72 hours before an elective admission or within two business days after an emergency or non-elective admission);
- Substance Use Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility). Intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing. Extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management (pre-notification required);
- Surgery - cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, and sleep apnea surgeries and orthognathic surgeries (pre-notification required);
- Therapeutics – all outpatient therapeutics (pre-notification required); and
- Transplantation services (as soon as the possibility of a transplant arises — and before a pre-transplantation evaluation).

Notification is required within two business days of admission or on the same day of admission if reasonably possible after you are admitted to a Non-Network Hospital as a result of an Emergency.

This notification process is mandatory and your cooperation in making that initial phone call is essential to the success of the program. Failure to initiate this notification process may result in a $1,000 penalty.

When calling Care Coordination about a planned hospital confinement or inpatient surgery, be prepared to provide general information about your diagnosis and treatment and the name of your doctor and hospital.

You can reach UnitedHealthcare Care Coordination at 1-866-317-6359.

Cancer Resource Services

Cancer Resource Services, a program offered through UnitedHealthcare, provides assistance, information and access to top cancer centers on an in-network basis if you or a covered Dependent is diagnosed with cancer. All non-Medicare eligible participants can use the services, use of the program is voluntary and there is no charge to take advantage of it. Here are some highlights of the program:

- Cancer Resource Services is intended to help you understand your cancer care options. They have agreements with many of the nation's leading cancer centers.
- It is **not** intended to offer medical advice — you still make the decision about what care to receive and where to receive it.
- By contacting Cancer Resource Services, you can determine the location of the nearest network cancer center and be sure that your claims will be paid on an in-network basis.
- If you are in the Non-Network Option or SDHP, you will continue to receive the benefits under your

option, but your charges will be based on the lower, discounted network fees.

To take advantage of these services you must contact Cancer Resource Services through UnitedHealthcare prior to receiving care at a participating Cancer Resource Services center.

24-Hour NurseLine

CITGO offers a dedicated NurseLine through UnitedHealthcare, with registered nurses available for medical treatment consultation 24 hours a day, seven days a week. The nurse can help you learn self-care techniques and understand what symptoms might mean at no cost to you.

You can reach the NurseLine toll-free at 1-866-735-5686 (PIN: 980) or via the Internet at www.myuhc.com.

Through the NurseLine, you can:

- find doctors and hospitals that meet quality and efficiency of care criteria;
- understand your symptoms and get answers to routine illness questions; help with minor injuries and treatment, chronic conditions, medication safety and heart health issues; assistance with choosing appropriate medical care; and information about working with your doctor;
- explore treatment options and alternatives;
- learn about managing pregnancy, diabetes and coronary artery disease;
- find out how to take medication effectively and safely; and
- access an extensive Health Information Library with over 1,100 prerecorded topics.

United Resource Networks (URN) Transplant Management

Transplantation services may be received at a designated United Resource Networks (URN) facility. Using a URN facility is voluntary; however, charges for services at a URN facility are covered at 100% (under the SDHP, the applicable deductible must first be satisfied) and expenses are covered for travel, lodging and meals as listed below.

URN is a group of hospitals that are highly specialized and are established leaders in the field of transplantation. URN facilities:

- provide a high quality of care;
- have high success rates;
- report shorter hospital stays; and
- report fewer incidents of complications.

For organ or tissue transplant services provided at a designated URN facility, URN provides specialized services including:

- referral to leading transplant institutions around the country;
- special managed care services provided by a regional organ transplant coordinator;
- negotiated discounts with network providers; and
- assistance with travel-related expenses. **The following expenses for travel, lodging and meals are available for in-network benefits only:**
  - transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant

procedure or necessary post-discharge follow-up;

- travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the designated URN facility;

- eligible expense for lodging and meals for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $50 for one person or up to $100 for two people; and

- if the patient is an eligible Dependent who is a minor Child, the transportation expenses of two companions will be covered and lodging and meal expenses will be reimbursed up to the $100 per diem rate.

- **Travel-related expenses are not provided for out-of-network benefits.**

There is a combined overall lifetime maximum benefit of $10,000 per covered participant for all transportation, lodging and meal expenses incurred and reimbursed under the Medical Program by the transplant recipient and companion(s) in connection with all transplant procedures.

Benefits are available for cornea transplants; however, there are no additional benefits if they are performed at a designated URN facility (they are covered the same as any other surgical procedure), and travel-related expenses are not reimbursed. If you receive services for a cornea transplant in-network, the benefit is subject to the coinsurance plus any deductibles, if applicable, and copays for your benefit option.

Bariatric Resource Services (BRS)

Bariatric Resource Services (BRS) is a surgical weight loss solution for those individual(s) who qualify clinically for bariatric surgery. Specialized nurses provide support through all stages of the weight loss surgery process. Our program is dedicated to providing support both before and after surgery. Nurses help with decision support in preparation for surgery, information and education important in the selection of a bariatric surgery program, and post-surgery and lifestyle management. Nurses can provide information on the nation's leading obesity surgery centers, known as Centers of Excellence. Access the Bariatric Resource Services Centers of Excellence program at **(888) 936-7246**.

Morbid Obesity Surgery

The Medical Program covers surgical treatment of morbid obesity provided all of the following are true:

- you are over the age of 18 and are physically mature;
- you have a minimum Body Mass Index (BMI) of 40, or $\geq$ 35 with at least 1 co-morbid condition present;
- you use a OptumHealth Bariatric Center of Excellence (COE);
- you have completed a multi-disciplinary surgical preparatory regimen, which includes a psychological evaluation; and
- you have a 6-month Physician supervised diet documented within the last 2 years.

The following are not covered under the surgical treatment of morbid obesity:

- revisions (performed primarily for weight gain); and
- excess skin removal, unless medically necessary.

All authorization information and enrollment for bariatric surgery must be initiated through OptumHealth's

Bariatric Resource Services (BRS) Program. Covered participants seeking coverage for bariatric surgery should notify OptumHealth as soon as the possibility of a bariatric surgery procedure arises (and before the time a pre-surgical evaluation is performed) at a bariatric surgery center by calling OptumHealth at **(888) 936-7246** to enroll in the program.

Hearing Aid Discount Program

CITGO offers a hearing aid discount program through UnitedHealthCare (UHC), in conjunction with Hi-HealthInnovations, to provide employees and their dependents enrolled in our medical plans with discounts on premium hearing aids and easy access to hearing tests.

According to the National Institutes of Health, people generally pay between $3,000 and $5,000 for a single hearing aid. Through the UHC/Hi-HealthInnovations program, you get custom-programmed, high-quality hearing aids at a fraction of the retail price.

To get started, UHC members submit their health plan information at www.hihealthinnovations.com/united and are emailed their low member pricing, hearing test options, and a physician certification form. Employees can use an existing hearing test from CITGO Health Services if it is less than one year old. In just three simple steps, you could have a custom-programmed hearing aid delivered to you from $599 to $799 depending on the model chosen.

More information on the steps required to take advantage of the Hearing Aid Discount benefit is available on the Benefits Connection website. Additional information can also be obtained by contacting Hi-HealthInnovations at 1-866-926-6632, Monday - Friday, 9:00 a.m. - 5:00 p.m. CT.

Personal Health Support

Personal Health Support programs that focus on prevention, education, and closing the gaps in care are provided by the Claims Administrator. These programs are designed to encourage an efficient system of care for you and your covered Dependents. A Personal Health Support Nurse is the primary nurse that the Claims Administrator may assign to you if you have a chronic or complex health condition. If a Personal Health Support Nurse is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

The following chart highlights some of the medical services and supplies that are covered under the Medical Program. **This is a summary only.** It is not intended to be all-inclusive. See also Medical Limitations and Exclusions for other important information.

	EPO	PPO		Non-Network	SDHP	
	Network Only	**In-Network**	**Out-of-Network**	**Non-Network**	**In-Network**	**Out-of-Network**
	You Pay:	**You Pay:**	**You Pay:**	**You Pay:**	**You Pay:**	**You Pay:**
General Information						
Annual Deductible	$0 per person; $0 per family	$350 per person; $1,050 per family maximum	$1,050 per person; $3,050 per family maximum	$600 per person; $1,800 per family maximum	$1,500 Employee Only; $3,000 all other levels	
Percentage of Cost You Pay - Your "coinsurance"	15%	20%	40%	20%	20%	40%
Annual Out-of-Pocket Maximums (Separate maximums apply for prescription drug, except for SDHP Option)	$5,350 medical + separate $1,250 Rx per person $10,700 medical + separate $2,500 Rx per family	$4,350/person ($4,000 medical + $350 deductible) + separate $1,000 Rx per person $9,050/family ($8,000 medical + $1,050 deductible) + separate $2,000 Rx per family	$13,050/person ($12,000 medical + $1,050 deductible) + separate $1,000 Rx per person $27,050/family ($24,000 medical + $3,050 deductible) + separate $2,000 Rx per family	$5,600/person ($5,000 medical + $600 deductible) + separate $1,000 Rx per person $11,800/family ($10,000 medical + $1,800 deductible) + separate $2,000 Rx per family	$4,000/Employee only coverage $8,000/Employee plus dependent coverage (Includes deductible and Rx costs)	

The Out of Pocket Maximum excludes certain expenses, including spending for non-covered services and amounts in excess of R&C.

Certain services and types of care require Pre-Notification before they are rendered. Ultimately, it is the participant's responsibility to make sure Pre-Notification rules are adhered to. Please be sure to review the Notification Requirements section of this Summary Plan Description for more information on how and when pre-notification is necessary.

	EPO	PPO		Non-Network	SDHP	
	Network Only	In-Network	Out-of-Network	Non-Network	In-Network	Out-of-Network
	You Pay:	You Pay:	You Pay:	You Pay:	You Pay:	You Pay:
Outpatient Services						
Allergy Testing and Treatment	15% for testing; $25 copay per office visit ($40 copay if specialist) for treatment	20% after deductible for testing; $25 copay per office visit ($40 copay if specialist) for treatment	40% after deductible	20% after deductible	20% after deductible	40% after deductible
Ambulance Air or ground	15%	20% after deductible	40% after deductible	20% after deductible	20% after deductible	40% after deductible
Chiropractic Care and Spinal Treatment Limit of 60 visits per year	15%	20% after deductible	40% after deductible	20% after deductible	20% after deductible	40% after deductible
Doctor Office Visits Including routine diagnostic testing and lab work	$25 copay per office visit ($40 copay if specialist)	$25 copay per office visit ($40 copay if specialist)	40% after deductible	20% after deductible	20% after deductible	40% after deductible
Emergency Care Hospital emergency room (copay waived if admitted directly through Emergency Room)	$150 copay per visit plus 15%	$150 copay per visit plus 20%	$150 copay per visit plus 20%	20% after deductible	20% after deductible	20% after deductible

	EPO	PPO		Non-Network	SDHP	
	Network Only	**In-Network**	**Out-of-Network**	**Non-Network**	**In-Network**	**Out-of-Network**
	You Pay:	**You Pay:**	**You Pay:**	**You Pay:**	**You Pay:**	**You Pay:**
Injections (including allergy injections) When received in doctor's office	$0 if no physician charge, otherwise, $25 copay per office visit ($40 copay if specialist)	$0 if no physician charge, otherwise, $25 copay per office visit ($40 copay if specialist)	40% after deductible	20% after deductible	20% after deductible	40% after deductible
Lab/X-Ray Including outpatient surgery, preadmission testing, and diagnostic services	0% (In-Network Only)	0%	40% after deductible	20% after deductible	20% after deductible	40% after deductible
Outpatient Surgery Includes operating and recovery room, services and supplies, facilities and surgeon fees	$200 outpatient facility copay per surgical admission; 15% after copay	$200 outpatient facility copay per surgical admission; 20% after copay and deductible	$250 outpatient facility copay per surgical admission; 40% after copay and deductible	20% after deductible	20% after deductible	40% after deductible
Preventive Care Periodic physicals; well-baby, child, adult care; immunizations; routine screenings prescribed by your physician when preventive coding is submitted	0%; not subject to deductible	0%; not subject to deductible	Not covered	0%; not subject to deductible	0%; not subject to deductible	Not covered

	EPO	PPO		Non-Network	SDHP	
	Network Only	In-Network	Out-of-Network	Non-Network	In-Network	Out-of-Network
	You Pay:	You Pay:	You Pay:	You Pay:	You Pay:	You Pay:
Rehabilitation Services Physical, occupational, speech and hearing. Limit of 60 visits per therapy per year.	15%	20% after deductible	40% after deductible	20% after deductible	20% after deductible	40% after deductible
Second Surgical Opinion	15%	20% after deductible	40% after deductible	20% after deductible	20% after deductible	40% after deductible
Urgent Care	$50 copay	$50 copay	40% after deductible	20% after deductible	20% after deductible	40% after deductible
Maternity and Pregnancy Services						
Doctor Office Visits	$40 copay (no copay for prenatal care after first visit)	$40 copay (no copay for prenatal care after first visit)	40% after deductible	20% after deductible	20% after deductible	40% after deductible
Hospital Inpatient Stay Including newborn care during initial hospital confinement	15% after $250 inpatient hospital copay	20% after $250 inpatient hospital copay and deductible	40% after $250 inpatient hospital copay and deductible	20% after deductible	20% after deductible	40% after deductible
Mental Health and Substance Abuse Services						
Inpatient	$250 copay per admission; 15% after copay	$250 copay per admission; 20% after copay and deductible	$250 copay per admission; 40% after copay and deductible	20% after deductible	20% after deductible	40% after deductible
Outpatient	$25 copay	$25 copay	40% after deductible	20% after deductible	20% after deductible	40% after deductible

	EPO	PPO		Non-Network	SDHP	
	Network Only	In-Network	Out-of-Network	Non-Network	In-Network	Out-of-Network
	You Pay:	You Pay:	You Pay:	You Pay:	You Pay:	You Pay:
Inpatient Hospital Services						
Inpatient Hospital Stay and Services Including semi-private room and board, intensive/ cardiac care, routine newborn care, misc. hospital services and supplies, surgeon's fees, anesthesia and its administration, and physician hospital visits	$250 copay per admission; 15% after copay	$250 copay per admission; 20% after copay and deductible	$250 copay per admission; 40% after copay and deductible	20% after deductible	20% after deductible	40% after deductible
Alternatives to Hospitalization						
Home Health Care Out-of-network benefits limited to 60 8-hour visits per year	15%	20% after deductible	40% after deductible	20% after deductible	20% after deductible	40% after deductible
Hospice Care	15% if at home $250 copay per confinement, 15% after copay	20% after deductible if at home $250 copay per confinement, 20% after copay	40% after deductible	20% after $600 deductible	20% after deductible	40% after deductible

	EPO	PPO		Non-Network	SDHP	
	Network Only	In-Network	Out-of-Network	Non-Network	In-Network	Out-of-Network
	You Pay:	You Pay:	You Pay:	You Pay:	You Pay:	You Pay:
Skilled Nursing/ Extended Care Facility 100-day maximum per year	15%	20% after deductible	40% after deductible	20% after deductible	20% after deductible	40% after deductible
Other Covered Services						
Bereavement Counseling Limited to $500 per person per incident	15%	20% after deductible	40% after deductible	20% after deductible	20% after deductible	40% after deductible
Durable Medical Equipment Including necessary repairs as required and replacement once every 3 years for the most cost-effective equipment	15%	20% after deductible	40% after deductible	20% after deductible	20% after deductible	40% after deductible
Oral Surgery Covered only in certain limited circumstances	$250 copay per admission (if inpatient), 15% after copay	$250 copay per admission (if inpatient), 20% after copay and deductible	$250 copay per admission (if inpatient), 40% after copay and deductible	20% after deductible	20% after deductible	40% after deductible
Private Duty Nursing Covered for outpatient services only	15%	20% after deductible	40% after deductible	20% after deductible	20% after deductible	40% after deductible

	EPO	PPO		Non-Network	SDHP	
	Network Only	In-Network	Out-of-Network	Non-Network	In-Network	Out-of-Network
	You Pay:	You Pay:	You Pay:	You Pay:	You Pay:	You Pay:
Prosthetic Devices Including necessary repairs as required and replacement once every 5 years	15%	20% after deductible	40% after deductible	20% after deductible	20% after deductible	40% after deductible
Radiology, Anesthesiology and Pathology (RAP) Services	Outpatient: 0% Inpatient: 15% (In-Network Only)	Outpatient: 0% Inpatient: 20% after deductible	40% after deductible	20% after deductible	20% after deductible	40% after deductible
Reconstructive Procedures, Surgery or Services	15%	20% after deductible	40% after deductible	20% after deductible	20% after deductible	40% after deductible
TMJ Treatment Non-surgical procedures and treatment only; $1,000 lifetime maximum	15%	20% after deductible	40% after deductible	20% after deductible	20% after deductible	40% after deductible
Transplantation Services	15%	20% after deductible	40% after deductible	20% after deductible	20% after deductible	40% after deductible
Vision /Hearing Exams Covered when due to injury or covered medical condition	15%	20% after deductible	40% after deductible	20% after deductible	20% after deductible	40% after deductible

MEDICAL PROGRAM - COST SHARING PROVISIONS

Copayments

Copayments, or copays, are a fixed dollar amount you pay for certain services received under the EPO Option and PPO Option. The amount of your copay is determined by the option you select and the services you receive.

Copays do not apply to the Non-Network Option or to the SDHP Option.

Annual Deductible

The annual deductible is the initial amount of eligible medical expenses you must pay before the Program pays benefits. Deductibles apply to each Plan Year and start over each January 1. The annual deductible does not include:

- monthly premium contributions;
- costs for prescription drugs (except under the SDHP);
- out-of-network amounts exceeding reasonable and customary (R&C) charges (see Reasonable and Customary (R&C) Charges);
- pre-notification failure penalties; or
- expenses for services not covered under the Medical Program.

Note: The annual deductible does not apply to the EPO Option.

Individual and Family Deductibles

PPO and Non-Network Options

The **individual deductible and the family deductible** work as follows:

- The individual deductible is the amount of covered medical expenses you must first pay for each covered person. Once a family member has met his or her individual deductible, the Medical Program will pay benefits for his or her covered expenses, regardless of whether other family members have incurred any covered expenses.
- Amounts applied to each covered person's individual deductible are also applied to the family deductible. However, no one individual in the family will have to meet a deductible greater than his or her individual deductible.
- The family deductible is met when the accumulated expenses that were applied to each family member's individual deductible equals or exceeds the family deductible amount.
- Once the family deductible has been met, all family members can begin receiving benefits for covered expenses without satisfying any additional deductible.

SDHP Option

Instead of an individual and family deductible, the SDHP deductible is determined by the level in which you are enrolled ("Employee Only", "Employee and Spouse", "Employee and Child(ren)", or "Employee and Family"):

- If you have "Employee Only" coverage under the SDHP, the Medical Program will pay benefits once

you have reached the $1,500 annual deductible.

- For all other levels, the deductible is $3,000. There is no individual deductible, and the full family deductible of $3,000 must be met as a group (in total or by one individual) before any benefits will be paid for you or your Dependents.

Under the SDHP, the total deductible must be met before the Medical Program begins paying benefits for retail and mail-order prescription drugs, except for certain preventive prescription drugs that are not subject to the deductible. Until the deductible is met, you will pay the full cost of any prescription drug that is not preventive.

How Deductibles Work For In-Network and Out-of-Network Services – PPO and SDHP Options

If you meet the annual out-of-network deductible and then go to a network provider, you do not have to also meet the annual in-network deductible. It is considered already met; or

- If you meet the annual in-network deductible and then go to an out-of-network provider, the annual out-of-network deductible would **not** be considered to have been met because it is a higher deductible. You would have to satisfy the out-of-network deductible before out-of-network benefits would be paid.
- The amount of your in-network deductible will apply toward your out-of-network deductible, however, your out-of-network deductible will never apply to your in-network deductible.

Coinsurance

After the annual deductible is met, if applicable, the Medical Program begins paying its percentage share of eligible expenses for certain Covered Health Services, and you pay the rest. The percentage you pay is your "coinsurance." The amount of coinsurance you pay is determined by the option you select.

In-Network and Out-of-Network Benefits in Action: An Example

Let's look at an example. Say you visit a provider who usually charges $5,000 for a service. But, that provider is in the network. That means they have agreed to accept a discounted rate – say, $4,000 – rather than the amount they normally charge. How much will you have to pay?

	EPO In-Network	PPO In-Network
Provider's Surgery Charge	$5,000	$5,000
Network Discount	$1,000	$1,000
Balance After Deductible	$4,000 - $0 = $4,000	$4,000 - $350 = $3,650
Your Cost Sharing	15% co-insurance	20% co-insurance
Your Medical Program pays	$4,000 x 85% = $3,400	$3,650 x 80% = $2,920
You pay	$4,000 x 15% = **$600**	$3,650 x 20% = $730 PLUS $350 deductible**: $1,080**

Now, let's say you visit a provider outside the network for the same service. The provider still charges $5,000 – and this time, they do not have any agreement with UHC to accept a lower rate. In this case, UHC will base their share of the cost on a Reasonable and Customary allowed amount for that service. This is the most money that they consider to be a fair and reasonable cost, based on what other providers in the area charge. It is not necessarily the same as UHC's discounted rate. In this case, let's say the allowed amount is $2,500.

So, what does that mean for you? Going out-of-network for this sample service could cost you thousands of dollars more.

	EPO Out-of-Network	PPO Out-of-Network
Provider's Charge	**$5,000**	**$5,000**
The Medical Program's Allowed Amount	$0	$2,500
Balance After Deductible	$5,000 - $0 = $5,000	$2,500 - $1,050 = $1,450
Your Cost Sharing	100%	40% of the allowed amount PLUS the difference between the R&C allowed amount and provider's charge
Your Medical Program pays	$0	60% of $1,450 = $870
You Pay	$5,000	40% of $1,450 = $580 PLUS $2,500 PLUS deductible
Your Total Cost	**$5,000**	**$4,130**

Annual Out-of-Pocket Maximum (Coinsurance Maximum)

The out-of-pocket maximum provision, also known as the coinsurance maximum, protects you from extreme financial loss in the event of catastrophic medical expenses. The out-of-pocket maximum limits the amount of covered expenses you must pay each year. There is an out-of-pocket maximum for each individual and for the entire family. The out-of-pocket maximums apply to each Plan Year and start over each January 1.

