CITGO Petroleum Corporation
Retiree Reimbursement Account Plan

Summary Plan Description

Effective January 1, 2014

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INTRODUCTION

CITGO Petroleum Corporation (the "Company") is pleased to provide you with this updated Summary Plan Description ("Summary"), effective January 1, 2014. This Summary describes the primary features of the CITGO Petroleum Retiree Reimbursement Account Plan ("Plan") for the exclusive benefit of certain retirees who are Medicare-eligible retirees and their eligible Spouses who are on Medicare. The Plan became effective January 1, 2013. This Summary supersedes the previous Summary Plan Description, effective January 1, 2013.

This Summary describes the primary Retiree Reimbursement Account ("RRA") features, but it does not describe the separate coverage provided under the Medicare Supplement or Medicare Advantage insurance programs and certain Dental and Vision insurance programs provided by UnitedHealthcare AARP Medical Products or MetLife, which are provided in connection with retiree programs, such as the Plan. The UnitedHealthCare insurance products are not part of the Plan, and the Company does not sponsor any of the UnitedHealthcare AARP Medicare Products or other insurance products available to you. You choose which UnitedHealthcare AARP Medicare Products in which you desire to enroll.

This Summary has been prepared to explain the provisions of the Plan with certain terms defined in the *Glossary Section*. A summary cannot include all details of the Plan document or the administration and operation of the Plan. Accordingly, if there is any conflict between this Summary and the terms of the Plan, the provisions of the actual Plan document will control.

Please read this Summary thoroughly to learn how the Plan works. Your RRA is administered by OptumHealth Financial Services, a division of UnitedHealthcare. If you have questions you may contact UnitedHealthcare Retiree Accounts at 877-298-2305 or 877-753-5150 for a dedicated CITGO retiree tele-sales representative.

ELIGIBILITY

Retiree who is eligible

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

- You are a retiree of the Company who at the time of retirement met the eligibility criteria for retiree health coverage as defined by the Company's health plan covering active employees ("Retiree").
- You are enrolled in a UnitedHealthcare AARP Medicare Product.
- Your primary health coverage is Medicare by reason of age (65 or older).

Retiree who is not eligible

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

- You are an active employee of the Company or any of its affiliates.

- Your CITGO retiree health coverage was cancelled as a result of your non-payment of your required contributions.
- You are retired from the Company but returned to active employment for the Company.
- You are a retiree of a related company or any subsidiary or affiliate which has not adopted the Plan.
- You are a non-resident alien.

Spouses who are eligible

Your eligible Spouse may also participate in the Plan. Your Spouse must meet all of the following requirements:

- His/her employment status is retired.
- His/her primary health coverage is Medicare by reason of age (65 or older).
- He/she is enrolled in a UnitedHealthcare AARP Medicare Product.
- He/she is not a non-resident alien.
- He/she is not covered by either a health plan or an arrangement similar to the Plan available from his/her own employment or retirement from any other employer.

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

When you and your Spouse are both Retirees of the Company

Married CITGO couples are each eligible for their own individual RRA account.

Termination of coverage

Coverage under the Plan for you and your covered Spouse, if applicable, will terminate on the earliest of the following dates:

- The date of your death.
- The date of the death of your surviving Spouse, if your surviving Spouse was covered under the Plan at the time of your death.
- The date your surviving spouse remarries, if your surviving spouse was covered under the Plan at the time of your death.
- The date you fail to pay health plan contributions for health plan coverage for your eligible dependents that are covered as a non-Medicare eligible Spouse or Child under the pre-65 retiree benefit program administered by the Company.
- The date you fail to pay plan contributions for your life insurance benefits administered by the Company.
- The date you are no longer eligible to participate in the Plan.

- The date the Plan is terminated.

THE RETIREE REIMBURSEMENT ACCOUNT

The RRA is considered a retiree health reimbursement arrangement or HRA under Internal Revenue Service guidance. The RRA can accumulate Benefit Dollars – credited monthly by the Company while you are eligible to participate. The Benefit Dollars are used to pay Eligible Premium Expenses and any remaining amounts can be used for specified Eligible HealthCare Expenses (described below). The RRA:

- Allows the Company to credit tax advantaged dollars for you to use for Eligible Premium Expenses associated with the purchase of a UnitedHealthcare AARP Medicare Product.
- Allows you to use any remaining balance of Benefit Dollars in your account for Eligible Healthcare Expenses or to save any remaining balance for future use.
- Allows you or your eligible surviving Spouse to access the RRA funds of the other if either of you die while a Plan Participant.
- Allows both you and your eligible Spouse to enroll in the Plan and each have an individual account with Benefit Dollars deposited for each of you.