Here is how the out-of-pocket maximum works:

- After you have paid your deductible (when applicable), and your out-of-pocket coinsurance costs for covered expenses (including your deductible) have reached your out-of-pocket maximum, the Medical Program will pay 100% **of any additional eligible medical expenses** you incur during the remainder of that Plan Year.
- Amounts applied to each individual's out-of-pocket maximum are also applied to the family out-of-pocket maximum. However, no one individual in the family will have to meet an out-of-pocket maximum greater than his or her individual out-of-pocket maximum.
- The family out-of-pocket maximum is met when the accumulated expenses that were applied to each

family member's individual out-of-pocket maximum equals or exceeds the family out-of-pocket maximum amount.

- Once the family out-of-pocket maximum has been met, all individual out-of-pocket maximums are considered to be met for the Plan Year.

The following out-of-pocket expenses do not apply to the out-of-pocket maximum and will **not** be paid at 100% even if you reach the maximum:

- monthly premium contributions;
- expenses for services not covered under the Medical Program;
- out-of-network expenses exceeding reasonable and customary charges;
- prescription drug expenses purchased through the Prescription Drug Program (which has a separate out-of-pocket maximum for the EPO, PPO and Non-Network Options). **If you are in the SDHP, the cost of prescription drugs ARE applied to your annual out-of-pocket maximum**; and
- pre-notification failure penalties.

PPO and SDHP In-Network and Out-of-Network Out-of-Pocket Maximum

If you:

- meet the annual out-of-network out-of-pocket maximum and then go to a network provider, you do **not** have to also meet the annual in-network out-of-pocket maximum. It is considered already met; or
- meet the annual in-network out-of-pocket maximum and then go to an out-of-network provider, the annual out-of-network out-of-pocket maximum would **not** be considered to have been met. You would have to satisfy the out-of-network maximum before out-of-network benefits would be paid at 100%.

MEDICAL PROGRAM - COVERED HEALTH SERVICES

The following chart gives additional benefit descriptions, explanations and limitations for certain Covered Health Services.

Ambulance	• **Emergency only (air or ground):** transportation must be a licensed ambulance service to the nearest hospital where emergency health services can be performed. Air transportation is covered if ground transportation is impossible or would put your life or health in serious jeopardy.
	• **Non-emergency:** transportation by professional ambulance, other than air ambulance (either ground or air ambulance, as UnitedHealthcare determines appropriate).
	• Transportation must be one of the following:
	  ◦ From a non-Network Hospital to a Network Hospital;
	  ◦ To a Hospital that provides a higher level of care that was not available at the original Hospital;
	  ◦ To a more cost-effective acute care facility; or
	  ◦ From an acute facility to a sub-acute setting.
	• Must be part of a medical care plan to receive non-emergency transport and prior notification is required. **You must notify Care Coordination at 866-317-6359 before using non-emergency ambulance services.**

Assistant Surgeons	Although certain procedures sometimes require an assistant surgeon, in many cases, an assistant surgeon is not considered a Covered Health Service. Covered Health Services for an assistant surgeon will be covered at 50% of the R&C amount or negotiated rate of the primary surgeon's fees.
Bereavement Counseling Services	The Medical Program pays up to $500 for bereavement counseling services provided by a licensed M.D., Ph.D., social worker or counselor for covered members of the patient's immediate family within six months after a covered patient's death.

Durable Medical Equipment	The Medical Program pays the applicable covered percentage of eligible charges after the deductible, if applicable, for the most cost-effective piece of equipment, including: • necessary required repairs of Durable Medical Equipment; • replacement once every three years; and • one wig per lifetime is covered if due to loss of hair resulting from treatment of a malignancy, a medical condition causing hair loss, or a permanent loss of hair from an accidental injury. **You must contact Care Coordination for any single item that is over $1,000 (either purchase price or cumulative rental).** Care Coordination will decide if equipment should be purchased or rented. You must purchase or rent the equipment from the vendor chosen by Care Coordination.
Emergency Care (Outpatient)	Emergency Care is services that are required to stabilize or initiate treatment in an emergency. Emergency Care must be received on an outpatient basis at a Hospital or Alternate Facility. **If you are in the EPO Option or PPO Option:** • you pay a $150 copay plus 15% (EPO) or $150 copay plus 20% (PPO) per visit to the emergency room (this is waived if you are admitted to the hospital directly through the emergency room); and • you should notify Care Coordination within two business days after you receive outpatient Emergency Care to ensure prompt payment. **If you are in the Non-Network Option or the SDHP:** • you pay your 20% coinsurance after you meet your deductible. **If you are admitted to the hospital following an emergency, you must notify Care Coordination within two business days. Please be sure to review the Notification Requirements of the Medical Program.**
Home Health Care	The Medical Program will pay for Home Health Care provided by or supervised by a registered nurse in your home, as follows: • services from a Home Health Care agency must be ordered by a Physician; • benefits are available only when Home Health Care is provided on a part-time, intermittent schedule and when skilled Home Health Care is required; • skilled Home Health Care is skilled nursing, skilled teaching and skilled rehabilitation services — not custodial care; • **for out-of-network benefits, coverage is limited to 60 visits per Plan Year, with one visit equal to eight hours**; and • you must notify Care Coordination before receiving services — **if you fail to do so, you will be subject to a $1,000 penalty.**

Hospice Care	Hospice care, both inpatient and outpatient, is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill patient. Under the Medical Program: • Hospice services must be ordered/prescribed by a Physician; and • you must notify Care Coordination at least 72 hours prior to receiving services — **if you fail to do so, you will be subject to a $1,000 penalty**.
Inpatient Hospital Services	• Semi-private room and board • Intensive/cardiac care • Routine newborn care • Miscellaneous hospital services & supplies • Surgeon • Anesthesia and administration • Physician hospital visits **If you are admitted to the hospital, you must notify Care Coordination at least 72 hours in advance (or within two business days following an emergency). Please be sure to review the Notification Requirements of the Medical Program.**
Lab/X Ray (Outpatient)	• Includes outpatient surgery preadmission testing and diagnostic services

Maternity and Pregnancy-Related Expenses	• **You or your Spouse:** The Medical Program will cover expenses incurred by you or your Spouse due to pregnancy, childbirth or pregnancy-related conditions in accordance with your benefit option. — Covered Health Services only include tests that your doctor may prescribe related to pregnancy, such as amniocentesis and sonograms (for example, an amniocentesis performed solely to learn the sex of the unborn child will not be covered). — Under the EPO Option and the in-network benefits for PPO Option, you pay a $40 copay for the initial office visit and then no copay is required for subsequent prenatal visits. • **Other Dependents:** Except for routine prenatal office visits, gestational diabetes screening, lactation counseling, and a breast pump, expenses incurred by a Child due to pregnancy, childbirth or pregnancy-related conditions **are not covered** under this Medical Program, although complications resulting from pregnancy, childbirth or pregnancy-related conditions are covered for a Child on the same basis as any other Illness. • **Abortion:** Expenses relating to an abortion for you or your Spouse will be covered when the procedure is a Covered Health Service or when the abortion is spontaneous (non-elective). Elective abortions **are not covered**, although complications resulting from an elective abortion are covered under the Medical Program. • **Hospital stay:** The minimum authorized length of stay for the mother and newborn is 48 hours following a normal vaginal delivery and 96 hours following a cesarean delivery. **If an attending physician wants the mother or newborn to stay longer than these minimums, you or your physician must notify Care Coordination as soon as reasonably possible.** • **Birthing centers:** Covered maternity and pregnancy-related services at an approved Free-Standing Birthing Center will be payable under the Medical Program. This includes room and board and miscellaneous supplies and services, including anesthesia and its administration. In-network benefits will apply only if the birthing center is a network facility. • **Midwife:** The Medical Program will cover in-network midwife services. Midwife services are not covered for out-of-network or non-network benefits.

Mental Health and Substance Abuse Treatment Inpatient	Mental health and substance abuse benefits are managed by United Behavioral Health (UBH). UBH's Total Care Management is an integrated, managed behavioral health program that provides around-the-clock access to master's-level counselors. The program provides management and oversight of outpatient mental health and substance abuse care to provide better service to participants and to improve their care. **Out-of-Network Mental Health Substance Abuse (MH/SA) Benefits** If you are in the Non-Network Option, the SDHP, or PPO Option, and you choose to use an out-of-network provider, the benefits paid by the Medical Program will be substantially lower. In addition, remember inpatient care and emergency care requires you to call UBH in order to avoid a penalty. The key to the MH/SA program is access to care and confidentiality. UnitedHealthcare and UBH have set up a network of providers through which you can get the care you require at a reduced cost. As with all goods and services covered under the Medical Program, only treatment that is determined to be a Covered Health Service will be covered under the UBH program. **Pre-Certification is required for Inpatient Mental Health and Substance Abuse Treatment.** **Before you receive inpatient mental health or substance abuse treatment, you must notify UBH at 1-888-231-4886.** The line is staffed 24 hours a day, seven days a week. **If you do not contact UBH to obtain authorization for inpatient treatment for mental health or substance abuse (at least 72 hours in advance of receiving services for a non-emergency admission or within 48 hours of an emergency or non-elective admission), you will be subject to a penalty of $1,000.**
Mental Health Substance Abuse Treatment Emergency Care	**Emergency Mental Health Substance Abuse Treatment** An **emergency** is any situation in which failure to get immediate care may result in serious harm or danger to yourself, the patient or to others. For emergency care, a UBH counselor will direct you to the appropriate resource for care. In an emergency situation, your priority is to get help as quickly as possible. If you cannot call UBH in an emergency and you are admitted to the hospital, you, a family member or your provider must call UBH no later than 48 hours after admission for authorization. **Failure to contact UBH will result in a $1,000 penalty.**

Mental Health Substance Abuse Treatment Outpatient	Mental health and substance abuse services received on an outpatient basis in a provider's office or an Alternate Facility include: • mental health, substance abuse and chemical dependency diagnostic evaluations and assessment • treatment planning • treatment and/or procedures • referral services • medication management • short-term individual, family and therapeutic group and provider-based case management services (including intensive outpatient therapy) • crisis intervention • intensive outpatient treatment • psychological testing For additional assistance with mental health or substance abuse issues, you can also access the Employee Assistance Program (EAP) at **www.liveandworkwell.com** — see the separate SPD for more information. The mental health and substance abuse program is intended to provide you with the resources necessary for you and your covered Dependents to get efficient and appropriate care for problems related, but not limited, to: • depression • drug and alcohol abuse • marital or family problems • anxiety • stress • grief • loss
Multiple Surgical Procedures	If more than one surgical procedure is performed on a participant during any one operation on the same day, the maximum allowable covered medical expense for the surgeons' charges will be based on: • the option's covered percentage for the primary surgical procedure; plus • 50% of what would normally be considered the R&C or negotiated rate for the secondary surgical procedure; plus • 50% of R&C or negotiated rate for any subsequent procedure. Criteria for providers who perform two or more surgical procedures through the same site during a single operation are subject to review. Reimbursement for each procedure will be made at the lesser of billed charges or the percentage of the R&C or negotiated rate.

Newborn and Well-Baby Care	Newborn coverage includes services and supplies provided to a newborn infant during the initial hospital confinement. The following charges will be covered under the Medical Program at the applicable covered percentage after the deductible, if applicable: • hospital charges, including nursery care; • doctor's charges for delivery and in-hospital visits; and • physician's charges for circumcision. Outpatient well-baby care includes routine examinations and immunizations provided in the doctor's office, and is covered at 100% and not subject to copays, deductible or coinsurance. **Except for the Non-network Option, all care must be received in the network.**
Oral Surgery Charges	The Medical Program will pay the applicable covered percentage of eligible charges after the deductible, if applicable, for the following expenses: • oral surgery and other dental restoration to natural teeth will be covered if required to correct fractures and dislocations resulting from an accident or injury which resulted in hospital confinement or hospital emergency room admission; and • upper and lower jawbone surgery as required for direct treatment of acute traumatic injury or cancer. Orthognathic surgery, jaw alignment and treatment for the temporomandibular joint, as a treatment of obstructive sleep apnea, is not covered. • other than as described under Temporomandibular Joint (TMJ) provisions, all other dental and oral surgery charges are subject to the provisions of your Dental Program.

Preventive Care	Preventive care includes: • periodic physicals associated with screenings and other services with an A or B rating in the current recommendations by the U.S. Preventive Services Task Force; • well-baby and well-child care and screenings as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; • well-woman care and screenings (including pap smear, pelvic exam and mammogram) as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; • well-man care; • recommended immunizations for adults and children from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and • office visits associated with receipt of such preventive care, unless the preventive care is billed separately from an office visit. Preventive care is covered at 100% and not subject to copays, deductibles or coinsurance. **Except for the Non-network Option, all care must be received in the network.** See the Benefits Connection website (www.hr.citgo.com) for lists of covered preventive services. Additionally information about your preventive care benefits under this Program can also be obtained from the UnitedHealthcare Customer Service Center at 1-866-317-6359.
Private Duty Nursing	Private duty nursing care is covered under the Medical Program as follows: • private duty nursing care must be given on an outpatient basis by a licensed nurse (R.N., L.P.N., or L.V.N.); • you must notify Care Coordination at least 72 hours prior to receiving services — if you fail to do so, you will be subject to a $1,000 penalty; and • private duty nursing received on an inpatient basis is not covered.
Prosthetic Devices	The Medical Program pays the applicable covered percentage of eligible charges after the deductible, if applicable, for the most cost-effective prosthetic device, including necessary required repairs of prosthetic devices and replacement once every five years. Repairs to rental equipment are not covered. **You must contact Care Coordination for any single item that is over $1,000 (either purchase price or cumulative rental).** Care Coordination will decide if equipment should be purchased or rented. You must purchase or rent the device from the vendor chosen by Care Coordination.

Radiology, Anesthesiology and Pathology (RAP)	If you are in the PPO or SDHP Option: • all RAP services will be paid at the in-network level regardless of whether the provider is in the network; and • all RAP services, except those received during a hospital stay, will be covered at 100%. For the EPO Option: • all RAP services, except those received during a hospital stay, must be provided by an In-Network provider to be covered. For the EPO, PPO and SDHP Options: • RAP services received during a hospital stay will be covered at the appropriate coinsurance for your benefit option.
Reconstructive Procedures	Services are considered reconstructive procedures when: • a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function for an organ or body part; and • by improving or restoring physiologic function, the target organ or body part is made to work better. • If the services improve appearance without making an organ or body part work better**, it is considered cosmetic and then it is not covered.** • If you or your Dependent receives benefits in connection with a mastectomy and elects breast reconstruction in connection with the mastectomy, the Medical Program shall also provide coverage for: o reconstruction of the breast on which the mastectomy has been performed; and o surgery and reconstruction of the other breast to produce a symmetrical appearance. **You must notify Care Coordination at least 72 hours before receiving reconstructive procedures to avoid a reduction in benefits.**

Rehabilitation Services — Outpatient Therapy	Rehabilitation services or outpatient therapy include: • physical therapy; • occupational therapy; • speech therapy; • hearing therapy; and • vision therapy (only if congenital or due to injury). The Medical Program pays the applicable covered percentage of eligible charges, after the deductible, if applicable, for rehabilitation services up to a maximum of 60 visits per therapy, per Plan Year. • Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician (when required by state law). • Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in your condition. • Speech therapy is only covered when the speech impediment or speech dysfunction results from injury, stroke or a Congenital Anomaly.
Reproduction Services	The following are covered, and certain of these services may be covered with no cost sharing as a preventive service: • contraceptive devices; • sterilization and reversals; • tubal ligation and reversals; and • infertility diagnosis.
Second Surgical Opinion	A "qualified" second surgical opinion is a second opinion obtained from a board-certified surgeon, who is not the surgeon originally scheduled to perform the surgery. Obtaining a second surgical opinion is voluntary on your part and is not required by the Medical Program. Covered charges include: • charges for consultation with the surgeon or surgeons, provided the surgeon examines the patient and furnishes a written report to the Claims Administrator; and • charges for lab and X-rays and their diagnostic procedures in connection with or as a result of the consultation. Charges are covered at the coinsurance level for your benefit option, after you meet the deductible, if applicable, and pay any required copays. If you need help finding a board-certified surgeon in your area, contact the UnitedHealthcare Customer Service Center at 1-866-317-6359.

Skilled Nursing Facility Care Facility/Extended Care Facility	The Medical Program pays Skilled Nursing Facility or Extended Care Facility benefits as follows: • **room and board accommodations and other services and supplies are covered for up to 100 days per Plan Year** at an approved Skilled Nursing Facility or Extended Care Facility; • care must be rehabilitative in nature and not custodial; • the Medical Program will pay the applicable covered percentage of eligible charges of the facility's regular charge for a semi-private room; and • you must notify Care Coordination at least 72 hours prior to receiving services for an elective admission or within two business days after an emergency or non-elective admission — **if you fail to do so, you will be subject to a $1,000 penalty**. **Note:** In general, the intent of skilled nursing is to provide benefits to employees and covered family members who are convalescing from an injury or illness that requires an intensity of care or a combination of skilled nursing, rehabilitation and facility services which are less than those of a hospital but greater than those that are available in the home setting.
Temporomandibular Joint (TMJ) Charges	The Medical Program will pay the applicable covered percentage of eligible charges after the deductible, if applicable, for non-surgical treatment of TMJ disorders, with a maximum of $1,000 per lifetime. Other than as described under Oral Surgery Charges, all other dental and oral surgery charges are subject to the provisions of your Dental Program.

Transplantation Services	The Medical Program will cover eligible services and supplies at the coinsurance level for your benefit option, after you meet the deductible, if applicable, for a participant who is a recipient of one of the following organ or tissue transplants: • Heart • Lung • Kidney • Kidney/pancreas • Small bowel • Cornea • Heart/lung • Bone marrow • Pancreas • Liver • Liver/small bowel Benefits are not available for the transplant if it is an Experimental or Investigational Service or an Unproven Service. If a separate charge is made for a bone marrow/stem cell search, a maximum benefit of $25,000 is payable for all charges made in connection with the search. **You must notify UnitedHealthcare as soon as the possibility of a transplant arises — and before a pre-transplantation evaluation.** For more information on available transplant benefits and resources, see United Resource Networks (URN) Transplant Management.
Urgent Care	An urgent care center is a facility other than a hospital that provides services that are required: • to prevent serious deterioration of your health; and • as a result of an unforeseen sickness, injury or the onset of acute or severe symptoms.
Vision and Hearing Services	The Medical Program will cover eligible expenses for eye examinations and hearing screenings due to injury or medical condition in accordance with your benefit option. All other vision charges are subject to the provisions of the Vision Program.

MEDICAL PROGRAM - LIMITATIONS AND EXCLUSIONS

The Medical Program will not pay medical benefits for any of the services, treatments, items or supplies described in this section as determined by the Claims Administrator in its sole discretion, even if it is recommended or prescribed by a Physician or it is the only available treatment for your condition. **This list of benefit exclusions is not all-inclusive**. If you have a question on a specific expense, contact the Claims Administrator.

Alternative Treatments	• Acupressure • Acupuncture not performed by a licensed acupuncturist • Aromatherapy • Hypnotism • Massage therapy • Rolfing (soft tissue manipulation and movement education that alters a person's posture and structure) • Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health
Appliances and Medical Supplies	• Devices used specifically as safety items or to affect performance in sports-related activities • Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: — Ace bandages — Elastic or support stockings — Gauze and dressings — Syringes (available through the Prescription Drug Program) — Diabetic test strips (available through the Prescription Drug Program) • Tubings, nasal cannulas, connectors and masks are not covered except when used with Durable Medical Equipment.
Comfort or Convenience	• Capital improvements to your home that do not have an exclusive health reason, such as swimming pool, spa or duct cleaning for allergies • Television and telephone • Beauty/barber service, including tanning beds • Guest services, supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: — Air conditioners — Air purifiers and filters — Batteries and battery chargers — Dehumidifiers and humidifiers • Devices and computers to assist in communication and speech • Lifts and ramps

Coverage for Services Provided under Another Plan	• Health services are excluded to the extent that coverage for those services is available under any government-sponsored plan or program, including those in which any government participates as anything other than as an employer, such as any workers' compensation laws or employer liability laws. This limitation applies even if the participant is not enrolled for all coverage for which he or she has become eligible. Benefits under the Medical Program will be reduced by the amount to which the participant would have been entitled under the governmental plan. The term "any government" includes the federal, state, provincial or local government or any political subdivision of the United States or any other country. This provision is subject to any provision or regulation of the governmental plan or program that requires that benefits under the Medical Program be utilized before benefits are available under the governmental plan. • Health services for treatment of military service-related disabilities are excluded when you are legally entitled to other coverage and facilities are reasonably available to you and all other health services while on active military duty.
Experimental or Investigational Services or Unproven Services	Experimental or Investigational Services and Unproven Services are excluded. The fact that an Experimental or Investigational Service or an Unproven Service is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition. If you have a life-threatening sickness or condition (one which is likely to cause death within one year of the request for treatment), the Claims Administrator may, in its discretion, determine that an Experimental or Investigational Service or Unproven Service meets the definition of a Covered Health Service for that sickness or condition. For this to take place, the Claims Administrator must determine, at its discretion, that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health. In the case of certain approved clinical trials that are excluded under this provision, the related health care services provided in connection with the clinical trial and would be otherwise covered under the Medical Program if the person were not enrolled in the clinical trial. An approved clinical trial is one that is approved by certain Federal government agencies, including the National Institutes of Health and the Food and Drug Administration. Covered services include physician charges, lab and x-rays, and other routine medical services.

Foot Care	• Except when needed for severe systemic disease: — Routine foot care (including the cutting or removal of corns and calluses) — Nail trimming, cutting or debriding • Hygienic and preventive maintenance foot care. Examples include the following: — Cleaning and soaking the feet — Applying skin creams in order to maintain skin tone — Other services that are performed when there is not a localized illness, injury or symptom involving the foot • Treatment of flat feet • Treatment of subluxation (misalignment of the bones that form a joint) of the foot
Nutrition	• Megavitamin and nutrition-based therapy • Nutritional counseling for either individuals or groups, including weight loss programs, health clubs and spa programs • Enteral feedings and other nutritional and electrolyte supplements, including infant formula, donor breast milk, nutritional supplements, dietary supplements, electrolyte supplements, diets for weight control or treatment of obesity (including liquid diets or food), food of any kind (diabetic, low fat, cholesterol), oral vitamins and oral minerals. The Medical Program will cover enteral feedings/nutritional formula for the sole source of nutrition provided through a feeding tube rather than through oral ingestion, or to treat inborn errors of metabolism.
Obesity	Non-surgical treatment of obesity and surgical treatment of obesity, except those described under Morbid Obesity Surgery and other than severe or morbid obesity as defined by the Body Mass Index (BMI) of or exceeding 40% or greater than 35% in conjunction with severe obesity with at least one co-morbid condition present.
Other Medical Services and Supplies	• Out-of-Network preventive care including well baby, routine physicals, checkup and immunizations under the PPO Option and SDHP Option • Custodial Care • Sex transformation operations • Domiciliary care • Respite care and rest cures • Psychosurgery • Medical and surgical treatment of snoring, except when provided as part of treatment for documented obstructive sleep apnea • Appliances specifically for snoring • Replacement of lost or stolen prosthetic devices • Air cleaners and filters • Instructions concerning hygiene and diet (including diabetic care and educational programs) • Surgical treatment for TMJ • Safety glasses

Outpatient Prescription Drugs	Prescription drugs taken on an outpatient basis are covered through the Prescription Drug Program rather than through the Medical Program.
Physical Appearance	• Cosmetic Procedures. Examples include: — Pharmacological regimens, nutritional procedures or treatments — Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures) — Skin abrasion procedures performed as a treatment for acne • Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. **Note:** replacement of an existing breast implant is considered reconstructive and is covered if the initial breast implant followed a mastectomy. • Physical conditioning programs such as athletic training, body-building, exercise, fitness flexibility and diversion or general motivation (includes health club dues) • Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. • Liposuction • Wigs are not covered **except** one per lifetime **is** covered if needed due to a loss of hair resulting from treatment of a malignancy, medical condition causing hair loss or permanent loss of hair from an accidental injury (also see Durable Medical Equipment)

Provider Limitations	• Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself • Services performed by a provider with your same legal residence • Services provided at a free-standing or hospital-based diagnostic facility without an order written by a physician or other provider. • Services that are self-directed to a free-standing or hospital-based diagnostic facility. • Services ordered by a physician or other provider who is an employee or representative of a free-standing or hospital-based diagnostic facility, when that physician or other provider: — has not been actively involved in your medical care prior to ordering the service; or — is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography testing. • Christian Science practitioners • Any charges by a provider sanctioned under a federal program for reason of fraud, abuse or medical competency • Any charges by a resident in a teaching hospital where a faculty physician did not supervise services • Services rendered through a medical department, clinic or similar facility provided or maintained by the patient's employer • Services of a personal trainer • Services of a naturalist
Rehabilitation Services	• Outpatient rehabilitation services, spinal treatment or supplies including, but not limited to, spinal manipulation by a chiropractor or other doctor, for the treatment of a condition which ceases to be a therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring • Spinal treatment, including chiropractic and osteopathic manipulation treatment, to treat an illness, such as asthma or allergies • Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from injury, stroke or a Congenital Anomaly or as a result of a medical condition • Speech therapy to treat stuttering, stammering or other articulation disorders

Reproduction	• Surrogate parenting • Fees or direct payment to a donor for sperm or ovum donations • Embryo transport • Monthly fees for maintenance and/or storage of frozen embryos • Over-the-counter contraceptive supplies • Health services and associated expenses for elective abortion • Fetal reduction surgery • Health services associated with the use of non-surgical or drug-induced pregnancy termination • In vitro fertilization, gamete intrafallopian transfer (GIFT) procedures and zygote intrafallopian transfer (ZIFT) procedures, and any related prescription medication treatment • Donor ovum and semen and related costs • Artificial insemination • Health services and associated expenses for infertility treatments • Maternity benefits for a covered Child
Smoking Cessation	Smoking cessation services other than preventive care counseling and certain prescribed cessation interventions
Transplants	• Health services for organ and tissue transplants except for those described under Transplantation • Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's benefits under the Medical Program). • Health services for transplants involving mechanical or animal organs • Any solid organ transplant that is performed as a treatment for cancer and any multiple organ transplant not specifically listed as covered • Health services for transplants that are an Experimental or Investigational Service or Unproven Service, unless in the Claims Administrator's judgment, which will be rendered in its sole discretion, such transplant health services should be covered.
Travel	• Travel or transportation expenses, even though prescribed by a physician. Some travel expenses related to covered transplantation services may be reimbursed (see United Resource Networks Transplant Management (URN)).
Vision and Hearing (See the Vision Program section below)	• Purchase cost of eye glasses, contact lenses, or hearing aids • Fitting and exam charge for hearing aids, eye glasses or contact lenses • Eye exercise therapy, unless due to Congenital Anomaly or rehabilitation due to accident • Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser and other refractive eye surgery

Other Exclusions	• Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country • Health services received after the date your coverage under the Medical Program ends, including health services for medical conditions arising before the date your coverage under the Medical Program ends unless hospitalized • Health services rendered to a person prior to the effective date of that person's coverage under the Medical Program • Services or supplies which are not Covered Health Services • Charges for items not necessary for treatment, such as hospital admissions kits or a TV set in a hospital • Charges and expenses in excess of Reasonable and Customary Charges • Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Medical Program • Health services which an employer is required by law to furnish in whole or in part, including services which are covered by any workers' compensation laws or employer liability laws • Physical, psychiatric or psychological exams, testing, vaccination, immunization or treatments that are otherwise covered under the Medical Program when: — Required solely for purposes of career, sports or camp, employment, insurance, marriage or adoption; — Related to judicial or administrative proceedings or orders; — Conducted for purposes of medical research; or — Required to obtain or maintain a license of any type. • Any charges for missed appointment, room or facility reservation, completing of claim forms or record processing • Any charges for services, supplies, or equipment advertised by the provider as free • Any charges prohibited by federal anti-kickback or self-referral statutes • Legal fees • Utilities to run machinery • Health services provided in a foreign country are excluded, unless required as Emergency Care or Emergency Health Services.

PRESCRIPTION DRUG PROGRAM - OVERVIEW

Whether you take medication on an ongoing basis, or you simply need a prescription filled from time to time, the Prescription Drug Program offers savings, convenience and service for you and your eligible Dependents. The Prescription Drug Program is administered by a partnership between UnitedHealthcare and Optum Pharmacy Benefits.

Highlights of the Prescription Drug Benefit

- You are automatically enrolled in the Prescription Drug Program if you participate in the Medical Program.
- You only need one ID card for your medical coverage and the Prescription Drug Program (e.g. there is no separate ID card for your prescriptions).
- **Under the EPO, PPO and Non-Network Options**, prescription drug expenses are not subject to the deductible, but they have an annual out-of-pocket prescription drug maximum that is separate from medical expenses.
- **Under the SDHP**, prescription drug expenses **are** subject to the deductible, but there is no separate prescription drug out-of-pocket maximum.
- **Retail** — you can purchase up to a 31-day supply of medications at a participating retail pharmacy.
- **Mail-order** — the mail-order service offers the convenience of purchasing up to a 90-day supply of maintenance medications.
- The Prescription Drug Program includes a mandatory generic provision, which means prescriptions will be filled using a generic medication when available unless your doctor specifies otherwise.

To find a participating retail pharmacy near you, visit www.myuhc.com and access the pharmacy link, or call the UnitedHealthcare Customer Service Center at 1-866-317-6359.

Prescription Drug Program Eligibility

Employees enrolled in Medical Program coverage are eligible for prescription drug benefits. Enrolled Dependents are also eligible for the benefits as long as the Prescription Drug Program is the Dependent's Primary Plan for prescription drugs. **If your Dependents have their primary medical coverage under any other group health plan (other than Medicare), they are not eligible for the Prescription Drug Program.** (See Coordination of Benefits (COB).)

The Prescription Drug List

UnitedHealthcare's Prescription Drug List (PDL) is a tool that guides you and your physician in selecting medications that will maximize your benefit. The PDL is a list of generic and brand-name prescription medicines that have been approved by the U.S. Food and Drug Administration (FDA).

Prescription medications are categorized into three tiers on the PDL — Tier 1, Tier 2 and Tier 3.

UnitedHealthcare's National Pharmacy and Therapeutics Committee, a team of physicians and pharmacists, meets regularly to review and update the list. The PDL can be updated during the year, usually at mid-year and year-end. They take into account the following factors:

- therapeutic advantages or limitations of a drug;

- side effects different from other drugs in the same therapeutic class;
- impact on health care costs and patient outcomes

Prescription Drug Summary Chart

The following is an overview of your prescription drug benefits.

	EPO Option, PPO Option and Non-Network Option	SDHP
Preventive drugs on the approved Preventive Drug List (See Annual Election Resources at www.hr.citgo.com for a list of SDHP preventive drugs)	**See Preventive Care Information at www.hr.citgo.com**	**Prescription Drug Program pays 100% with no deductible. All other covered drugs you pay 100% of the discounted amount until the annual deductible is met when you use a network retail or mail order pharmacy.**
	You Pay:	**You Pay:**
Prescription Drug Annual Out-of-Pocket Maximum	EPO - $1,250 per person; $2,500 per family. PPO and NonNetwork - $1,000 per person, $2,000 per family Includes prescription drug expenses only — separate from the out-of-pocket maximum for medical expenses.	$4,000 per person; $8,000 per family. Includes ALL eligible medical and prescription drug expenses. **There is no separate prescription drug maximum.**
Retail — Up to a 30-Day Supply		
Tier 1 - Mainly generic	25% coinsurance, with a $10 minimum and a $150 maximum	25% coinsurance*, with a $10 minimum and a $150 maximum after deductible
Tier 2 - Mainly preferred brand	30% coinsurance, with a $20 minimum and a $150 maximum	30% coinsurance*, with a $20 minimum and a $150 maximum after deductible
Tier 3 - Mainly non-preferred brand	30% coinsurance, with a $30 minimum and a $150 maximum	30% coinsurance*, with a $30 minimum and a $150 maximum after deductible
Mail-Order — Up to a 90-Day Supply		
Tier 1 - Mainly generic	25% coinsurance, with a $25 minimum and a $150 maximum	25% coinsurance*, with a $25 minimum and a $150 maximum after deductible
Tier 2 - Mainly preferred brand	30% coinsurance, with a $50 minimum and a $150 maximum	30% coinsurance*, with a $50 minimum and a $150 maximum after deductible
Tier 3 - Mainly non-preferred brand	30% coinsurance, with a $75 minimum and a $150 maximum	30% coinsurance*, with a $75 minimum and a $150 maximum after deductible

* **SDHP participants pay 100% of the cost of the prescription until the annual deductible has been met.** Then, they pay the coinsurance amounts shown in this chart up to the total out-of-pocket maximum.

Prescriptions received by the Mail-Order pharmacy that are less than a 46-day supply will be processed at the retail coinsurance level.

The list does not restrict what your physician can prescribe or what a pharmacist can dispense.

Physicians are encouraged to follow the Prescription Drug List when prescribing medicines for Prescription Drug Program participants; however, you and your physician will have the choice in what is prescribed.

The most current and complete PDL is available via the Web at www.myuhc.com, or by calling the UnitedHealthcare Customer Service Center 1-866-317-6359. A copy is also available on the Benefit Connections website at www.hr.citgo.com. Physicians participating in the UnitedHealthcare Choice Network receive a copy of the PDL every year or they can access it online at www.unitedhealthcareonline.com.

Prescription Drug Annual Out-of-Pocket Maximum

The prescription drug out-of-pocket maximum does not apply to the SDHP.

Under the **EPO Option,** the annual prescription drug out-of-pocket maximum is $1,250 per person or $2,500 per family. Under the **PPO Option and the Non-Network Option**, the annual prescription drug out-of-pocket maximum is $1,000 per person or $2,000 per family. The prescription drug out-of-pocket maximums apply to each Plan Year and start over each January 1.

Here is how the prescription drug out-of-pocket maximum works:

- After your out-of-pocket costs for covered prescription drugs have reached your prescription drug out-of-pocket maximum, the Prescription Drug Program will pay 100% **of covered prescription drug expenses** you incur during the remainder of that Plan Year.
- Amounts applied to each individual's prescription drug out-of-pocket maximum are also applied to the family prescription drug out-of-pocket maximum. However, no one individual in the family will have to meet an out-of-pocket maximum greater than his or her individual out-of-pocket maximum.
- The family prescription drug out-of-pocket maximum is met when the accumulated expenses that were applied to each family member's individual prescription drug out-of-pocket maximum equals or exceeds the family prescription drug out-of-pocket maximum amount.
- Once the family prescription drug out-of-pocket maximum has been met, all individual prescription drug out-of-pocket maximums are considered to be met for the Plan Year.

The SDHP and the Prescription Drug Benefit

Unlike the other Medical Program options, the SDHP has a combined medical and prescription drug deductible. If you participate in the SDHP, **you must pay the full price of any prescription drug until the annual deductible is met.** Using a participating network pharmacy or mail order, the full price is the discounted network cost. However, certain preventive drugs are covered at 100% without the deductible.

There is no separate prescription drug out-of-pocket maximum under the SDHP. Your covered

prescription drug expenses and medical expenses are **all** applied to the annual out-of-pocket maximum. Once the out-of-pocket maximum is met, the Medical Program and Prescription Drug Program will pay 100% of additional covered medical and prescription drug expenses for the remainder of the Plan Year. For more information, see Annual Out-of-Pocket Maximum (Coinsurance Maximum). The SDHP annual deductible and out-of-pocket maximums are shown in the medical chart.

Retail Pharmacy Program

The retail pharmacy program is designed to provide you with prescriptions to treat short-term illnesses or ailments.

Locating Participating Pharmacy

There are over 64,000 participating pharmacies you can use to fill your prescriptions. To find a participating retail pharmacy, visit www.myuhc.com and access the pharmacy link. Just enter your ZIP Code under Locate a Pharmacy and view a map with up to 25 pharmacies in that area. For each pharmacy listed, you can click on a link to get directions from your chosen starting address and print the directions, if you like. Or you can call the UnitedHealthcare Customer Service Center at 1-866-317-6359.

By presenting your combined medical and prescription drug ID card at a participating pharmacy, you will pay the coinsurance amounts shown in the chart (after the applicable deductible, if you are enrolled in the SDHP) for up to a 31-day supply of the medication.

If the cost of the drug is less than the minimum, then you will only be required to pay the lesser cost of the drug. Also, if the drug falls within the rules of the mandatory generic provision (see Mandatory Generic Provision), you will pay more if you choose to have the prescription filled with a brand-name drug.

In order to receive network prescription drug benefits, always remember to show your medical/prescription drug ID card to the network pharmacist at the time your prescription is filled.

My Prescriptions Dashboard

Everything you need in order to manage your medications is in one handy place. On the Optum Manage My Prescriptions Dashboard (at www.myuhc.com) you can quickly and easily refill and renew prescriptions, see your order status, track orders, look up medication lists and prices, and more. It also includes a helpful reminder calendar that shows when your prescriptions are ready to refill or renew. You can even send the information to your personal Microsoft Outlook, Yahoo or Google calendar.

Mail-Order Prescription Drug Program

The mail-order prescription drug program offers convenience and cost savings on medications you take on a regular basis. You can fill your long-term or maintenance prescriptions through the mail-order program.

You can receive up to a 90-day supply of maintenance medication prescribed by your doctor for chronic or long-term conditions, and you will pay the coinsurance amounts shown in the prescription drug chart (after the applicable deductible, if you are enrolled in the SDHP).

Prescriptions received by the mail-order pharmacy that are less than a 46-day supply will be processed at

the retail pharmacy coinsurance level.

Prescriptions filled through the mail-order service will be filled with the generic equivalent when available and permissible by law, unless your doctor specifically requests a brand-name drug. Also, if the drug falls within the rules of the mandatory generic provision you will pay more if you choose a brand-name drug.

Examples of conditions that may require long-term or maintenance drugs are:

- high blood pressure;
- heart or thyroid conditions;
- diabetes; and
- glaucoma.

Filling Your Mail-Order Prescription

You can fill a new mail-order prescription by completing an order form and mailing it in with your prescription along with your payment.

The first time the doctor prescribes you a long-term or maintenance medication, ask for two prescriptions:

- one prescription for up to a 30-day supply to be filled at a participating network retail pharmacy (so you can start your new medication right away); and
- one prescription for the maximum supply you need (up to a 90-day supply) with three refills if appropriate. You will use this prescription to take advantage of the savings available through home delivery.

Please note, even if your physician writes a prescription for less than a 90-day supply, you will be charged for each refill.

Mail-Order Refills

If your prescription includes refills, you can reorder on or after the refill date indicated on your refill slip or medication container, or when you have less than 14 days of medication left. You can refill your prescription:

- On the Internet — log onto www.myuhc.com and access the pharmacy link. Have your ID card, the prescription number and your credit card ready.
- By phone — call 1-866-317-6359. Have your ID card, the prescription number and your credit card ready.
- By mail — use the refill and order forms provided with your medication. You can also use the forms you used to fill a new mail-order prescription.

If you refill your prescriptions online, you can register to have your refills automatically filled. You will receive an email notifying you when your refill has been completed.

Mandatory Generic Provision

Under the mandatory generic provision, you will pay more for a brand-name drug if:

- the physician does not write a prescription as “dispense as written” (DAW); and/or
- generic is available, and you request the brand-name drug.

Your cost will be your coinsurance of the total cost for the brand (25% or 30% depending on the Tier), plus the difference between the cost of the brand-name and the generic drug. When a preferred brand drug is less expensive (in a lower tier) than its generic equivalent, the mandatory generic provision is waived and no penalty will apply.

Generic vs. Brand-name

There is very little difference between a generic and brand-name medication, except cost. A generic drug contains the same active ingredients in the same dosage form as the brand-name drug. The generic drug is therapeutically equivalent to the brand-name drug, but sold under its chemical or “generic” name.

The FDA regulates the quality, strength and purity of generic medications, requiring that generic drugs contain the same active ingredients and be equivalent in strength and dosage to the original brand-name drugs.

Generic drugs cost less because they do not require the same level of sales, marketing, research and development expenses associated with brand-names.

Example of Mandatory Generic Cost Difference

John’s doctor issues a prescription and does not include “dispense as written.” When John fills the prescription at a retail pharmacy, he requests a brand-name drug (Tier 2) rather than the available generic (Tier 1).

If the total cost of the Tier 2 medication was:	And the total cost of the Tier 1 generic was:	John’s cost for the Tier 2 medication would be:	If John had requested the generic, his cost would have been:
$100	$80	$50 (30% of $100) + ($100 - $80)	$20 (25% of $80)
$100	$50	$80 (30% of $100) + ($100 - $50)	$12.50 (25% of $50)

Mandatory Specialty Pharmacy Program

Specialty pharmaceuticals are true "wonder drugs," but treatment with them is often intensive and complex. Optum helps you through a comprehensive and personalized service.

- OptumRx supplies nearly 400 specialty medications, in 25 categories, with more added as they come to market
- Coordinated next-day deliveries for your convenience
- Free supplies (when appropriate)
- Proactive refill reminders by phone
- Free educational materials sent to you

All Prescription Drug Program participants should use the OptumRx Specialty Pharmacy when they are prescribed a specialty medication. Simply have your physician's office call OptumRx to set up your first medication fill (see additional information below). Visit Specialty Programs and Services at www.optumrx.com to help you manage your condition and to discover all the benefits of the OptumRx Specialty Pharmacy.

OptumRx is your designated specialty pharmacy. Setting up your prescription only takes a few easy steps:

- Call OptumRx at 1-888-739-5820. Have your insurance card, physician's name and phone number available when you call.
- A Patient Care Coordinator will help set up your account and transfer your prescriptions to OptumRx. If needed, they will contact your doctor for a new prescription.
- You and your doctor make decisions about your prescription medications, so we encourage you to discuss lower-cost options that may also treat your condition. Pharmacists are available to discuss possible lower-cost options and may contact your doctor at your request to determine if one is right for you.
- During the call, we will schedule your first medication delivery, which includes medical supplies and a welcome packet.
- Your Patient Care Coordinator will let you know if a Clinical Management Program is available for your condition, at no extra cost to you.
- After setting up your medication delivery, be sure to sign up for My Medication Reminders™ at www.optumrx.com to receive text messages reminding you to take your medication as directed by your doctor.

Coupons

UnitedHealthcare and OptumRx may not permit certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance or apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at www.myuhc.com or by calling the number on your ID card.

PRESCRIPTION DRUG PROGRAM – ELIGIBLE DRUGS

The following types of prescription medications are covered under the Prescription Drug Program:

- federal legend drugs;
- state restricted drugs;
- compound* and foreign emergency prescriptions;
- insulin;
- needles and syringes;
- growth hormones;
- diabetic supplies;
- oral contraceptives; and
- self-administered injectables.

*Compound medications containing bulk chemicals that have not been approved by the U.S. Food and Drug Administration (FDA) may not be covered. Prescription Drug Products covered under your pharmacy benefit plan must be approved by the FDA.

Generally, new drugs that fall into one of the above categories will be covered under the Prescription Drug Program upon the drug's approval by the Food and Drug Administration (FDA).

If you have a question about whether a specific prescription drug is covered, call the UnitedHealthcare Customer Service Center at 1-866-317-6359.