Any remaining Benefit Dollars in your RRA will be transferred to your eligible surviving spouse. However, if you are single or your surviving Spouse dies or remarries, the RRA account will be forfeited.

Online tool to help you manage your RRA

Once you enroll, you can access your RRA online via www.UHCRetireeAccounts.com where you can view your RRA summary, contributions, available balance, claims and obtain forms.

EMPLOYER CONTRIBUTIONS

Your RRA is neither insured nor funded; it is a recordkeeping credit in the books and records of the Company. All reimbursements are paid from the Company's general assets, and no retiree contributions are permitted or required.

This Benefit Dollar amount to be credited to each RRA is determined by the Company. For each month of eligibility of a Retiree or eligible Spouse, Benefit Dollars are credited as follows:

Contribution Category	Monthly Company Credit of Benefit Dollars
Eligible Retiree and/or Eligible Spouse	**$192 per month of eligibility each**

*Your eligible Spouse must meet all of the eligibility requirements to participate in the Plan.

Benefit Dollars will roll over from month-to-month and year-to-year if not used.

As of January 1, 2014, the RRA has a calendar Plan Year from January 1 through December 31 of each year. Your RRA will utilize such twelve-month Plan Year for purposes of incurring claims and obtaining reimbursements. The Plan permits claims incurred during the Plan Year to be submitted for reimbursement during a so-called "run-out" period, which lasts until 90 days after the end of the Plan Year (or March 31, except in Leap Years). During the run-out period, you or your covered Spouse may submit claims for RRA reimbursement. Claims must be received by UnitedHealthcare by the last day of the run-out period. Any claims received after the end of this run-out period will not be reimbursed.

During the Plan Year, eligible claim submissions for a particular month are suspended when a sufficient balance does not exist. Claims are reimbursed up to the amount available in the account. Any remaining portion of the reimbursement request will be held in suspense until the next month. At the end of the Plan Year, any remaining suspended claims (if applicable) will not be reimbursed. However, if the account has an unused RRA balance as of the end of the run-out period for the prior Plan Year, that unused RRA balance will rollover to be used for the current Plan Year.

These claims submission rules are summarized in the following chart:

EVENT	DATE
Beginning of Plan Year	January 1
End of Plan Year (final day to incur expenses for the current Plan Year)	December 31
Final filing date during next Plan Year for claims incurred in the prior Plan Year	90 days after the end of the Plan Year (March 31, except in Leap Years) (claims must be received by UHC on or before this date)
Date when unused funds (if any) roll over and are available in the account	Mid-April of the next Plan Year (approximately 10 business days after the final filing date at the end of March)

You can keep track of the Benefit Dollars in your RRA account by going online to www.UHCRetireeAccounts.com or by calling UnitedHealthcare Retiree Accounts at 877-298-2305.

Benefit Dollars for mid-year enrollments

If you become an eligible Retiree during the Plan Year and enroll in a UnitedHealthcare AARP Medicare Product, the Company will credit Benefit Dollars to your RRA account for each full month of participation, effective as of the first day of the month in which you are eligible and enrolled in the Plan.

USING BENEFIT DOLLARS FROM YOUR RRA

Your Benefit Dollars may be used to pay for Eligible Premium Expenses for the UnitedHealthcare AARP Medicare Product you select. Any remaining Benefit Dollars credited to your RRA account may be used for Eligible Healthcare Expenses and Eligible Premium Expenses as defined in this Summary to help you pay a portion of your out-of-pocket costs incurred as an eligible Retiree or an eligible Spouse.

After you incur an Eligible Healthcare Expense, you may then submit a reimbursement request form as described under the section, *Requesting Reimbursement From Your RRA*, to be reimbursed from your RRA for the Eligible Healthcare Expenses.

If your eligibility under the Plan terminates for any reason other than death, the funds in your RRA will be forfeited, unless you elect COBRA coverage.

Important Note: Any expense for which you have received reimbursement through your RRA cannot be used as a healthcare expense deduction on your federal income tax return and cannot be reimbursed or reimbursable under any other plan covering health benefits, including a spouse's plan.