PRESCRIPTION DRUG PROGRAM - EXCLUSIONS

The following are excluded under the Prescription Drug Program:

- prescription for an amount dispensed (days' supply or quantity limit) that exceeds the supply limit under the Prescription Drug Program;
- prescription drug products dispensed outside the United States, except as required for emergency treatment;
- drugs that are prescribed, dispensed, or intended for use while you are an inpatient in a hospital, skilled nursing facility or alternative facility (these drugs may be covered under the Medical Program);
- Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by the Claims Administrator to be experimental, investigational or unproven;
- prescription drug products furnished by any local, state or federal government;
- any prescription drug product to the extent payment or benefits are provided or available from a local, state or federal government (for example Medicare) whether or not payment or benefits are received, except as otherwise provided by law;
- prescription drug products for any condition, injury, sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or similar laws, whether or not a claim for such benefits is made or benefits are received;
- any product dispensed for the purpose of appetite suppression and other weight loss products other than prescription weight loss drugs;
- any specialty medication prescription drug product (including, but not limited to, immunizations and allergy serum) which, due to its characteristics as determined by the Claims Administrator, must typically be administered or supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to Depo Provera and other injectables used for contraception;
- Durable Medical Equipment and prescribed and non-prescribed outpatient supplies, other than diabetic supplies and inhaler spacers specifically stated as covered;
- general vitamins, except the following which require a prescription order or refill: prenatal vitamins, vitamins with fluoride, single entity vitamins and legend drugs;
- unit dose packaging of prescription drug products;
- medications for cosmetic purposes;
- prescription drug products, including new prescription drug products or new dosage forms that are determined to not be a Covered Health Service;
- prescription drug products as a replacement for a previously dispensed prescription drug product that was lost, stolen, broken or destroyed;
- prescription drug products when prescribed to treat infertility, except that vaginal fertility drugs will be covered with notification and prior authorization;
- prescription drug products for smoking cessation;
- compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a prescription order or refill.
- compounded drugs that contain a non-FDA approved bulk chemical.
- compounded drugs that are available as a similar commercially available Prescription Drug.
- compounded drugs that do not contain at least one ingredient that requires a prescription order or refill.
- compounded drugs that contain at least one ingredient that requires a prescription order or refill are

assigned to Tier 3;

- drugs available over-the-counter that do not require a prescription order or refill by federal or state law before being dispensed, except for drugs that are covered under the preventive care benefit with a prescription.
- certain prescription drug products that are therapeutically equivalent to an over-the-counter drug.
- prescription drug products that are comprised of components which are available in over-the-counter form or equivalent.
- new prescription drug products and/or new dosage forms until the date they are reviewed and assigned to a tier by the Claims Administrator's Prescription Drug List Management committee.
- growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
- the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
- certain Prescription Drug Products that have not been prescribed by a specialist physician.
- Prescription Drug Products that contain (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug.
- Prescription Drug Products that contain (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug.
- any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury.

DENTAL PROGRAM - OVERVIEW

The Dental Program provides you and your family with coverage for regular dental checkups, preventive care and other services to keep your teeth and gums healthy.

Overview of Dental Program Options

The Plan offers the following Dental Program options:

- Dental Basic Option
- Dental Plus Option
- No Dental coverage

The Dental Program options differ by some of the services they cover, your cost for coverage, and our out-of-pocket costs when you receive care. Both the Basic and Plus options cover Preventive and Diagnostic care at 100% with no deductible.

The Dental Basic Option provides coverage for routine preventive and diagnostic care and basic and major restorative care at a moderate cost. This option **does not** cover orthodontia or implant services. The Dental Plus Option provides the same coverage as the Dental Basic Option **and** also covers eligible implant services and orthodontia expenses. As a result, the Dental Plus option has a higher contribution for coverage and a higher annual maximum. The chart below compares the key similarities and differences between the Dental Program options.

	DENTAL BASIC OPTION		**DENTAL PLUS OPTION**	
DENTAL SERVICE	**You Pay:**	**You Pay:**	**You Pay:**	**You Pay:**
	PDP Network Provider	**Out of Network Provider**	**PDP Network Provider**	**Out of Network Provider**
Annual deductible	$50 per individual		$50 per individual	
Annual maximum benefit	$1,500 per person		$3,000 per person	$1500 per person
Diagnostic and Preventive Services				
Oral Exams	$0, no deductible	$0, no deductible	$0, no deductible	$0, no deductible
Bitewing/Full Mouth X-Rays	$0, no deductible	$0, no deductible	$0, no deductible	$0, no deductible
Prophylaxis Treatments	$0, no deductible	$0, no deductible	$0, no deductible	$0, no deductible
Fluoride Treatments	$0, no deductible	$0, no deductible	$0, no deductible	$0, no deductible
Basic Services				
Fillings (amalgam, composite, synthetic porcelain and plastic restorations)	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Endodontic and Periodontic Care	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Extractions and related surgical procedures	20% after deductible	40% after deductible	20% after deductible	40% after deductible

	DENTAL BASIC OPTION		DENTAL PLUS OPTION	
DENTAL SERVICE	**You Pay:**	**You Pay:**	**You Pay:**	**You Pay:**
Major Services				
Crowns, inlays, onlays, jackets and cast restoration benefits	50% after deductible	60% after deductible	50% after deductible	60% after deductible
Implant services (repair, maintenance and removal)	Not covered	Not covered	50% after deductible	60% after deductible
Orthodontia Services				
Orthodontia	Not covered	Not covered	50% after deductible	60% after deductible
Lifetime maximum orthodontia benefit	Not covered	Not covered	$3,000/per person	$1,500/per person

The MetLIfe Dental Preferred Provider (PDP) Network

The two Dental Program options work in much the same way. You can go to any licensed dental provider for your dental care, but you save money when you access care through the MetLife Preferred Dentist Program (PDP). MetLife Dental administers the dental benefits and provides the PDP network of dental providers.

When you use a MetLife Dental PDP network provider, you will receive in-network benefits, which means you pay less for your care.

If you access care from a dentist who is not in the PDP network, you will receive a lower level of coverage under the Dental Program and you will not receive the network discounted fees. You will also be responsible for any charges that exceed the Reasonable and Customary (R&C) allowed amount.

To find a PDP dentist, visit MetLife's website, which is available at www.mybenefits.metlife.com/MyBenefits or call MetLife at 1-800-942-0854. If you go to a non-MetLife dentist, you will receive out-of-network coverage, and your costs may be higher because non-MetLife dentists are not subject to negotiated fees and you are responsible for any charges that exceed the Dental Program's usual, reasonable, and customary (URC) amounts.

It is your responsibility to ensure that you use MetLife PDP providers if you want to receive the benefit of lower, discounted rates. Keep in mind that network providers occasionally change and that some areas do not have network providers, so you'll want to make sure the dentist you choose is still in the MetLife network before you make an appointment.

Following is more information about network vs. non-network:

	In-Network	Non-Network
Providers	You must use a provider in the MetLife Dental PDP network	You can go to any licensed provider outside the MetLife Dental PDP network
Deductible and Annual Maximum	Your deductible and annual maximum are lowest when you use PDP providers, which means **less out-of-pocket cost for you**	Your deductible and annual maximum are highest when you use out-of-network providers, which means **more out-of-pocket cost for you**
What the Dental Program Pays	The plan pays a higher percentage of covered dental expenses after you pay the annual deductible	The plan pays the lowest percentage of covered dental expenses after you pay the annual deductible
Reasonable & Customary (R&C)	You do not have to worry about amounts above URC	You must also pay amounts above URC
Claims	You do not have to file claims – your PDP provider will do it for you	You may have to file your own claims

Dental Identification Cards

You do not need an ID card for the Dental Program and an ID card is not required to receive services. However, one is available as a courtesy and convenience to you should you wish to have an ID card to take to your appointment. You can print a personalized ID card online when you go to www.mybenefits.metlife.com/mybenefits

DENTAL PROGRAM - IMPORTANT FEATURES

Predetermination of Benefits

For dental treatments likely to cost more than $300, your dentist should request a predetermination of benefits before beginning treatment. To make this request, you do not need a special claim form. Your dentist should complete a regular MetLife or universal claim form, with a diagnosis of the condition, the proposed course of treatment with itemized services, and charges for each procedure. Dates of service do not need to be included with this initial approval request.

MetLife reviews the proposed treatment to determine how coverage would apply and sends back to the dentist a predetermination of benefits form. This form states the MetLife approved costs for the procedures recommended.

If alternative, less costly treatments are available, MetLife informs you and your dentist, in writing, of benefits that the Dental Program option pays. You and your dentist are free to pursue any treatment plan. However, the Dental Program pays only for the least expensive but equally effective procedure.

If you do not have a predetermination of benefits for any treatment costing more than $300 and your claim is reviewed after treatment, reimbursement may be less than you expect. Any pre-determination of benefits is subject to Dental Program limits at the time services are rendered, and therefore does not guarantee payment of estimated benefits.

Reasonable and Customary (R&C) Charges

If you choose to see an out-of-network provider, the Dental Program will reimburse a portion of covered expenses up to the lesser of:

- the amount billed for the services; or
- an amount determined by MetLife to be reasonable and customary (R&C) for that service.

The R&C charge is the lower of the provider's usual charge or the prevailing charge in the geographic area where it is furnished — as determined by MetLife. To determine the R&C charge, MetLife takes into account the:

- complexity of the service;
- degree of skill needed;
- type or specialty of the provider;
- range of services provided by a facility; and
- prevailing charge in the area in which services are performed.

If you incur a covered expense that is above the R&C limit, you are responsible for paying the excess amount (R&C Excess). You have the right to have MetLife review your claim if you or your dentist believe that there are special circumstances that justify the charge over the R&C limit. The R&C Allowed percentage for non-network benefits is 80%.

Necessary Dental

The fact that a dentist may recommend that you receive a dental service does not mean:

- That the dental service will be deemed to be necessary; or
- That the benefits under the Dental Program will be paid for the expenses of the dental service.

Claims Administration will make the decisions to determine whether the dental service:

- Is necessary in terms of generally accepted dental standards; and
- Is qualified for benefits under the Dental Program. In most cases, care prescribed by your dentist is considered necessary dental services, as defined by this Dental Program.

However, there are exceptions which are not eligible for coverage under this Dental Program. These include cosmetic dentistry and treatment considered to be experimental or investigational because it does not meet generally accepted standards of dental practice in the U.S.

Alternative Procedures

If alternative procedures, services, or courses of treatment can be performed to properly correct a dental condition and they meet generally accepted standards of dental care, the Plan Administrator will consider alternative procedures that may accomplish a professionally satisfactory result at the least costly expense for the Dental Program.

If you and your dentist decide on a more expensive method of treatment than that which is pre-determined by the Claims Administrator, the excess amount will be your responsibility.

Effective Date of Coverage

Dental expenses that you or your family members incur will be covered under this Dental Program, provided coverage is in effect on the date you or your Dependents incur the dental expense. The following schedule is used to determine the date on which a covered dental expense is deemed to have started:

- For full or partial dentures, on the date on which the final impression was taken;
- For fixed bridgework, crowns, inlays, and onlays, on the date on which the tooth was first prepared;
- For root canal therapy, on the later of either the date on which the pulp chamber is opened or on the date on which the canals are explored to the apex;
- For periodontal surgery, the date on which the surgery is actually performed; and
- For all other services, the date on which the service is performed.

Treatment in Progress on Effective Date of Coverage

Benefits are not provided for treatment received prior to the effective date of coverage under the Dental Program. Claims for a course of treatment that was started prior to a person's coverage under the Dental Program but is completed after the effective date of coverage under the Dental Program will be evaluated to determine how much of the charge applies to treatment received while covered under the Dental Program. Only that portion of the charges which are covered under the Dental Program and apply to treatment received while covered will be considered to be a covered dental expense.

However, expenses for bridges, crowns, and dentures for which impressions were made prior to the effective date of a person's coverage under the Dental Program will not be considered to be a covered dental expense even though the installation of such prosthesis may take place after the effective date of the person's coverage.

Restoration Limitations

Your dentist may choose any of several different materials such as metal, acrylic (plastic), and porcelain from which to prepare a crown, pontic, or jacket for a missing or diseased tooth which cannot be restored properly by a less costly procedure. The list below designates the material that is recognized under the Dental Program as being the standard for determining the maximum benefit for specified teeth.

Name of Teeth	Standard Material for Maximum Benefits Under the Dental Program
Upper and lower incisors (8)	Porcelain & porcelain to metal
Upper and lower cuspids (4)	Porcelain & porcelain to metal
Upper and lower bicuspids (8)	Porcelain fused to metal & porcelain
Upper and lower molars (12)	Metal

If a tooth is restored by use of a crown, pontic, or jacket, and the material used is less expensive than the material above, the benefit payable under the Dental Program will be based on the usual, necessary, and customary charge for the material used.

Prosthodontic Limitations

If a standard partial denture meets accepted standards of dental practice in determining the benefits payable under the Dental Program, only the usual, necessary, and customary charge for the standard denture will be allowed toward the cost of a more elaborate or precision appliance that the patient and the dentist may choose. The balance of the cost will not be considered to be a covered dental expense.

If a standard denture meets accepted standards of dental practice; and if in the provision of denture services, the patient and the dentist decide on personalized restorations or specialized techniques as opposed to standard procedures; the usual, necessary, and customary charge for the standard denture service will be used in determining the benefits payable under the Dental Program. The balance of the cost will not be considered to be a covered dental expense.

Extension of Benefits to Complete Treatment

If your dental coverage ends, you may extend your MetLife coverage for 30 days for the following dental services, provided your benefits would have otherwise been paid:

- For an appliance — or modification of an appliance — for which an impression was taken before your coverage ended;
- For a crown, bridge, or gold restoration for which the tooth was prepared before your coverage ended; and/or
- For root canal therapy, provided the pulp chamber was opened before your coverage ended.

DENTAL PROGRAM - COVERED DENTAL EXPENSES

Following is a detailed description of covered dental expenses under the Dental Program options. If you have questions about covered dental expenses under your Dental Program option, call MetLife Dental at 1-800-942-0854.

Benefits payable under the Dental Program apply only to covered dental expenses. In order to be considered a *covered dental expense*, charges must meet the following conditions:

- Covered dental expenses are those which are reasonable and customary charges actually incurred for **necessary** dental services and supplies for a participant or Dependent under the care of a duly qualified dentist or physician, licensed to practice wherever the service is rendered.

For purposes of this summary, all services described on the following pages will be eligible for reimbursement so long as they meet the definition of a covered expense. In addition, whenever a patient receives a more expensive treatment than is customarily provided, the Dental Program will pay only the applicable allowance for the *less* expensive procedure.

For purposes of benefit determination under the Dental Program, dental services are broken down into four main categories, which are:

- Preventive and Diagnostic Services;
- General Services;
- Prosthetic Services; and
- Orthodontic Services.

You should become familiar with which types of services are covered under these four categories and the applicable level of coverage under the Dental Program.

Some limitations and exclusions of coverage may apply to particular services and supplies, as outlined in this summary.

Annual Deductible

The deductible is the amount you must pay each Plan Year before the Dental Program begins to pay benefits for most services. You do not have to meet the deductible before the Dental Program begins paying for your preventive care.

Coinsurance

Coinsurance is the percentage of the covered charges you pay after you meet the deductible. The annual out-of-pocket maximum is the most the Dental Program will pay toward each covered person's eligible dental care in a Plan Year. Note that expenses above the allowed amounts are not applied toward the annual out-of-pocket maximum.

Annual and Lifetime Maximums

The annual maximum is the maximum benefit amount your plan option will pay each Plan Year. The amount of benefits you use in a given plan year apply to both the in-network and out-of-network maximums

for the year.

This means maximum dental benefits allocated per participant in a given calendar year will never be greater than the in-network annual maximum. As a result, if you reach the annual in-network maximum you have used all your dental benefits for that year.

The Orthodontia Lifetime Maximum of $3,000 in-network and $1,500 out-of-network is the only lifetime limit under the Dental Program. The $3,000 in-network benefit will be off-set by any orthodontia benefits that were previously paid prior to January 1, 2012.

Preventive and Diagnostic Services

To encourage preventive care and detect small problems before they become larger dental and financial concerns, the Dental Program pays 100% of the R&C charges for covered preventive and diagnostic services. You will pay any R&C Excess. These charges are not subject to the deductible. Services and supplies included in this category are:

- **Oral Examinations:** Not more often than twice each calendar year.
- **Routine Cleaning and Scaling of Teeth:** Not more often than twice each calendar year.
- **X-Rays:** Bite-wing X-Rays are covered, but not more often than twice each calendar year. Full mouth series of X-Rays (Panorex), including bite-wing x-rays if necessary, are covered provided 36 months have passed since your last full mouth series of X-Rays.
- **Fluoride Applications:** For a Child under age 19, but not more than twice each calendar year.
- **Space Maintainers:** Must replace prematurely lost primary teeth for a Child under age 19. Covers both the space maintainer and the fitting procedure. Space maintainers are fixed or removable appliances designed to prevent adjacent and opposing teeth from moving.
- **Sealant Treatment:** For a Child under age 19, but not more than once every 36 months and for each non-restored molar and bicuspids only. Sealants are materials other than fluorides painted on the grooves of the teeth in an attempt to prevent future decay.

General Services

General Services include the following list of dental treatment:

- **Fillings:** Includes amalgam, silicate, acrylic, synthetic porcelain and composite filling restorations
- **Extractions:** Including extractions performed in connection with orthodontic treatment.
- **Oral Surgery**: including extractions, removal of impacted teeth, root removal, surgical removal of erupted teeth and associated routine post-operative visits.
- **General Anesthetics:** sedation that renders a patient unconscious is covered only when medically necessary and when administered in connection with oral or dental surgery. May be covered if due to cavities for small children.
- **Antibiotic Drugs:** Administered by a dentist in his or her office.
- **Periodontics:** Any surgical procedure necessary for the treatment of periodontal and other diseases of the gums, the tissues of the mouth, or bones supporting the teeth once per quadrant per year (including scaling and root planing once per quadrant per year when done as part of periodontal

services).

- **Endodontic Treatment:** including root canal therapy.
- **Repairs:** Repair or re-cementing of crowns, inlays, onlays, bridgework, or dentures.
- **Relining or Rebasing of Dentures:** more than six months after the installation of an initial or replacement denture, but not more than one relining or rebasing in any period of 36 consecutive months.
- **Perio Maintenance:** includes scaling with cleaning.
- **Consultations:** diagnostic service provided by dentist or physician other than practitioner providing treatment. Two per calendar year.
- **Occlusal adjustments:** enhances the healing of potential tissues affected by lesions of occlusal trauma. Covered as needed.
- **Bruxism:** appliances (mouth guard) or treatment for grinding of teeth.

Major Services

After you satisfy your annual deductible, the Dental Program pays 50% of R&C charges for covered major services, as outlined below:

- **Inlays, Onlays, Gold Fillings, or Crown Restorations:** to restore diseased teeth, but only when the tooth, as a result of extensive caries or fracture, cannot be restored with an amalgam, silicate, acrylic, synthetic porcelain, or composite filling restoration.
- **Bridgework:** Initial installment of fixed bridgework to replace missing natural teeth (including inlays and crowns as abutments except periodontal splinting).
- **Dentures:** Initial installation of partial or full removable dentures (including adjustments during the six month period following installation).
- **Replacement of Bridgework, Crowns and Dentures:** Replacement of an existing partial removable denture by a new denture, or the addition of teeth to an existing partial removable denture, but only if satisfactory evidence is present that:
  - the replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture was installed; or
  - the existing denture or crown is unserviceable, cannot be made serviceable and was installed under the Dental Program or any other group plan at least 60 months prior to the replacement of the denture or bridgework; or
  - the existing denture is an immediate, temporary denture which cannot be made permanent and replacement by a permanent denture takes place within 12 months from the date of initial installation of the immediate, temporary denture; or
  - replacement of an existing denture or bridgework that is at least 60 months old and is no longer serviceable; or
  - replacement of a bridge due to the extraction of a natural tooth, but only to the extent that the new pontic and abutment will be covered if less than 60 months old.
  - Normally, partial dentures will be replaced by partial dentures, but if a result consistent with generally accepted standards of dental practice can be achieved with only bridgework, the

Reasonable and Customary charge for such bridgework will be a covered dental expense.

- **Implants (Dental Plus only):** Initial placement to replace one or more natural teeth, which are lost while covered by the Dental Program.
  - Implant replacement is covered once every 5 years if necessary and appropriate.

Orthodontic Services (Dental Plus only)

The Dental Program pays 50% for covered orthodontic services up to an overall maximum lifetime benefit of $3,000 for each covered participant. At no time will any participant receive greater than $3,000 in total benefits for orthodontia treatment. These charges are not subject to the deductible. Orthodontic Services include:

- **Braces:** and other appliance therapy,
- **Surgical therapy:** the surgical repositioning of the jaw, facial bones, teeth, or any combination thereof to correct malocclusion.

There is a $1,500 maximum benefit limitation on Out-of-Network orthodontic coverage.

Orthodontic treatment means preventive and corrective treatment of all those dental irregularities which result from the abnormal growth and development of the teeth and the related structures of the mouth or as a result of accidental injury which require repositioning (except for preventive treatment) of teeth to establish normal alignment.

The benefits payable for orthodontic treatment are based on the orthodontist's estimate of total charges for the entire course of treatment. Twenty-five percent (25%) of the fee for the entire course of treatment will be considered by MetLife to be the initial charge and will be paid under the Dental Program as an orthodontic expense. The remaining 75% of the charges for the entire course of treatment will be divided by the number of months that the course of treatment will take, and the resulting amount will be considered to be the monthly charge which will be paid under the Dental Program as an orthodontic expense.

Payment of the monthly benefits for Orthodontic Services will be made as long as the course of treatment continues, unless coverage under the Dental Program ceases, or the Lifetime Maximum has been reached.

Example: Let's make the following assumptions:

- Contract Amount: $4,000
- Down payment required: $500
- Number of treatment months: 24
- Monthly payment: $104.17 for 24 months

The Claims Administrator will authorize an initial payment of 25% of the total contract price toward the eligible amount of the down payment. In this example 25% of $4,000 is $1,000. Based on 50% orthodontic coverage, the payment to the orthodontist would be $500 ($1,000 x 50%).

For ongoing monthly insurance reimbursements, the Claims Administrator will deduct the initial payment amount ($1,000) from the total contract amount ($4,000) and prorate the remainder ($3,000) over the number of treatments, in this example 24 months; arriving at a monthly coverage amount of $125 ($3,000 divided by 24). This is the amount that the Claims Administrator will consider each month.

Remember that the initial payment also goes against the maximum. Therefore, the in-network benefit amount of $3,000 minus the $500 Initial Payment leaves $2,500 to apply towards the monthly claims. $2,500 divided by $62.50 (the monthly payment) equals 40 months to exhaust your benefit allowance.

If You Have Elected a Health Care Spending Account

Claims for orthodontic services will be reimbursed through your Health Care Spending Account 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 the services up front, rather than making monthly payments. You must provide proof of payment (for instance a copy of the check). In the above example, the monthly out-of pocket payments are eligible for reimbursement.

Please contact UnitedHealthcare if you have any questions regarding the reimbursement of orthodontic expenses under the CITGO Flexible Benefits Program for Salaried and Hourly Employees (toll free at 1-866-317-6359, option 6). Health Care Spending Account information is available in a separate SPD under Flexible Spending Accounts.

DENTAL PROGRAM - EXCLUSIONS

The following list of Dental Exclusions is not all-inclusive. Other specific expenses may be determined not to be covered under the Dental Program by the Claims Administrator or the Plan Administrator. If you have a question on a specific expense, you should contact the Claims Administrator.

Expenses not covered under the Dental Program include, but are not limited to:

- Charges in excess of the reasonable and customary fees (R&C Excess) as determined by the applicable schedule of the Claims Administrator;
- Treatment for accidental dental injury which results in a hospital confinement or emergency room treatment (covered by Medical Program);
- Services rendered to a person prior to the effective date of that person's coverage under the Dental Program;
- Services rendered to a person after the termination of the person's coverage, except those services started prior to termination;
- Services not specifically included in the Dental Program;
- Treatment performed by any person other than a dentist. However, scaling or cleaning of teeth and topical application of fluoride, to the extent covered under the Dental Program, may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of and billed for by the dentist;
- Services or supplies that are cosmetic in nature, unless a newborn defect, including personalization or characterization of dentures;
- Harmful habits except bruxism – grinding of teeth;
- Any service or supply required directly or indirectly to treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joint (TMJ) and its associated structures. TMJ is covered by the CITGO Medical Program;
- Fees charged for the completion of a claim form;
- The replacement of a lost, missing, or stolen prosthetic device;
- Replacement or repair of an orthodontic appliance;
- Any duplicate prosthetic device or any other duplicate appliance;
- Services which an employer is required by law to furnish in whole or in part, including services which are covered by any workers' compensation laws or employer liability laws;
- Services rendered through a medical department, clinic, or similar facility provided or maintained by a patient's employer;
- Services or supplies for which no charge is made that the person covered under the Dental Program is legally obligated to pay or for which no charge would be made in the absence of dental expense coverage;
- Services or supplies which are not necessary, according to generally accepted standards of dental practice as determined by the Claims Administrator;
- Services or supplies which do not meet accepted standards of dental practice, including charges for services or supplies which are experimental or investigational in nature;
- Expenses for bridges, crowns, and dentures for which impressions were made prior to the effective date of a person’s coverage under the Dental Program even though the installation of such prosthesis

may take place after the effective date of the person's coverage;

- Expenses for dentures or bridgework to replace one or more natural teeth lost prior to the effective date of a person's coverage under the Dental Program or to replace congenitally missing natural teeth;
- Services or supplies received as a result of dental disease, defect, or injury resulting from an act of war, declared or undeclared;
- Treatment of a covered person for an injury or illness resulting from a felony committed by that person;
- Instructions concerning oral hygiene and diet;
- A plaque control program (a series of instructions on the care of teeth);
- Appliances or restorations used to alter vertical dimension or restore occlusion;
- Periodontal splinting;
- Cast restorations for teeth which are restorable by other means (for example, silicate or composite filling), or for the purpose of periodontal splinting or changes in vertical dimension;
- Replacement of an existing cast restoration which was installed within the immediately preceding 5 years or replacement of an existing cast restoration which can be repaired;
- Repetition of a periodontal procedure, including scaling and root planing and gingival curettage, in the same area of the mouth within the indicated limits;
- Services to the extent that coverage for such services is provided under any other group plan, except the group Medical Program, to which the Company makes contributions on behalf of employees;
- Myofunctional therapy;
- Services caused by attrition and wearing down of teeth; and
- Dental services to the extent that coverage for those services are available under any government-sponsored plan or program, including those in which any government participates as anything other than as an employer. This limitation applies even if the participant is not enrolled for all coverage for which he or she has become eligible. Benefits under the Dental Program will be reduced by the amount to which the participant would have been entitled under the governmental plan. The term "any government" includes the federal, state, provincial, or local government or any political subdivision thereof of the United States or any other country. This provision is subject to any provision or regulation of the governmental plan or program which requires that benefits under the Dental Program be utilized before benefits are available under the governmental plan.

VISION PROGRAM - OVERVIEW

The Vision Program is designed to promote and encourage regular comprehensive vision care, to provide benefits for services that are essential to the proper care of your vision, and to help defray a portion of the vision expenses incurred by you and your family members.

Overview of Vision Options

- Vision Basic Option
- Vision Plus Option
- No Vision Coverage

Vision Identification Cards

You do not need an ID card for the vision program and an ID card is not required to receive services. However, one is available as a courtesy and convenience to you should you wish to have an ID card to take to your appointment. You can print an ID card online at www.uhcvision.com.

Following is information about network vs. non-network vision providers:

IN-NETWORK VS. OUT-OF-NETWORK PROVIDERS	
If You Use a UHC Vision In-Network Provider	**If You Use an Out-Of-Network Provider**
The provider will submit your claim forms.	You will need to file your own claim forms.
The providers have discounted rates so you don't have to worry about being charged more than your co-pay (unless you select materials over the maximum allowable expense covered by the Vision Program).	You must pay any charges in excess of the maximum allowable expense covered by the applicable wholesale allowance limits.
UHC Vision will pay benefits to participating providers directly, so you only pay your portion of the cost.	You must pay the provider and then file your receipts with UHC Vision for reimbursement.

Get the Most Value from the Vision Program

You may choose to receive vision care and materials from any vision service provider you wish. However you receive higher benefits when you use a UHC Vision provider. When you need eye care services, you choose whether or not to use a member of the UHC Vision national network of vision care providers. You receive the highest benefit, or most value, from the Vision Program when you use in-network providers. To use in-network services, each time you need care you should:

- Find a participating provider on the UHC Vision web site at: http://www.uhcvision.com. You can also call the UHC Vision Provider Locator at 1-800-839-3242. A list of providers is also available from the Benefits HelpLine by calling 1-888-443-5707.
- Make an appointment with your provider and identify yourself as a UHC Vision participant.

- Pay your co-pay when you meet with the provider. No identification card is required. Let your provider know if you would like to be fitted for eyeglasses or contact lenses. **Be sure to ask what frames or lenses are covered in full before making your final decision.**
- That's it! You do not need to file a claim when you receive care from an in-network provider. UHC Vision will pay the participating provider directly for covered services and materials. However, you will be responsible for paying any costs for non-covered services and materials.

Participating Providers

Neither sole private practice provider networks nor sole retail chain provider networks satisfy everyone. Some people prefer to use the services of a private practice provider, especially if they have a longstanding relationship with a family eye doctor. Others prefer to use the services of a retail chain provider. Retail chain providers allow access to evening and weekend appointments. In addition, many retail chain providers have the ability to provide eyewear within 24 hours.

UHC Vision national network offers the greatest choice and convenience with a diverse network of over 17,000 providers. The UHC Vision network includes private practice as well as leading retail chain providers. To find a **UHC Vision Provider i**n the Network, call **1-800-839-3242** or visit the website at **www.uhcvision.com**

Cost Savings

Participating providers have contracted with UHC Vision for discounted fees. A lower cost results in lower out-of-pocket expense for you. Participating providers also extend lower, negotiated fees on services not covered by the Vision Program (including cosmetic expenses).

Out-of-Network Benefits

If you use an out-of-network provider, you will pay in full at the time of your appointment, submit your receipts to UHC Vision, and receive reimbursement according to the benefit schedule of wholesale allowance limits. Be sure to submit your claim for services and materials purchased on different dates at the same time to receive reimbursement (only one reimbursement per participant every twelve months).

VISION PROGRAM – COVERED SERVICES

The vision services described in this SPD will be eligible for reimbursement under the Vision Program. In addition, whenever a patient receives a more expensive treatment than is customarily provided, the Vision Program will pay only the applicable wholesale allowance for the less expensive procedure.

Some limitations and exclusions of coverage may apply to particular services and supplies, as outlined in this summary. Please refer to the section Vision Program Limitations and Exclusions for listings of certain expenses that are not covered under this Vision Program.

Vision Benefit Summary Chart

Vision Benefit	Vision Basic		Vision Plus	
	In Network	Out-of-Network	In Network	Out-of-Network
Eye Exam	Once Per Calendar Year		Once Per Calendar Year	
Eyeglass Lenses or Contact Lenses	Once Per Calendar Year		Once Per Calendar Year	
Frames	Once Every Two Years		Once Per Calendar Year	
Vision Exam by a licensed Optometrist or Ophthalmologist	$10 Exam Copay	up to $50	$10 Exam Copay	up to $50
Frames	$ 25 Materials Copay with up to **$130 retail frame allowance** at a UHC Vision network provider	up to $45	$ 25 Materials Copay with up to **$250 retail frame allowance** at a UHC Vision network provider	up to $45
Single, Bifocal, Trifocal and Lenticular Lenses*	Covered in full. Except that progressive lenses and lens' coatings are **covered at a discount only**	Up to $80, varies by lens type	Covered in full, including pProgressive lenses, scratch coating and anti-reflective coating	Up to $80, varies by lens type
Elective Contact Lenses in lieu of eyeglasses	Covered-in-full elective contact lenses, fitting/evaluation fees, up to 6 boxes	up to $150	Covered-in-full elective contact lenses, fitting/evaluation fees, up to 6 boxes	up to $150
Medically necessary contact lenses are determined by your vision provider for both in-network and out-of-network coverage. If your provider considers your contacts medically necessary, your provider should contact UnitedHealthcare (UHC) Vision concerning coverage.				

*** The network provider materials co-pay will apply once if frames and lenses are purchased at the same time.**

Routine Vision Examination

A routine vision examination of the condition of the eyes and principal vision functions according to the standards of care in the jurisdiction in which the covered person resides is covered once per calendar year, to include:

- A case history, including chief complaint and/or reason for examination, patient medical/eye history, current medications, etc.;
- Recording of monocular and binocular visual acuity, far and near, with and without present correction (20/20, 20/40, etc.);
- Cover test at 20 feet and 16 inches (checks eye alignment);
- Ocular motility including versions (how well eyes track) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception;
- Pupil responses (neurological integrity);
- External and Internal exam;
- Retinoscopy (when applicable) - objective refraction to determine lens power of corrective subjective refraction – to determine lens power of corrective lenses;
- Phorometry/Binocular testing - far and near: how well eyes work as a team;
- Tests of accommodation and/or near point refraction: how well covered person sees at near point (reading, etc.);
- Tonometry, when indicated: test pressure in eye (glaucoma check);
- Ophthalmoscopic examination of the internal eye;
- Confrontation visual fields;
- Biomicroscopy;
- Color vision testing;
- Diagnosis/prognosis; and specific recommendations.

In lieu of a complete exam, retinoscopy (when applicable) - objective refraction to determine lens power of corrective subjective refraction - to determine lens power of corrective lenses. Post examination procedures will be performed only when materials are required.

Eyeglass Lenses

Lenses that are mounted in eyeglass frames and worn on the face to correct visual acuity limitations.

Eyeglass Frames

A structure that contains eyeglasses lenses, holding the lenses in front of the eyes and supported by the bridge of the nose.

Optional Lens Extras

Special lens stock or modifications to lenses that do not correct visual acuity problems. Optional Lens Extras include options such as, but not limited to, tinted lenses, polycarbonate lenses, transition lenses, high-index lenses, progressive lenses, ultraviolet coating, scratch-resistant coating, edge coating, and photochromatic coating.

Contact Lenses

Lenses worn on the surface of the eye to correct visual acuity limitations.

Medically Necessary Contact Lenses

This benefit is available where a provider has determined a need for and has prescribed the service. Such determination will be made by the provider and not by UHC Vision. Contact lenses are necessary if the covered person has:

- Keratoconus or irregular astigmatism;
- Anisometropia of 3.50 diopters or more;
- Post-cataract surgery without intraocular lens; or
- Visual acuity in the better eye of less than 20/70 with visual correction by eyeglasses but better than 20/70 with visual correction by contact lenses.

If your provider considers your contacts necessary, you should ask your provider to contact UHC Vision for necessity approval before you purchase such contacts.

Important to Remember:

- Benefit frequency based on the calendar year.
- Your $150 allowance and buy up allowance is applied to the fitting/evaluation fees as well as the purchase of contact lenses. For example, if the fitting/evaluation fee is $30, you will have $120.00 toward the purchase of contact lenses. The allowance may be separated at some retail chain locations between the examining physician and the optical store.
- UHC Vision offers an Additional Materials Discount Program. At a participating network provider you will receive a 20% discount on an additional pair of eyeglasses or contact lenses. This program is available after your vision benefits have been exhausted. Please note that this discount shall not be considered insurance, and that UHC Vision shall neither pay nor reimburse the provider or member for any funds owed or spent. Not all providers may offer this discount. Please contact your provider to see if they participate.
- Discounts on contact lenses may vary by provider.
- Additional materials do not have to be purchased at the time of initial material purchase.
- Additional materials can be purchased at a discount any time after the insured benefit has been used.
- The Vision Plan offers access to discounted laser vision correction through the Laser Vision Network of America.

VISION PROGRAM - LIMITATIONS AND EXCLUSIONS

The following list of **Not Covered Expenses** is not all-inclusive. Other specific expenses may be determined to be not covered under the Vision Program by the insurer or the Plan Administrator. If you have a question on a specific expense, you should contact the insurer.

This Vision Program is designed to cover your visual needs rather than cosmetic materials. If you select any of the following, you will be responsible for the additional charge:

- Blended lenses;
- Oversize lenses;
- Progressive multifocal lenses;
- Frames that exceed the Vision Program allowance;
- Certain limitations on low vision care;
- Cosmetic lenses;
- Optional cosmetic processes.

The following professional services or materials are not covered:

- Orthoptics or vision training and any associated supplemental testing;
- Plano lenses (non-prescription);
- Two pair of glasses in lieu of bifocals;
- Lenses and frames furnished under this Program that are lost or broken will not be replaced or repaired except at the normal intervals when services are otherwise available;
- Medical or surgical treatment of the eyes which requires the services of a physician;
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment;
- Services or materials for which the covered person may be paid under Workers' Compensation Law or other similar employer's liability law;
- Services which the covered person obtains at no cost from any federal, state, county, city or other governmental organization, except Medicaid;
- Sunglasses, plain;
- Corrective vision services, treatments and materials of an experimental nature;
- Post cataract lenses are excluded if vision problems can be corrected with glasses;
- Non-prescription items;
- Services and materials which are not specifically listed as covered;
- Cosmetic extras, except as stated in the Eligible Benefits section.

PROVISIONS THAT CAN AFFECT MEDICAL, DENTAL AND VISION BENEFITS

COORDINATION OF BENEFITS (COB)

Coordination of Benefits (COB) applies when participants have health care coverage under more than one benefit plan. In these situations, it is necessary to determine which plan has primary responsibility for the payment of benefits.

When Coordination of Benefits is Applicable

The benefits payable under the Programs are coordinated with benefits payable under other group health plans not sponsored by the Company. "Other plans" are those which provide benefits or services in connection with medical care or treatment and may include:

- a medical plan sponsored by another employer (the employer may pay all or part of the cost for coverage and/or take payroll deductions);
- any other group insurance or group-type coverage;
- Medicare (see Effect of Eligibility for Medicare);
- Medicaid; or
- any other government-sponsored plan (i.e., Tricare for military dependents).

The COB provision applies only when group health plans are involved. It does not apply to benefits payable under any private accident or health insurance plans you or your Dependents may have.

If you or a covered Dependent are covered under more than one group plan and you incur an expense that is covered — partially or in full — under at least one of the plans:

- benefits related to that expense will be paid under the Primary and Secondary Plans as determined under the COB provisions; and
- under no circumstances will the sum of the benefits paid from each plan exceed the actual expense incurred.

If your Dependent's Primary Plan is another group health plan (other than Medicare), your Dependent is not eligible for the Prescription Drug Program. Therefore, COB will not apply (see Prescription Drug Program). The following summarizes how coordination of benefits works.

Applying Coordination of Benefits for the Medical and Dental Programs

When an individual is covered under more than one group health plan:

- one plan is determined to be the Primary Plan and the others are considered Secondary Plans;
- the Primary Plan pays benefits first as if the Secondary Plan(s) did not exist; and
- the Secondary Plan(s) then consider the difference, up to the total allowable expenses incurred.

No plan will pay more than it would have paid without the COB provision. In order to pay claims, the Claims Administrator must determine the Primary Plan and the Secondary Plan(s).

Applying Coordination of Benefits for the Vision Program

The Coordination of Benefits provisions in this section of the SPD do not apply to the Vision Program.

Determination of Primary and Secondary Plans

The coverage plan that covers the person other than as a dependent — for example as an employee, member or subscriber — is Primary, and the coverage plan that covers the person as a dependent is Secondary.

If your Spouse is covered under one of the Programs but is also covered under another group plan, your Spouse's group plan will always be the Primary Plan for your Spouse.

Otherwise, this Plan is usually the Primary Plan if:

- the expenses are for you (the Company employee or retiree);
- the expenses are for your child and the month and day of your birth comes earlier in the year than the month and day of birth of any other person who is covering the child as a dependent under a group plan (this is known as the "Birthday Rule"). If both parents have the same birthday, the coverage plan that covered either of the parents longer is Primary;
- the expenses are for your child, and you are separated or divorced and have custody of the child — or a court decree, or a QMCSO (see Qualified Medical Child Support Orders), has established you as financially responsible for the child's medical expenses;
- you are an active employee age 65 or over and your other group health plan is Medicare; or
- you are an active employee and the expenses are for your Spouse who is age 65 or over, and your Spouse's other group health plan is Medicare.

In order to avoid delays in claims processing, your claims should be submitted to the Primary Plan as soon as possible. When you file a claim, you will have to give information about any other plans under which you are covered.

Non-Duplication of Benefits

If one of the Programs is the Secondary Plan, submit a copy of the Explanation of Benefits (EOB) from the Primary Plan, along with an itemized statement of expenses and a claim form, if necessary, for benefits consideration.

Under the non-duplication of benefits provision, the Program will consider benefit payments you receive from the Primary Plan. The Program makes up the difference up to the maximum amount the Program would have paid if there were no other medical coverage.

RIGHT OF RECOVERY - OVERPAYMENT OF BENEFITS

If any Program pays benefits, the Program has the right to recover the overpayment if either of the following apply:

- all or some of the expenses were not paid by the benefit recipient (i.e., any individual for whom benefits are paid by the Plan) or did not legally have to be paid by the benefit recipient;
- all or some of the payment exceeded the benefits under the Program; or
- all or some of the payment was made in error.

The benefit recipient, another person or the organization that received the overpayment must make a refund to the Program.

If the benefit recipient, or any other person or organization that was paid, does not promptly refund the full amount, the amount of any future benefit payments may be reduced.

The refund equals the amount paid in excess of the amount that should have been paid under the Program. If the refund is due from another person or organization, the benefit recipient agrees to help get the refund when requested.

Such recovery shall be returned by the Plan Administrator, trust or other entity which made the excess payment on behalf of the Program.

SUBROGATION

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any benefit, the Plan (with respect to the applicable Program) shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and benefits the Plan provided to benefit recipients from any or all of the following:

- third parties, including any person alleged to have caused a benefit recipient to suffer injuries or damages;
- any person or entity who is or may be obligated to provide benefits or payments to a benefit recipient, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators; and/or
- any person or entity liable for payment to a benefit recipient on any equitable or legal liability theory.

In addition to any subrogation rights and in consideration of the coverage provided by this Summary Plan Description, the Plan shall also have an independent right to be reimbursed by benefit recipients for the reasonable value of any services and benefits the Plan provides to benefit recipients, from any or all of the persons or entities listed above.

These third parties and persons or entities are collectively referred to as "Third Parties."
Benefit recipients agree as follows:

- That a benefit recipient will cooperate with the Plan in a timely manner in protecting the Plan's legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - providing any relevant information requested by the Plan;

  - signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim;
  - responding to requests for information about any accident or injuries;
  - appearing at depositions and in court; and
  - obtaining the consent of the Plan or its agents before releasing any party from liability for payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits and/or the institution of legal action against a benefit recipient.
- That the Plan has the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- That no court costs or attorneys' fees may be deducted from the Plan's recovery without the Plan's express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and the Plan is not required to participate in or pay court costs or attorneys' fees to the attorney hired by a benefit recipient to pursue his or her damage/personal injury claim.
- That regardless of whether a benefit recipient has been fully compensated or made whole, the Plan may collect from benefit recipients the proceeds of any full or partial recovery that a benefit recipient or his or her legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment. The proceeds available for collection shall include, but not be limited to, any and all amounts earmarked as non-economic damage settlement or judgment.
- That benefits paid by the Plan may also be considered to be benefits advanced.
- That benefit recipients agree that if they receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, then a constructive trust shall be imposed on such funds, and the benefit recipient will serve as a constructive trustee over the funds and failure to hold such funds in trust will be deemed as a breach of the benefit recipient's duties hereunder.
- That benefit recipients or an authorized agent, such as the benefit recipient's attorney, must hold any funds received from any potentially responsible party that are due and owed to the Plan, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract and may result in the termination of health benefits or the institution of legal action against the benefit recipient.
- That the Plan shall be entitled to recover reasonable attorney fees from benefit recipients incurred in collecting from the benefit recipient any funds held by the benefit recipient that he or she recovered from any Third Party.
- That the Plan may set off from any future benefits otherwise allowed by the Plan the value of benefits paid or advanced under this section to the extent not recovered by the Plan.
- That benefit recipients will neither accept any settlement that does not fully compensate or reimburse the Plan without the Plan's written approval, nor will the benefit recipient do anything to prejudice the Plan's rights under this section.
- That benefit recipients will assign to the Plan all rights of recovery against Third Parties, to the extent of the reasonable value of services and benefits the Plan provided, plus reasonable costs of collection.
- That the Plan's rights will be considered as the first priority equitable lien against Third Parties, including tortfeasors for whom benefit recipients are seeking recovery, to be paid before any other of the benefit recipient's claims are paid.
- That the Plan's rights will not be reduced due to the benefit recipient's own negligence.
- That the Plan may, at its option, take necessary and appropriate action to preserve its rights under

these subrogation provisions, including filing suit in the benefit recipient's name, which does not obligate the Plan in any way to pay the benefit recipient part of any recovery the Plan might obtain.

- That the Plan shall not be obligated in any way to pursue this right independently or on behalf of the benefit recipient.
- That if the injury or condition giving rise to subrogation or reimbursement involves a minor child, this section applies to the parents or guardian of the minor child.
- That if the injury or condition giving rise to subrogation or reimbursement involves the wrongful death of a Plan beneficiary, this section applies to the personal representative of the deceased Plan beneficiary.

Participants may be contacted by a subrogation service provider, Ingenix, to gather information about medical treatment received.

Ingenix will use several factors to decide whether to contact you, including the kind of injury or illness and the type of treatment received. If you receive a letter or call from Ingenix asking whether medical treatment was the result of an accident or injury, please respond promptly.

BENEFIT CLAIMS AND APPEALS PROCEDURE

When you receive medical, prescription drug mental health and/or chemical dependency care, dental, or vision care from an In-Network provider, your provider should automatically file a claim for you.

If you receive care or treatment from an Out-of-Network provider (if applicable), you will usually need to pay the provider directly at the time you receive care and then file a claim with the Claims Administrator for reimbursement of your eligible expenses. Your claim must include the appropriate paperwork and receipts. If you receive reimbursement from another source, such as your Spouse's plan, your claim must include the Explanation of Benefits from that plan. Be sure to keep a copy of everything for your records.

Most claim forms can be obtained at the Benefits Forms link on the Benefit Connections website. You can also request claim forms by calling the Benefits HelpLine at 1-888-443-5707 or by calling the Claims Administrator directly at the number provided on the ID card for the coverage for which you are filing a claim.

You must submit medical, prescription drug and dental claims that you incur during the benefit Plan Year within 24 months from the date of service. Vision claims must be submitted within 12 months from the date of service.

For example, assume you incur a medical, prescription drug or dental claim in October 2014, you have until October 2016 to submit the claim. If you incurred a vision claim in October 2014, then you have until October 2015 to file the claim. However, be aware when you use a Network medical, dental or vision provider, they are required to file the claim according to the contract agreement with the carrier.

The Programs do not pay claims that are submitted after the deadline.

Timeframes for Benefit Determinations

The timeframes for benefit determination for health care benefits vary depending on the type of claim as described below.

Medical Care Urgent Claims

Medical care is "urgent" if waiting to obtain care could seriously jeopardize the participant's life, health, or ability to regain maximum function. Also, care may be urgent if, in a doctor's opinion, it would subject the participant to severe pain if care or treatment were not provided. The Claims Administrator will respond to urgent claims as soon as possible and within 72 hours after receiving the claim.

If you require care that is classified as being urgent, but do not submit enough information for the Claims Administrator to make a determination, the Claims Administrator will notify you within 24 hours. You have 48 hours after that time to supply any additional information. Until you supply this information, the time limits that apply for the review are suspended (or "tolled").

Medical Concurrent Care Decisions

These are decisions involving an ongoing course of treatment over a period of time or a number of treatments. If you or your Dependent is undergoing a course of treatment, or is nearing the end of a prescribed number of treatments, you may request extended treatment or benefits. If the course of treatment involves urgent care and you request extended treatment, or benefits at least 24 hours before the expiration of the authorized treatments, the Claims Administrator will respond to your claim within 24 hours. If you reach the end of a pre-approved course of treatment before requesting additional benefits, the normal "pre-service" or "post-service" time limits will apply, as described below.

Medical Pre-service Determinations

A "pre-service" determination requires the receipt of approval of those benefits in advance of obtaining the medical care. The Claims Administrator will respond to a pre-service claim within 15 days after receiving the claim (which may be extended up to 15 additional days if necessary due to reasons beyond the Claims Administrator's control).

If you request a review for pre-service benefits, but do not submit enough information for the Claims Administrator to make a determination, the Claims Administrator will notify you within 15 days. You have 45 days after that to supply any additional information. Until you supply this information, the time limits that apply to the Claims Administrator are tolled.

Medical Post-service Claim Determinations

A "post-service" determination is made for benefits after you have already received care or treatment. A "post-service" determination does not require advance approval of benefits. The Claims Administrator will respond to a post-service claim within 30 days after receiving the claim (which may be extended up to 15 additional days if necessary due to reasons beyond the Claims Administrator's control).

In the case of pre-service determinations and urgent claims, if you fail to follow the specified procedure for filing your claim, the Claims Administrator will notify you of the failure and of the proper procedure. This notice will be provided to you no later than five days after your incorrectly filed claim is received (24 hours in the case of an urgent claim). The notice from the Claims Administrator may be an oral notice, unless you specifically request written notice.

> **Example:** If you have an urgent medical situation, the Claims Administrator must respond to your initial request for benefits within 72 hours, and no extensions are permitted. If the Claims Administrator needs more information from you to make a determination, you will have 48 hours from the time you are notified to supply that information. The time period during which you are gathering that additional information does not count toward the time limits that apply to the Claims Administrator.

Claim Denial

If your claim for benefits is denied (either in whole or in part), the Claims Administrator will send you a written explanation of why the claim was denied. In the case of an urgent claim, this can include oral notification, as long as you are provided with a written notice within three days.

This explanation will contain the following information:

- The specific reason for the denial;
- References to the specific Program provisions on which the denial is based;
- A description of additional material or information that you may need to supply to perfect the claim, and an explanation of why such material or information is necessary;
- A description of the Program's review procedures and applicable time limits, including a statement of your rights to bring a lawsuit under ERISA following an adverse decision at the final level of appeal.

For medical claims, the explanation will also contain the following information:

- Information identifying your claim (including the date of service, the healthcare provider, and the claim amount, if applicable) and a statement that the diagnosis and treatment codes and their respective meanings are available upon request;
- The reason for the adverse decision will include the denial code and its meaning, and a description of the Plan's standard, if any, that was used in denying the claim;
- An explanation of the internal appeals and external review procedures, including information regarding how to initiate an appeal;
- If the adverse decision was made with respect to an urgent care claim, a description of the Plan's expedited review process;
- Contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes;
- If the denial is based on an internal rule, guideline, or protocol, the denial will say so and state that you can obtain a copy of the rule, guideline, or protocol, free of charge upon request;
- If the denial is based on an exclusion applicable to medical necessity or experimental treatment or similar exclusion, the denial must explain the scientific or clinical judgment for determination, applying the terms of the Program to the medical circumstances, or state that such an explanation will be provided upon request, free of charge; and
- If the denial involves urgent care, you will be provided an explanation of the expedited review procedures applicable to urgent claims.

Claims Appeals

If your claim for benefits is denied, you have the right to make an appeal:

- You may call the Claims Administrator and ask why your claim was denied. You may discover that a simple error was made. If so, you may be able to correct the problem right over the telephone.
- If you cannot correct the problem by phone, or if you choose not to call the Claims Administrator, you have the right to file a level 1 appeal by writing directly to the Claims Administrator. Be sure to explain why you think your claim should be paid and provide all relevant details.
- If your claim is denied by the level 1 appeals review committee, and it is not an urgent claim or administrative claim, ask the Claims Administrator to submit your claim to the appropriate level 2 appeals review committee as indicated in the chart under "Claims and Appeals Contact Information."

In deciding appeals, the Claims Administrator identified in the chart under Level 1 Appeals and Level 2 Appeals acts as or for the appropriate named fiduciary for purposes of deciding appeals and has discretionary authority to interpret the Program and to make factual determinations as to whether you are

entitled to benefits.

Administrative Claims

Claims that are not a claim for a specific benefit under a Program are called "administrative claims" (e.g., you believe that you are being charged too much for the benefit coverage you have elected). Because your claim is not for the payment of a specific benefit under a Program, your claim is treated as an administrative claim. Administrative claims must be submitted to the Claims Administrator within 65 days from the date you know or should have known that there is an issue, dispute, problem or other claim with respect to the Program.

If a claim involves a Program change or amendment, you are considered to know about your claim when the change or amendment is first communicated to participants in the Program, and the 365-day period for filing a claim begins on the date the change is first communicated, whether or not the change or amendment has become effective by that date.

If you do not file a benefit claim or an administrative claim by the applicable deadline and in the proper manner, your claim will expire and be automatically denied if it is subsequently filed. You will not be able to proceed with a lawsuit based on that claim.

Time frame for Benefit Determinations for Administrative Claims

For administrative claims, the Claims Administrator must respond to your request within 60 days and may take one 60-day extension if circumstances warrant.

Denied Claims and Appeals for Administrative Claims

The rules in the "Claim Denial" and "Claim Appeals" sections of this SPD also apply to administrative claims.

There is only one level of appeal for administrative claims. You may file a claim appeal with the Claims Administrator within 65 days if your initial claim for benefits is denied and you would like to appeal that denial. Your appeal must be considered within 60 days, with a 60-day extension permitted if necessary.

Limits on Legal Actions

If your claim for benefits or administrative claim is denied on the final level of appeal, you generally may file a lawsuit under ERISA regarding your claim, provided that you comply with the deadlines for filing a lawsuit described in this section. If you wish to file a lawsuit, you must do so by the earlier of the date that is 12 months after the date your claim was denied on appeal or the date that is 12 months from the date a cause of action accrued. A cause of action "accrues" when you know or should know that the Claims Administrator or CITGO, as plan sponsor, has clearly denied or otherwise repudiated your claim.

> **Example #1:** If your claim for payment of a medical expense (other than an urgent claim) is denied after a second level of appeal, the 12-month period begins on the date of the denial of the second level of appeal.
>
> **Example #2:** If your urgent claim is denied, and you file suit after the first level appeal, the 12-month

period begins on the date of the denial of the first level appeal. If you file a voluntary level 2 appeal of an urgent claim denial, the 12-month period begins on the date of the denial of the level 2 appeal.

Timing of Your Appeal

If you make a claim for benefits and the Claims Administrator denies that claim, you have the right to appeal the denial. The appeal procedures must be exhausted before you can initiate a lawsuit to enforce your rights under ERISA (see "Employee Retirement Income Security Act of 1974" for details).

In the case of medical, prescription drug, dental, vision, and health care flexible spending account (FSA) benefit claims, you have 180 days from the time that you receive a claim denial from the Claims Administrator to file an appeal. In the case of administrative claims and all other benefits, you have 60 days from the time that you receive a claim denial from the Claims Administrator to file an appeal. Below are the timeframes that apply when you file an appeal.

Appeals for Urgent Care Claims

There is only one level of appeal that is required for urgent claims. You may file an urgent claim appeal with the Claims Administrator within 180 days if your initial claim for benefits is denied. Your appeal must be considered within 72 hours, with no extensions. You may file a lawsuit under ERISA if your appeal of an urgent claim is denied. However, if you wish, you may file a voluntary level 2 appeal of an urgent claim denial with the Claims Administrator within 180 days, and your appeal will be considered within 72 hours, with no extensions.

For urgent claims, the level 2 appeal is voluntary — it is your choice to request it or not — and you are not required to file a voluntary level 2 appeal in order to file a lawsuit. If you would like additional information to help you decide whether to file a voluntary level 2 appeal of an urgent claim denial, please call the Claims Administrator. Your decision as to whether to file a voluntary level 2 appeal of an urgent claim denial will have no effect on any of your other rights under the Program, and the same rules and procedures apply to a voluntary level 2 appeal of an urgent claim denial as for all other level 2 appeals.

Appeals for Pre-Service Claims (other than urgent claims)

There are two levels of appeal.
Level 1 appeal: You may file a level 1 appeal with the Claims Administrator within 180 days if your initial claim for benefits is denied and you would like to appeal that denial. Your appeal must be considered within 15 days, with no extensions.

Level 2 appeal: If your first appeal is denied by the Claims Administrator, you may file a level 2 appeal with the Claims Administrator within 180 days, and your appeal must be considered within an additional 15 days, with no extensions.

Appeals for Post-Service Claims

There are two levels of appeal.
Level 1 appeal: You may file a level 1 appeal with the Claims Administrator within 180 days if your initial claim for benefits is denied and you would like to appeal that denial. Your appeal must be considered within 30 days, with no extensions.

Level 2 appeal: If your first appeal is denied by the Claims Administrator, you may file a level 2 appeal with the Claims Administrator within 180 days, and your appeal must be considered within an additional 30 days, with no extensions.

Appeal Denial

If your appeal of a benefit claim is denied (either in whole or in part), the Claims Administrator will send you a written explanation of why the claim was denied.

This explanation will contain the following information:

- The specific reason for the denial;
- References to the specific Program provisions on which the denial is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information that (a) was relied upon in making the benefit determination; (b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document was relied on in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required in making the determination;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures; and
- A statement of your right to bring an action under Section 502(a) of ERISA after a final adverse decision upon appeal.

For medical appeals, the explanation will also contain the following information:

- Information identifying your claim (including the date of service, the healthcare provider, and the claim amount, if applicable) and a statement that the diagnosis and treatment codes and their respective meanings are available upon request;
- The reason for the adverse decision will include the denial code and its meaning and a description of the Plan's standard, if any, that was used in denying the claim;
- An explanation of the internal appeals and external review procedures, including information regarding how to initiate an appeal;
- Contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information that constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for your diagnosis, without regard to whether such document was relied on in making the benefit determination;
- A copy of any internal rule, protocol, or criterion that was relied on in making the decision, or a statement that a copy of the rule, protocol, or criterion on which the decision relied is available free of charge upon request; and
- If the adverse determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment applying the terms of the Plan to your medical circumstances, or a statement that this will be provided free of charge upon request.

External Review Process

The Plan's external review process gives you the opportunity to have certain claim denials reviewed by independent reviewers. An independent review organization (IRO) will refer your request for External Review to a neutral, independent expert in the area in question. The review will be completed within 31 days, unless extraordinary circumstances exist and more time is needed, in which case you will be notified before the end of the thirty-day period. The decision of the independent external expert reviewer is binding on the Claims Administrator and the Plan. You will not be charged a professional fee for the review. Contact the Claims Administrator to request an external review.

Claims and Appeals Contact Information

Carrier / Administrator	Initial Claims Submission	First Level Appeal	Second Level Appeal
MetLife Dental	MetLife Dental Claims Services P.O. Box 981282 El Paso, TX 79998-1282	MetLife Dental Member Appeals P.O. Box 981282 El Paso, TX 79998-1282	CITGO Petroleum Corporation P. O. Box 4689 N5063 Houston, TX 77210-4689
UnitedHealthcare Medical Claims	UnitedHealthcare Attention: Claims Department P.O. Box 740800 Atlanta, GA 30374-0816	UnitedHealthcare Attention: Claims Appeals P.O. Box 30432 Salt Lake City, UT 84130-0432	CITGO Petroleum Corporation P. O. Box 4689 N5063 Houston, TX 77210-4689
United Behavioral Health(Mental Health and Substance Abuse)	United Behavioral Health Attention: Claims Department P. O. Box 30757 Salt Lake City, UT 84130	United Behavioral Health Attention: Claims Appeals P. O. Box 30757 Salt Lake City, UT 84130	CITGO Petroleum Corporation P. O. Box 4689 N5063 Houston, TX 77210-4689
Optum RX (Prescription Drugs)	Optum RX Attention: Claims Department P. O. Box 29077 Hot Springs, AR 71903	Optum RX Attention: Claims Appeals P. O. Box 29077 Hot Springs, AR 71903	CITGO Petroleum Corporation P. O. Box 4689 N5063 Houston, TX 77210-4689
UnitedHealthcare (UHC) Vision	UnitedHealthcare Vision Claims Department P. O. Box 30978 Salt Lake City, UT 84130	UnitedHealthcare Vision Claims Appeals P. O. Box 30978 Salt Lake City, UT 84130	CITGO Petroleum Corporation P. O. Box 4689 N5063 Houston, TX 77210-4689

Additional Information about the Appeals Process

In filing an appeal, you have the opportunity to:

- Submit written comments, documents, records and other information relating to your claim for benefits.
- Have reasonable access to and review, upon request and free of charge, copies of all documents, records and other information relevant to your claim, including the name of any medical or vocational expert whose advice was obtained in connection with your initial claim.
- Have all relevant information considered on appeal, even if it wasn't submitted or considered in your initial claim.

In the case of appeals of medical, dental, vision, and health care flexible spending account (FSA) benefit claims:

- The decision on the appeal will be made by a person or persons at the Claims Administrator who is not the person who made the initial claim decision and who is not a subordinate of that person.
- In making the decision on the appeal, the Claims Administrator will give no deference to the initial claim decision.
- If the determination is based in whole or in part on a medical judgment, the Claims Administrator will consult with a health care professional who has appropriate training and experience in the field of

medicine involved in the medical judgment. The health care professional will not be the same individual who was consulted (if one was consulted) with regard to the initial claim decision and will not be a subordinate of that person.

- If benefits are still denied on appeal, the notice that you receive from the final review level (usually the level 2 review) will provide:
  - The specific reasons for the denial.
    - Reference to the Program provisions on which the decision was based.
    - A statement that you may receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim.
    - A statement describing any additional appeal procedures, and a statement of your rights to bring suit under ERISA. (See "Employee Retirement Income Security Act of 1974" for details.)
  - Depending on the type of claim, the notice that you receive from the final review level will also contain the following information:
    - If the denial is based on an internal rule, guideline, or protocol, the denial will say so and state that you can obtain a copy of the rule, etc., free of charge upon request.
    - If the denial is based on an exclusion applicable to medical necessity or experimental treatment or similar exclusion, the denial will explain the scientific or clinical judgment for determination applying the terms of the Program to the medical circumstances, or state that such an explanation will be provided upon request, free of charge.

At both the initial claim level, and on appeal, you may have an authorized representative submit your claim for you. In this case, the Claims Administrator may require you to certify that the representative has permission to act for you. The representative may be a health care or other professional. However, even at the appeal level, neither you nor your representative has a right to appear in person before the Claims Administrator or the review panel.

LEAVES AND OTHER EVENTS AFFECTING COVERAGE

When you are enrolled, your medical, prescription drug, dental and vision coverage will continue, and contributions will be deducted from your paycheck, during any Company-approved absences with full or partial pay.

Your coverage will also continue as long as you are still eligible and your status is approved by the Company as:

- approved Leave of Absence;
- absence due to short-term disability;
- absence due to Family Medical Leave (FMLA); or
- absence due to military leave (other than active duty).

If you wish to waive your coverage while on a leave of absence, you must notify the Benefits HelpLine at 1-888-443-5707.

Payment of Contributions While on Leave

If you are not receiving a paycheck, you must make the required contribution within a 30-day grace period in order to continue coverage, unless you qualify for waiver of contributions as explained below.

If payments are not made within the 30-day grace period, coverage may be terminated once final written notice has been given. If coverage is terminated due to non-payment of contributions:

- **During your approved leave of absence or absence due to disability:** When you return to active employment, you will be eligible to enroll during the next Annual Election Period; or
- **During your absence due to FMLA or military leave:** You will be notified in writing at least 15 days before coverage is terminated. When you return to active employment, your coverage will be effective on your first day back at work.

NOTE: Any illnesses or injuries deemed by the United States Department of Veterans Affairs to have been connected to service in the armed forces while on military leave will not be covered under the Programs.

If you do not return to employment at the end of your leave of absence, your coverage will terminate on the last day of the month in which the leave expires, provided the required contributions for coverage during that month have been made.

If you lose coverage under the Programs, you may be eligible to receive COBRA continuation coverage in certain situations (see COBRA Continuation).

Waiver of Contributions While on Leave

You may be eligible for a waiver of Medical Program contributions for up to six months. To be eligible for a waiver, you must be:

- absent due to short-term disability, and
  - receiving no pay, or

  - receiving pay that is not sufficient to cover all of your insurance deductions; or
- on an approved unpaid leave of absence.

While the waiver is in effect, your coverage will remain unchanged at no cost to you for up to six months. You will be notified if you are eligible for the waiver of contributions while on leave.

WHEN COVERAGE ENDS

Unless you are eligible to continue coverage as explained under COBRA Continuation, your coverage under a Program will end on the last day of the month in which the earliest of the following occurs:

- you no longer meet the eligibility requirements (including approved leave status);
- you terminate employment and are not eligible to continue coverage as a retiree (see Retired Employees Coverage);
- you become eligible for other Company-sponsored health care coverage (for example, the hourly medical program);
- you waive coverage during the Annual Election Period or due to an eligible status change;
- the Program terminates; or
- you fail to make contributions in a timely manner.

Coverage for your dependent(s) will end when your coverage ends. Your dependent's coverage also ends on the last day of the month in which he or she no longer meets the eligibility requirements.

Upon your retirement, you may be eligible for continued medical coverage (see Retire Employees Coverage for more information).

If You are Covered as a Retiree

If you fail to make your required Program contributions:

- your coverage will be terminated once final written notice has been given;
- you will **not** be eligible to re-enroll in retiree medical at a later date;
- if you are rehired, you may re-enroll as an active employee in the same manner as any other new employee; and
- then when you retire again, you **WILL NOT** be eligible for retiree coverage because of your previous non-payment of contributions.

Certificate of Creditable Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires health plans to provide Certificates of Creditable Coverage to individuals who lose coverage under the employer's group health plan. You and/or your Dependents may receive a Certificate of Creditable Coverage from UHC or UnitedHealthcare Benefit Services ("UHC COBRA") when:

- your medical coverage ends;
- you or your Dependent(s) lose or drop medical coverage under the Medical Program; or
- you or your Dependents request a Certificate of Creditable Coverage within 24 months after your coverage ends. To request a certificate, call UHC COBRA at 1-866-747-0048.

You may need to furnish the certificate if you become eligible for coverage under a new group health plan that excludes or limits coverage for pre-existing conditions (medical conditions that you have within a certain period of time before you enroll). If you become covered under another group health plan, check with that plan's plan administrator to see if you need to provide this certificate.

Special Extension of Medical Benefits

Under the following conditions, certain medical benefits may remain in force even if your coverage under the Medical Program otherwise terminates:

- **If you are totally disabled when your coverage under the Medical Program terminates,** all covered medical expenses for the ailment causing the disability are eligible for reimbursement for a maximum of 12 months while you are still totally disabled.
- **If you or your covered Dependent is confined in a hospital when coverage under the Medical Program terminates,** covered medical expenses for the ailment causing the confinement will be eligible for reimbursement so long as the confinement is continuous for a period not to exceed 12 months following termination of Medical Program coverage.

COBRA CONTINUATION

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (known as "COBRA"), you and your covered Dependents may temporarily continue your coverage under any of the Programs if it is lost due to certain "qualifying events" (see COBRA Qualifying Events below).

After a qualifying event occurs, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary," provided any required notice of the event is properly and timely provided to the COBRA Administrator.

COBRA continuation coverage with respect to a Program is the same coverage that the Program gives to other participants or beneficiaries who are covered under the same option under the Program and who are not receiving continuation coverage. Each qualified beneficiary who elects COBRA continuation coverage will have the same rights under a Program as other participants or beneficiaries covered under the Program, including special enrollment rights and the right to add or change coverage during the Annual Election Period.

Qualified beneficiaries who elect COBRA continuation coverage must pay the entire cost of that coverage, plus an administration fee. If you become eligible for COBRA, you will be notified at the time you are offered COBRA continuation coverage of the amount and the date that payment is due for any coverage you elect.

COBRA Qualifying Events

Eligible Employees

As an employee, you will become a qualified beneficiary if you lose coverage under the Plan due to:

- termination of employment, other than for gross misconduct; or
- a reduction in hours that results in loss of coverage.

Eligible Dependents

Your covered Spouse and/or Children will become qualified beneficiaries if they lose coverage under a Program due to:

- termination of your employment, other than for gross misconduct;
- a reduction in your hours that results in loss of coverage;
- your death;
- your entitlement to Medicare;
- your divorce or legal separation; or
- your Child's loss of eligibility for coverage.

Special Retiree Qualifying Event

If you are a retiree and a bankruptcy proceeding in a case under Title 11 of the United States Code is commenced with respect to the Company, you and your eligible Dependents may qualify for COBRA coverage. When the qualifying event is the bankruptcy of the Company, the term "lose coverage" includes any substantial elimination of coverage within one year before or after the date the bankruptcy proceeding

commences.

Special FMLA Qualifying Event

In addition to the qualifying events described above, you, your Spouse or your Child may have a COBRA qualifying event if all of the following conditions are met:

- you, your Spouse or your Child is covered under a Program on the day before the first day of a leave of absence under the Family and Medical Leave Act of 1993 (FMLA leave) or you, your Spouse or your Child become covered under the Program during an FMLA leave;
- you **do not** return to employment with the Company at the end of the FMLA leave; and
- you, your Spouse or your Child would, in the absence of COBRA continuation coverage, lose coverage under the Program before the end of what would be the maximum coverage period.

Under these conditions, the qualifying event date is the last day of the FMLA leave unless coverage is lost at a later date (in which case, the date coverage is lost is the qualifying event date).

Meeting the above requirements will not be a qualifying event if, on or before the last day of your FMLA leave, the Company eliminated coverage under the Program for the class of employees to which you would have belonged if you had not taken FMLA leave (while continuing to employ that class of employees).

Eligibility for Reservists Called to Active Duty

A qualifying event will occur and COBRA continuation coverage for up to 24 months may be available for you and your covered Dependents if:

- you are a reservist in the Armed Forces of the United States who is called up to active duty; and
- coverage for you and your Dependents is not otherwise continued under the Program.

Length of COBRA Coverage

Depending on the qualifying event, coverage may be continued from the date coverage would otherwise end, as follows:

COBRA Qualifying Event	Maximum Amount of Time Coverage May Continue Under COBRA	
	For You	For Your Qualified Beneficiary
You terminate employment (other than for gross misconduct) OR Your hours are reduced, resulting in a loss of coverage	18 months (may be extended due to disability — see below)	18 months (may be extended due to disability or for a second qualifying event — see below)
You die	N/A	36 months
You become entitled to Medicare	N/A	36 months (special rules apply)
You and your Spouse divorce or are legally separated	N/A	36 months

COBRA Qualifying Event	Maximum Amount of Time Coverage May Continue Under COBRA	
Your Child no longer qualifies as an eligible Dependent	N/A	36 months

Extension of COBRA Coverage Due to Disability

You and each of your qualified beneficiaries may be eligible to extend your COBRA coverage **for an additional 11 months** after the original 18-month COBRA period (for a total of 29 months) if you or your qualified beneficiary qualifies for disability as determined under Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act at any time during the first 60 days after continuation coverage.

- To receive the extension, notice of the determination of disability under the Social Security Act must be provided in writing to UHC COBRA within 60 days after the date of the Social Security Administration's determination, but before the end of the original 18-month period of COBRA coverage.
- The extension will continue as long as you or your qualified beneficiary remains eligible for disability benefits under the Social Security Act, **but not for more than a maximum of 29 months from the original qualifying event.**

If you and/or your qualified beneficiary(ies) are enrolled in COBRA continuation coverage and are determined to be disabled, contact UHC COBRA at 1-866-747-0048 to find out if you qualify for an extension of coverage.

If you receive a determination from the Social Security Administration that you or your qualified beneficiary is no longer considered disabled:

- you must notify UHC COBRA within 30 days after this determination; and
- if the date of the determination is after the original 18-month COBRA period, your COBRA benefits will cease the first day of the month beginning 30 days after the date of determination.

Extension of Continuation Coverage Due to a Second Qualifying Event

If you are receiving COBRA continuation coverage as a result of your termination of employment or reduction in hours, up to an 18-month extension of coverage may be available to your qualified beneficiary if a second qualifying event occurs during the first 18 months of COBRA (within the first 29 months in the case of a disability). A second qualifying event includes:

- your death;
- your entitlement to Medicare;
- your divorce or legal separation; or
- your Child's eligibility for coverage ends.

The maximum amount of continuation coverage under COBRA is 36 months from the date of the first qualifying event. In order to qualify, you or your qualified beneficiary must notify the Benefits HelpLine at 1-888-443-5707 within 60 days after the second qualifying event.

Notification of the Qualifying Event

The Company will notify the COBRA Plan Administrator, UnitedHealthcare Benefit Services ("UHC COBRA") if the qualifying event for COBRA coverage is:

- your death;
- termination of your employment;
- a reduction in your hours;
- your entitlement to Medicare; or
- commencement of a bankruptcy proceeding.

It is your responsibility to notify the Benefits HelpLine at 1-888-443-5707 within 60 days after the later of a qualifying event or the date benefits will be lost if your covered Spouse or Child loses coverage under a Program due to:

- divorce or legal separation; or
- your Dependent's loss of eligibility under the Program.

Enrolling in COBRA Coverage

When UHC COBRA has been notified by the Plan Administrator or you (or someone acting on behalf of you or a qualified beneficiary) that a qualifying event has occurred, UHC COBRA will send a package of information to the individual(s) who are entitled to continuation coverage with:

- an explanation of the right to continue coverage;
- instructions on how to elect COBRA;
- the cost for COBRA coverage; and
- an election agreement.

You and/or your qualified beneficiary(ies) will have 60 days from the date coverage would be lost due to a qualifying event (or the date you are notified of your COBRA rights, if later) to elect COBRA continuation coverage.

Each qualified beneficiary may independently elect COBRA coverage. You or your Spouse, however, may elect COBRA coverage on behalf of all the qualified beneficiaries.

If you choose to waive coverage during the 60-day election period, you may revoke the waiver in writing at any time before the 60-day period ends, and you will be entitled to COBRA continuation coverage as long as you and/or your qualified beneficiary(ies) meet all of the other conditions for continuation of coverage and the required contributions are paid on a timely basis.

If you have questions about the enrollment materials or COBRA rules and regulations, call UHC COBRA Services at 1-866-747-0048.

If you do not elect continuation coverage, your benefits will terminate in accordance with the terms of the Program.

Paying for COBRA Coverage

In order to continue your coverage under COBRA, you must pay the **full** monthly cost (your premium and the Company's contribution), plus a 2% administration fee.

If you or your qualified beneficiary is receiving the additional 11 months of COBRA coverage because of disability (see Extension of COBRA Coverage Due to Disability), the cost for each of those additional 11 months is 150% of the full monthly cost.

UHC COBRA will send monthly invoices with the COBRA coverage cost and the payment due date. The required contribution or premium must be paid on a timely basis, as follows:

- the first payment of contributions or premiums may be required **45 days** after the date of your COBRA coverage election;
- after that, payments are typically considered timely if they are paid within 30 days after the due date; and
- if the COBRA Administrator does not receive the full payment for any coverage period, COBRA coverage will be terminated retroactively to the end of the month for which the last full payment was made, and you will lose all rights to further COBRA continuation coverage under the applicable COBRA Program. **Once coverage is terminated, it cannot be reinstated.**

The amount of your COBRA premium may change from time to time during your period of COBRA coverage — you will be notified of COBRA premium changes.

Your medical coverage is not reinstated until UHC COBRA receives your first payment. The first payment made is generally applied to the COBRA continuation coverage period beginning immediately after the date coverage was lost or with the effective date of your COBRA continuation coverage, if later. This means Claims for reimbursement will not be processed and paid until you have elected COBRA continuation coverage and the first contribution payment has been timely paid and received.

Termination of COBRA Coverage

Extended coverage under COBRA cannot be terminated before the end of the maximum continuation period unless:

- you or your qualified beneficiary fails to pay the required contributions when due;
- you or your qualified beneficiary becomes entitled to Medicare;
- you or your qualified beneficiary becomes covered under a group health plan of another employer. However, if the other employer's medical plan contains an exclusion or limitation with respect to any pre-existing condition(s), you or your qualified beneficiary may continue COBRA coverage under the Program to cover the exclusion or pre-existing condition only;
- the Company terminates medical coverage for all its active and/or retired employees; or
- in the case of extended coverage due to disability (see Extension of COBRA Coverage Due to Disability), the disabled individual ceases being disabled under the Social Security Act.

You or your qualified beneficiary must notify the COBRA Administrator within 30 days if, after electing COBRA, you or your qualified beneficiary:

- becomes entitled to Medicare;

- becomes covered under another group health plan coverage; or
- is determined by the Social Security Administration to no longer be disabled.

Other Coverage Continuation Options

In addition to the option to continue benefits under the provisions of COBRA, certain continuation benefits are available to your enrolled Dependents if you die as an active employee or as a retiree.

If You Die When Not Eligible for Retiree Coverage

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

- six months following the end of the month in which your death occurred if your death is not the result of an on-the-job accident;
- for your Spouse, the end of the month following the date your Spouse remarries;
- the end of the month following the date that your Dependent loses eligibility under the Programs;
- the end of the month following the date coverage under the Programs terminates due to failure to make required contributions in a timely manner; or
- the effective date of an amendment or termination of the Programs that ends coverage for surviving or any Spouses or Children.

The above continuation of coverage will be offset (or run concurrently) with COBRA coverage (see Continuation of Coverage under COBRA.

If You Die When Retired or When Eligible for Retiree Coverage

- If you die as an active employee and you are eligible for retiree coverage under the Programs or you die as an eligible retiree, your covered Dependents may continue coverage under the Programs **until the earlier of:**
  - for your Spouse, the end of the month following the date your Spouse remarries;
  - your Spouse's attainment of age 65;
  - the end of the month following the date that your Dependent loses eligibility under the Programs;
  - the end of the month following the date coverage under the Programs terminates due to failure to make required contributions in a timely manner; or
  - the effective date of an amendment or termination of the Programs that ends coverage for surviving or any Spouses or Children.

If You Die As A Result of a Work Related Accident

- If you die as an active employee as a result of a work related accident and you are eligible for coverage under the Programs, your covered Dependents may continue coverage under the Programs **until the earlier of:**

- for your Spouse, the end of the month following the date your Spouse remarries;
- your Spouse's attainment of age 65;
- the end of the month following the date that your Dependent loses eligibility under the Programs;
- the end of the month following the date coverage under the Programs terminates due to failure to make required contributions in a timely manner; or
- the effective date of an amendment or termination of the Programs that ends coverage for surviving or any Spouses or Children.

PLAN ADMINISTRATION

CITGO Petroleum Corporation ("CITGO") is the Plan Sponsor. The CITGO Benefit Plans Committee is the Plan Administrator.

The Plan Administrator is responsible for the administration of the Plan (including the Programs described in this SPD) 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 will be final, conclusive and binding on all persons with respect to all issues and questions relating to the Plan.

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.

Agreements with Administrators and Insurer

The Plan Administrator has entered into agreements with administrators and insurers to provide the benefits described in this Summary Plan Description.

The Claims Administrators for medical and dental benefits make all payments of benefits under the terms of the Plan. Neither the Company nor the Claims Administrators insure medical, pharmacy and dental benefits described in this summary.

Plan Expenses

Assets of the Plan are used to pay benefits, premiums and administrative expenses. Administrative expenses paid by the Plan may include, but are not limited to:

- Claims Administrator fees;
- COBRA continuation coverage administration fees;
- actuary fees; and
- consulting fees.

The Plan Administrator has the authority to establish and implement guidelines for the payment of administrative expenses reasonably necessary for the operation and administration of the Plan.

CITGO Employees' Benefit Trust

Assets of the Plan consist of contributions by participants and the Company. Contributions to the Plan are held in the CITGO Employees' Benefit Trust, and can be used for any of the benefits provided under the Plan. The current Trustee is:

The Bank of Oklahoma, N.A.
Trust Division

Bank of Oklahoma Tower
P.O. Box 880
Tulsa, Oklahoma 74101-0880

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 for any of the Programs. 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.

Future of the Plan

It is the Company's intention to continue to provide benefits to participants of the Plan. However, the Company reserves the right to amend, modify or terminate the Plan, in whole or in part, at any time and for any reason, including but not limited to, discontinuing Company contributions and/or benefits, including retiree benefits. Such actions will be effective as of any date designated by the Company. In addition, the Plan Administrator has the right to modify or amend the Plan at any time, including changes to assure compliance with applicable sections of the Internal Revenue Code or ERISA.

Plan Document

Every effort has been made to make this SPD as correct and complete as possible. However, the terms of the applicable Plan document will control in the event of any conflict between the Plan document and any other materials addressing the Plan.

No Guarantee of Employment

Participation in any of the benefit plans sponsored by the Company does not constitute a contract or guarantee of employment.

ADDITIONAL INFORMATION

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

Plan Name	**The CITGO Petroleum Corporation Medical, Dental, Vision and Life Insurance Program for Salaried Employees**
Type of Plan	Welfare plan
Plan Sponsor	CITGO Petroleum Corporation
Plan Sponsor's Employer Identification Number	73-1173881
Plan Administrator	Benefit Plans Committee – Secretary CITGO Petroleum Corporation P.O. Box 4689 Houston, TX 77210-4689 888-443-5707
Agent for Service of Legal Process **In addition, service of legal process may be made upon the Plan Administrator or Trustee**	Benefit Plans Committee – Secretary CITGO Petroleum Corporation P.O. Box 4689 Houston, TX 77210-4689 888-443-5707
Plan Number	515
Plan's Effective Date	January 1, 1984
Plan Year	January 1 – December 31
Plan Funding	The Plan is currently funded by employer and participants' contributions. Plan assets are held in the CITGO Employees' Benefit Trust by the Trustee
Trustee	The Bank of Oklahoma, N.A. Trust Division Bank of Oklahoma Tower P.O. Box 880 Tulsa, OK 74101-0880
Medical Claims Administrator	UnitedHealthcare P.O. Box 740800 Atlanta, GA 30374-0800 UnitedHealthcare Customer Service Center 1-866-317-6359 www.myuhc.com Group number: 229556
Dental Claims Administrator	MetLife P.O. Box 981282 El Paso, TX 79998-1282 MetLife Customer Service 1-800-942-0854 Participating Dentist Program (PDP) 1-800-474-7371

Vision Plan Insurer	UnitedHealthcare Vision 450 Columbus Boulevard Hartford, CT 06103 Customer Service 1-800-454-0233 www. myuhcvision.com Group Number: A907
CITGO Benefits HelpLine	1-888-443-5707 or Email: Benefits@CITGO.com

IMPORTANT NOTICES

YOUR RIGHTS UNDER ERISA

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 any one of the Programs, you are entitled to certain rights and protections under ERISA. ERISA provides that all Program 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 Administrator may make a reasonable charge for the copies.

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

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 under the Programs.

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 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 a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court after exhausting all of your appeal rights. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that 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 at 1-866-444-3272.

Rights of States Where Eligible Employees or Dependents are also Eligible for Medicaid Benefits

Compliance by the Plan with Assignment of Rights

Benefit payments with respect to a covered eligible employee or dependent who is also covered by a state plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act (as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993) — referred to in this section as a state's Medicaid program — will be made in accordance with any assignment of rights made by or on behalf of the covered person as required by a state Medicaid program.

Enrollment and Provision of Benefits Without Regard to Medicaid Eligibility

With respect to enrollment in the Programs or the payment of benefits under the Programs, the Programs will not take into account the fact that a covered person is also eligible for or qualifies for medical assistance under a state Medicaid plan.

Acquisition by States of Rights of Third Parties (State Subrogation Rights)

The Programs will honor any subrogation rights that a state may have gained from a covered person eligible for Medicaid by virtue of the state's having paid Medicaid benefits for which the Programs have a legal liability for covering.

Women's Health and Cancer Rights Act of 1998

The Medical Program provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses and for complications resulting from a mastectomy, including lymphedemas.

If you elect breast reconstruction in connection with a mastectomy, coverage will be provided in a manner determined in consultation with you and your physician for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedemas.

These benefits are subject to all terms of the Medical Program, including relevant deductibles, coinsurance and out-of-pocket provisions applicable to other medical and surgical benefits provided under the Medical Program.

Newborns' and Mothers' Health Protection Act of 1996

The Newborns' and Mothers' Health Protection Act of 1996 (the Newborns' Act), signed into law on September 26, 1996, requires plans that offer maternity coverage to pay for at least a 48-hour hospital stay following childbirth (96-hour stay in the case of a cesarean section).

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable).

In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours, as applicable).

Uniformed Services Employment And Reemployment Rights Act

If you are absent from employment for more than 30 days by reason of service in the uniformed services, you may elect to continue group health plan coverage for you and your Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended.

The terms "uniformed services" or "military service" mean service in:

- the Armed Forces;
- the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training or full-time National Guard duty;
- the commissioned corps of the Public Health Service; and
- any other category of persons designated by the U.S. President in time of war or national emergency.

If qualified under USERRA, you may elect to continue coverage under the Programs by notifying the Plan

Administrator or Benefits HelpLine and providing payment of any required contribution for coverage. This may include the amount the Plan Administrator normally pays on your behalf. If your military service is less than 31 days, you may not be required to pay more than your regular contribution amount, if any, for continuation of health coverage.

You may continue Program coverage under USERRA for up to the lesser of:

- the 24-month period beginning on the date of your absence from work; or
- the day after the date on which you fail to apply for, or return to, a position of employment.

Regardless of whether you continue your coverage under the Programs during your military service, if you return to work, you and your eligible dependent's coverage will be reinstated under the Program(s). No exclusions or waiting period may be imposed on you in connection with this reinstatement, unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

Qualified Medical Child Support Orders (QMCSOs)

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

- they are currently covered under a Program;
- they are dependent on you for financial support; or
- you have legal custody of the children.

The Plan Administrator is required to comply with the medical child support order ONLY if it is determined to be a Qualified Medical Child Support Order (QMCSO).

A QMCSO must meet specific legal requirements, as outlined in the Program's written procedures for QMCSOs, which is available free of charge upon request from the Benefits HelpLine. If you are going through a divorce or separation involving medical coverage for eligible children, you should:

- ask your attorney to obtain a copy of the Program's QMCSO procedures;
- request that your attorney send a draft of your proposed medical child support order to the Plan Administrator for review before it is approved by the state court (to determine if the order meets the requirements for a QMCSO); and
- send a final certified copy of the court-approved QMCSO to the Plan Administrator.

Once the Plan Administrator determines that an order is qualified, the Plan Administrator will take whatever actions are required to comply with the QMCSO. **Coverage of the child will begin as soon as administratively possible after receipt and approval of the QMCSO — it is not effective retroactive to the effective date of the QMCSO.**

Under current law:

- a QMCSO cannot require a Program to pay a greater benefit than the benefit that would otherwise be paid from the Program if no QMCSO existed; and
- benefits must be paid directly to the child or the child's custodial parent or legal guardian, instead of to the Program participant (you).

DEFINITIONS

Alternate Facility — a health care facility that is not a hospital or a facility that is attached to a hospital, and that is designated by the hospital as an alternate facility. This facility provides one or more of the following services on an inpatient or outpatient basis, as permitted by law:

- pre-scheduled surgical services;
- emergency health services; and
- pre-scheduled rehabilitative, laboratory or diagnostic services.

An Alternate Facility may also provide mental health services or substance abuse services on an outpatient or inpatient basis.

Annual Election Period — a period during which you may elect or make changes to your benefits under the Programs.

Benefits — your right to payment for Covered Health Services that are available under the Programs. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Programs.

Benefits HelpLine — a CITGO 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 at Benefits@CITGO.com.

BMI or Body Mass Index — a measure used in obesity risk assessment to determine the degree of obesity by approximating the measure of total body fat as compared with the assessment of body weight alone.

Care Coordination — a program provided by the Claims Administrator designed to encourage an efficient system of care for covered persons by identifying and addressing possible unmet covered health care needs, and reviewing the medical necessity for certain services.

Certificate of Creditable Coverage — a document furnished by a group health plan or a health insurance company that shows the amount of time the individual has had coverage. This document is used to reduce or eliminate the length of time a preexisting condition exclusion applies.

Child (or Children) — subject to additional terms set forth in the Eligibility section, any one of the following who are under the age of 26 (other than for continuation of coverage for a disabled dependent child)**:**

- Your biological child.
- Your legally adopted child or a child placed with you for adoption.
- Your stepchild.
- A child for whom you or your current Spouse have been awarded legal guardianship or legal custody by court of law.

CITGO — CITGO Petroleum Corporation.

Claims Administrator — the company, or its affiliate, that provides certain claim administration services for an applicable Program.

COBRA Administrator — the company, or its affiliate that provides certain COBRA administration

services.

Company — CITGO Petroleum Corporation and any of its subsidiaries or affiliated companies.

Congenital Anomaly — a physical developmental defect that is present at birth, and is identified within the first 12 months of birth.

Cosmetic Procedures — procedures or services that change or improve appearance without significantly improving physiological function, as determined by Care Coordination.

Covered Health Service(s) — those health services provided for the purpose of preventing, diagnosing or treating a sickness, injury, mental illness, substance abuse or their symptoms.

Covered Health Services must be provided:

- when the Program is in effect;
- prior to the effective date of an individual's termination of coverage under the Program; and
- only when the person who receives services is a covered person and meets all eligibility requirements specified for the Program.

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

Custodial Care — services that:

- are non-health related services, such as assistance in activities of daily living (including but not limited to feeding, dressing, bathing, transferring and ambulating); or
- are health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the services is not changing; or
- do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Dependent — a Spouse or a Child.

Durable Medical Equipment — medical equipment that is all of the following:

- can withstand repeated use;
- is not disposable;
- is used to serve a medical purpose with respect to treatment of a sickness, injury or their symptoms;
- is generally not useful to a person in absence of a sickness, injury or their symptoms; and
- is appropriate for use in the home.

Eligible Expenses — the amounts the Program will pay for Covered Health Services determined based on either of the following:

- when covered medical, pharmacy, dental or vision services are received from a Network provider, eligible expenses are the Claim Administrator's contracted fee(s) with that provider;
- when covered medical, pharmacy, dental or vision services are received from a Non-network provider as a result of an Emergency or as arranged by the Claims Administrator or insurer, eligible expenses

are billed charges unless a lower amount is negotiated or authorized by law; or

- when covered medical, pharmacy, dental or vision services are received from a Non-network provider, eligible expenses are determined, based on:
  - Negotiated rates agreed to by the Non-network provider and either the Claims Administrator or one of the Claim Administrator's vendors, affiliates or subcontractors, at the Claims Administrator's discretion.
  - If rates have not been negotiated, then one of the following amounts:
    - For covered medical, dental or vision services, eligible expenses are determined based on available data resources of competitive fees in that geographic area.
    - For Mental Health Services and Substance Use Disorder Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.
    - When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market.
    - When a rate is not published by CMS for the service, the Claims Administrator uses a gap methodology established by OptumInsight and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, the Claims Administrator will use a comparable scale(s). UnitedHealthcare and OptumInsight are related companies through common ownership by UnitedHealth Group. Refer to UnitedHealthcare's website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Eligible Expenses are determined solely in accordance with the Claims Administrator's reimbursement policy guidelines. The Claims Administrator develops the reimbursement policy guidelines, in the Claims Administrator's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- as indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS);
- as reported by generally recognized professionals or publications;
- as used for Medicare; or
- as determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the Claims Administrator accepts.

Emergency — a serious medical condition or symptom resulting from injury, sickness or mental illness

which is both of the following:

- arises suddenly; and
- in the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Care — medical care and treatment provided after the sudden onset of a medical condition manifesting itself by acute symptoms, including severe pain, which is severe enough that the lack of immediate medical attention could reasonably be expected to result in any of the following:

- the patient's health would be placed in serious jeopardy;
- bodily function would be seriously impaired; or
- there would be serious dysfunction of a bodily organ or part.

In addition, Emergency Care includes immediate mental disorder treatment when the lack of the treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons.

Emergency Health Services — health care services and supplies necessary for the treatment of an emergency.

Experimental or Investigational Services — medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

- not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information, as appropriate for the proposed use; or
- subject to review and approval by any institutional review board for the proposed use (devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational); or
- the subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

If you have a life-threatening sickness or condition (one which is likely to cause death within one year of the request for treatment) the Claims Administrator may, in its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that sickness or condition. Prior to such consideration, the Claims Administrator must determine that, although unproven, the procedure or treatment has significant potential as an effective treatment for that sickness or condition.

Extended Care Facility — a facility accredited by The Joint Commission (previously known as the Joint Commission on Accreditation of Healthcare Organizations) as an extended care or similar non-acute care facility**.**

Family — when used to describe coverage levels means the employee, a Spouse and at least one Child.

Free-Standing Birthing Center — a specialized facility which meets all of the following requirements:

- it is primarily a place for delivery of children following a normal, uncomplicated pregnancy, that is operated and equipped in accordance with any applicable state law;

- it is equipped to perform routine diagnostic and laboratory examinations, such as hematocrit and urinalysis for glucose, protein, bacteria and specific gravity;
- it has available to handle foreseeable emergencies trained personnel and necessary equipment, including but not limited to oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders;
- it is operated under the full-time supervision of a licensed doctor of medicine (MD) or registered graduate nurse (RN);
- it maintains a written agreement with at least one hospital in the area for immediate acceptance of patients who develop complications; and
- it maintains an adequate medical record for each patient, which contains prenatal history, prenatal examination, any laboratory or diagnostic tests and postpartum summary.

Home Health Care — services received from a Home Health Care agency that are ordered by a physician and provided by or supervised by a registered nurse in your home. The Home Health Care services must be provided on a part-time, intermittent schedule and when skilled Home Health Care is required.

Skilled Home Health Care is skilled nursing, skilled teaching, and skilled rehabilitation services when **all** of the following are true:

- it must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient;
- it is ordered by a physician;
- it is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair;
- it requires clinical training in order to be delivered safely and effectively; and
- it is not custodial care.

The following services will not be covered:

- custodial care;
- domiciliary care;
- respite care; and
- rest cures.

Hospice — a centrally administered program of palliative and supportive services which provides physical, psychological, social and spiritual care for dying persons (who have six months or less to live as diagnosed and certified by the attending physician) and their families. Services are provided by a physician-supervised interdisciplinary team of professionals and volunteers. Hospice services are available in the home. Home care is available on a part-time, intermittent, regularly scheduled, and around-the-clock or on-call basis. Bereavement services are available to the family.

Hospital — an institution, operated as required by law that is both of the following:

- is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of physicians; and
- has 24-hour nursing services.

A hospital is not primarily a place for rest, custodial care or care of the aged and is not a nursing home,

convalescent home or similar institution.

Injury — bodily damage other than sickness, including all related conditions and recurrent symptoms.

In-Network or Network (Area/Benefits) — encompasses a group of participating physicians, health practitioners, health facilities, hospitals, dentists, optometrists and opticians that have contracted with a Program's designated network provider. If your zip code is listed in the network ZIP code list, you live in a network area. The network areas are determined by the Plan Administrator.

Inpatient Rehabilitation Facility — a hospital (or a special unit of a hospital that is designated as an inpatient rehabilitation facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay — an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Medical Child Support Order —any judgment, decree, order or court-approved settlement agreement that:

- provides for child support or health benefit coverage with respect to a child, is issued pursuant to a state domestic relations law and relates to benefits under a group health plan; or
- is issued pursuant to a law relating to medical child support with respect to a group health plan.

Medicare — Parts A, B, C and D of the insurance program of medical care benefits provided under Title XVIII of the United States Social Security Act of 1965, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Illness — those mental health or psychiatric diagnostic categories that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded under the Medical Program. The fact that a condition is listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the covered condition is a Covered Health Service.

Midwife — a person who has an active license to practice midwifery granted by the state board of health.

Network — when used to describe a provider of health care services, this means a provider that has a participation agreement in effect with the Claims Administrator or an affiliate (directly or through one or more other organizations) to provide Covered Health Services to covered persons.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a network provider for only some products. In this case, the provider will be a network provider for the health services and products included in the participation agreement, and an out-of-network provider for other health services and products. The participation status of providers will change from time to time. The Claims Administrator's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Network Benefits — benefits for a Covered Health Service that are provided by (or directed by) a network physician or other network provider in the provider's office or at a network facility.

Network Benefits List — a list of the ZIP codes that are mandatory network areas. The list is available online through the CITGO intranet or at http://www.hr.CITGO.com or by calling the Benefits HelpLine at 1-888-443-5707.

Non-Network or Out-of-Network — encompasses physicians, health practitioners, health facilities, hospitals, pharmacies, dentists, optometrists and opticians that are not contracted with a Program's designated network provider. If your zip code is not listed in the Network Benefits List, you live in a Non-Network area and network benefits will not apply.

Nurse — a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.", "L.P.N.", or "L.V.N.".

Out-of-Network Benefits — if you are enrolled in the PPO Option or the SDHP Option, you receive out-of-network benefits any time you receive care without using a Network provider. Out-of-network benefits are more limited than network benefits and are subject to reasonable and customary (R&C) guidelines.

Physician — any Doctor of Medicine, "MD", or Doctor of Osteopathy, "DO", who is properly licensed and qualified by law.

Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a physician does not mean that benefits for services from that provider are available to you under a Program.

Placed with You for Adoption — a child is considered as being placed with you for adoption in connection with adoption proceedings when there is an assumption and retention by an eligible employee of the legal duty for the total or partial support of a child to be adopted. The child's placement terminates when the legal duty likewise terminates.

Plan – CITGO Petroleum Corporation Medical, Dental, Vision and Life Insurance Program for Salaried Employees.

Plan Administrator – CITGO Benefit Plans Committee.

Plan Sponsor – CITGO Petroleum Corporation.

Plan Year – January 1 to December 31

Preadmission Test — a test performed in anticipation of a hospital confinement if:

- the test is related to the problem for which hospitalization is required;
- the test has been ordered by a physician after a condition requiring the confinement has been diagnosed and the hospital admission has been requested; and
- the test is done within seven days prior to the hospital admission.

Pregnancy — includes all of the following:

- prenatal care;
- postnatal care;

- childbirth; and
- any complications associated with pregnancy.

Preventive Care — medical services aimed at early detection and intervention. Services focus on wellness, health promotion and other activities that reduce the likelihood of illness or injury.

Primary Plan or Payor — when determining coordination of benefits, the plan that considers eligible expenses before any other group plan.

Programs — the health care programs under the Plan that are described in this SPD:
- Medical Program and Prescription Drug Program
- Dental Program
- Vision Program

They are referred to collectively as the "Programs" and may be referred to individually as "Program," depending on the context.

Psychologist — a person who is licensed or certified as a clinical psychologist. Where no licensure or certification is required, "psychologist" means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner if the person is:
- operating within the scope of a license; and
- performing a service for which benefits are provided under the Program when performed by a psychologist.

Qualified Family Status Change – an event described in the summary plan description for the Flexible Benefits Program for Salaried and Hourly Employees, and includes events such as marriage, birth of a child, adoption and divorce.

Qualified Medical Child Support Order (QMCSO) — a Medical Child Support Order that has been determined to be qualified. A QMCSO creates or recognizes the right of a child (alternate recipient) to be covered under your Company-sponsored group health care plan to the extent he or she would otherwise be eligible for participation under the Program. The following enrollment rules apply:
- if the child is not already covered under the Program, you will be allowed to enroll the child as directed under the QMCSO;
- the Program's late enrollment provisions will not apply; and
- the enrollment is considered an eligible status change (see Changing Your Coverage).

Reasonable and Customary (R&C) Charges

If you choose to see an out-of-network provider, the Program will reimburse a portion of covered expenses up to the lesser of:
- the amount billed for the services; or
- an amount determined by the Claims Administrator or insurer to be reasonable and customary (R&C) for that service.

The R&C charge is the lower of the provider's usual charge or the prevailing charge in the geographic area where it is furnished. To determine the R&C charge, the Claims Administrator or insurer takes into account

the:

- complexity of the service;
- degree of skill needed;
- type or specialty of the provider;
- range of services provided by a facility; and
- prevailing charge in the area in which services are performed

Regular Full-Time Employee — an employee of the Company who is regularly scheduled to work at least 40 hours per week.

Regular Part-Time Employee — an employee of the Company who is regularly scheduled to work at least 20 but less than 40 hours per week.

Room and Board — room, board, general duty nursing, intensive nursing care in an intensive care unit by whatever name it is called and any other services regularly rendered by the hospital as a condition of occupancy of the class of accommodations occupied, but not including professional services of physicians or special nursing services rendered outside of an intensive care unit by whatever name it is called.

Secondary Plan — when determining coordination of benefits, the plan that considers eligible expenses after another group plan.

Semi-Private Room — a room with two or more beds. When an inpatient stay in a semi-private room is a Covered Health Service, the difference in cost between a semi-private room and a private room is a covered benefit only when a private room is necessary in terms of generally accepted medical practice, or when a semi-private room is not available.

Sickness — a physical illness, disease or pregnancy. The term Sickness as used in this SPD includes Mental Illness, or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness, or substance-related and addictive disorder.

Skilled Nursing Facility — a facility approved by Medicare as a Skilled Nursing Facility. If not approved by Medicare, the facility may be covered if it meets the following tests:

- it is operated under applicable licensing and other laws;
- it is operated under the supervision of a licensed physician or registered graduate nurse (RN) who is devoted full time to supervision;
- it is regularly engaged in providing room and board continuously;
- it provides 24 hour a day skilled nursing care of sick and injured persons at the patient's expense during the convalescent stage of an injury or sickness;
- it maintains a daily medical record of each patient who is under the care of a duly licensed physician;
- it is authorized to administer medication to patients on the order of a duly licensed physician; and
- it is not, other than incidentally, a home for the aged, the blind or the deaf, a hotel, a domiciliary care home, a maternity home, or a home for alcoholics or drug addicts or the mentally ill.

Specialist — a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Spinal Treatment — detection or correction (by manual or mechanical means) of subluxation(s) in the body to remove nerve interference or its effects. The interference must be the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Spouse —

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

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

Individuals who enter into any civil union, domestic partnership, same-sex marriage or similar arrangement with an eligible employee are not entitled to benefits under the Program as a Spouse.

Substance Use Disorder Services — Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that the treatment of the disorder is a Covered Health Service.

United Resource Networks Facility or URN — a hospital that the Claims Administrator determines is a United Resource Networks Facility. A designated United Resource Networks Facility has entered into an agreement with the Claims Administrator to render Covered Health Services for the treatment of specified diseases or conditions. A designated United Resource Networks Facility may or may not be located within your geographic area. The fact that a hospital is a network hospital does not mean that it is a designated United Resource Networks Facility.

Unproven Services — services that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs:

- well-conducted randomized controlled trials (two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received); or
- well-conducted cohort studies (patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group).

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

If you have a life-threatening sickness or condition (one that is likely to cause death within one year of the request for treatment) the Plan Administrator or the Claims Administrator may, at their discretion, determine that an Unproven Service meets the definition of a Covered Health Service for that sickness or condition. For this to take place, the Plan and the Claims Administrator must determine that the procedure or

treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

You or Your (even when not capitalized) — you, the eligible employee or eligible retiree. It does not mean your dependents or any other person, institution, or other entity.

CONTACT INFORMATION

CITGO BENEFITS CONTACT INFORMATION

CITGO BENEFITS HELPLINE
1-888-443-5707
benefits@citgo.com

MEDICAL/Care Coordination
UNITEDHEALTHCARE
Customer Service -1-866-317-6359

NurseLine Services: PIN: 980
1-866-735-5686

Pre-determinations and Pre-certifications
www.myuhc.com
1-866-317-6359

FIND A DOCTOR at www.myuhc.com

CANCER & TRANSPLANT RESOURCE SERVICES
Customer Service -1-866-317-6359

BARIATRIC RESOURCE SERVICES
Customer Service – 1-888-936-7246

MENTAL HEALTH HOSPITALIZATION
Customer Service -1-888-231-4886

PRESCRIPTION DRUG
OPTUM RX
Customer Service -1-866-317-6359
www.myuhc.com

DENTAL
METLIFE
Customer Service -1-800-942-0854
www.metlife.com/mybenefits

VISION
UNITEDHEALTHCARE VISION
Customer Service -1-800-638-3120
www.myuhcvision.com

FLEXIBLE SPENDING ACCOUNTS (FSA)
UNITEDHEALTHCARE
Customer Service – 1-800-331-0480
Fax – 1-866-262-6354
www.myuhc.com

EMPLOYEE ASSISTANCE PROGRAM (EAP)
UNITED BEHAVIORAL HEALTH
Customer Service -1-888-231-4886
www.liveandworkwell.com Access Code: 42920

POST 65 RETIREE BENEFITS
UNITEDHEALTHCARE MEDICARE SOLUTIONS
Customer Service -1-877-753-5150
www.myuhcplans.com/citgo

COBRA & HIPAA INFORMATION
UHC COBRA SERVICES
1-866-747-0048
HIPAA CERTIFICATE OF COVERAGE
1-866-747-0048

HEALTH SAVINGS ACCOUNTS (HSA)
FIDELITY
Customer Service -1-800-544-3716
www.netbenefits.com or www.401k.com

HEALTHY REWARDS PROGRAM
OPTUM/UNITED HEALTHCARE
www.myuhc.com

CITGO BENEFITS CONNECTION
Benefits summaries, brochures and forms
www.hr.citgo.com

Appendix I

HIPAA PRIVACY INFORMATION

Notice of Privacy Practices

The HIPAA Regulations require the Plan to provide you with a notice describing the Plan's privacy practices and other information regarding your privacy rights with respect to protected health information. This notice is provided at the time of enrollment to new Plan enrollees. In addition, an updated notice will be provided to all Plan participants within 60 days after any material revision of the notice. Copies of the notice are available at all times on the CITGO intranet, at http://www.hr.CITGO.com or by calling the Benefits HelpLine.

Appendix II

PROOF OF ELIGIBLE DEPENDENT STATUS DOCUMENTATION

Eligible Dependent Definition	Proof Type	Required Documentation for Proof of Eligibility
Legal Spouse A person of the opposite sex to whom you are legally married at the relevant time and which marriage is effective under the laws of the state in which the marriage was contracted, including a person legally separated but not under a decree of absolute divorce. **Common Law Spouse** Your Common Law spouse of the opposite sex, if Common Law marriage is recognized in the state of which you are a legal resident.	**Proof of Relationship**	**One of the following:** ○ **Marriage Certificate:** Must contain • Name of the employee • Name of the spouse • Date of marriage • Certifier's signature/official seal**;** **OR** ○ **U.S. Tax Return Indicating Married (first page only):** Must contain • Tax authority (state or federal) • From [current and/or previous] tax years • Name of employee • Name of the spouse • Married filing jointly, or married filing separately • If married filing separately, spouse's name must appear on form ***NOTE:*** *To maintain confidentiality, please black out SSN and financial information.*
Child of the Employee*, Spouse or Common Law Spouse **Common Law Spouse is only applicable in States where Common Law Marriage is Permitted and advance approval by CITGO is required for a common law spouse to be recognized by the plan.** *Includes any of the following (see list below) under the age of 26: a) A biological child b) A stepchild c) An adopted child or a child placed with you	**Proof of Relationship**	**One of the following:** ○ **Birth Certificate:** Must contain • Name of the employee, spouse • Name of the child • Date of birth**; OR** ○ **Hospital Birth Record:** Must contain • Name of the employee, spouse • Name of the child • Date of birth**; OR** ○ **Naturalization Certificate or Consular Report of Birth Abroad:** Must contain • Name of the employee, spouse • Name of the child • Date of birth; **OR** ○ **U.S. Tax Return Showing Child**

Eligible Dependent Definition	Proof Type	Required Documentation for Proof of Eligibility
or your current spouse for adoption d) A child for whom you or your current spouse have been awarded legal guardianship or legal custody by court of law. * coverage ends the end of the month the dependent turns age 26		**Exemption (first page only):** Must contain • Tax Authority (state or federal) • From [current and/or previous] tax years • Name of the employee, spouse • Name of the child ***NOTE:*** *To maintain confidentiality, please black out SSN and financial information;* **OR** ○ **Adoption Paperwork:** Must contain • Name of the employee, spouse • Name of the child • Notary signature/indication document has been filed in court**;** **OR** ○ **Legal Guardianship Court Order:** Must contain • Name of the employee, spouse • Name of the child • Notary signature/indication document has been filed in court**;** **OR** ○ **Divorce Decree, Custody Agreement, or Qualified Medical Child Support Order (QMCSO):** Must contain • Name of the employee, spouse • Name of the child • Notary signature/indication document has been filed in court