Eligible premium expenses

The Benefit Dollars credited to your RRA may be used to pay for Eligible Premium

Expenses. Eligible Premium Expenses include:

- UnitedHealthcare AARP Medicare Advantage Premiums.
- UnitedHealthcare AARP Medicare Supplement Premiums.
- UnitedHealthcare AARP Medicare Part D Premiums.
- UnitedHealthcare AARP or MetLife FSD Retiree Dental Plan Premiums.
- UnitedHealthcare AARP Vision Plan Premiums.
- COBRA Premiums under a Company-sponsored plan for Dental and Vision.

Eligible healthcare expenses

You may choose to use the funds in your RRA to pay for Eligible Healthcare Expenses that are typically not covered by retiree-sponsored health plans or other health plans, but covered when you use your Benefit Dollars. These additional expenses must be considered a healthcare or "medical" expense under Section 213(d) of the Internal Revenue Code of 1986, as amended from time to time, and must also be for Healthcare. See the Glossary. A description of many items which may constitute Eligible Healthcare Expenses, is available in IRS Publication 502, which is available from any regional IRS office or IRS website.

If you incur Eligible Healthcare Expenses, the entire cost of these expenses is your responsibility. If you have Benefit Dollars available in your RRA account, you may request reimbursement for Eligible Healthcare Expenses from your RRA. If you choose to use your RRA funds to pay for any Eligible Healthcare Expenses, you will be required to pay the provider for services and submit a reimbursement request form, as described under *Requesting Reimbursement From Your RRA.*

The IRS has specific guidelines that must be followed for many of these items to be considered Eligible Healthcare Expenses. For more information on how a specific benefit below is covered please call UnitedHealthcare Retiree Accounts at 877-298-2305. The following list shows some examples of the Eligible Healthcare Expenses that can be reimbursed under your RRA:

- Acupuncture.
- Alcohol and drug addiction treatment.
- Breast reconstruction surgery.
- Dental treatment.
- Diagnostic tests and devices.
- Doctor's visits.
- Prescriptions.
- Eyeglasses, contact lenses and exams.
- Fertility enhancements.

- Hearing aids and batteries.
- Operations/surgery (non-cosmetic).
- Nursing services.
- Physical therapy.
- Psychiatric care.
- Smoking cessation.

Ineligible healthcare expenses

The following are examples of expenses that cannot be reimbursed under your RRA:

- Expenses that are or may be reimbursed by another medical, dental, vision or accident plan or insurance policy, workers' compensation, or through Medicare, Medicaid or another similar federal or state program.
- Expenses you already claimed or will claim as deductions or credits on a federal or state income tax return.
- Expenses incurred for cosmetic surgery or similar procedures, unless they are determined to be medically necessary.
- General health and wellbeing expenses, such as exercise, fitness, nutrition programs, recreation, vacations, spa memberships or cosmetic services.
- Expenses that are incurred before you become a Plan participant.

REQUESTING REIMBURSEMENT FROM YOUR RRA

Three ways to file your claim

Once you have paid for your Eligible Premium Expense or other Eligible Healthcare Expense with cash, check or credit card, you have the following three reimbursement options:

- **Online** – Go online at www.UHCRetireeAccounts.com and follow the claim submission link through your login. Further instructions for claim submission are provided at the web location.
- **Fax** – Claims may be faxed to UnitedHealthcare with documentation to 855-244-5016. Faxed claims received by UnitedHealthcare after 1:00 PM Central time will be considered as received on the following business day.
- **Mail** – Claims should be sent to UnitedHealthcare, Attention: EV Team, P.O. Box 30516, Salt Lake City, UT 84130-0516.

All claims must be incurred during the Plan Year. (January 1 – December 31 each year). The Plan permits claims incurred during the Plan Year to be submitted for reimbursement during a so-called "run-out period," which lasts until 90 days after the end of the Plan Year (or March 31, except in Leap Years). Claims must be received by

UnitedHealthcare by the last day of this run-out period. Any claims received after the end of this run-out period will not be reimbursed.

During the Plan Year, eligible claim submissions for a particular month are suspended when a sufficient balance does not exist. Claims are reimbursed up to the amount available in the account. Any remaining portion of the reimbursement request will be held in suspense until the next month. At the end of the Plan Year, any remaining suspended claims (if applicable) will not be reimbursed.

However, if you have an unused RRA balance as of the end of the run-out period for the prior Plan Year, that unused RRA balance will rollover for use in the current Plan Year.

EVENT	DATE
Beginning of Plan Year	January 1
End of Plan Year (final day to incur expenses for the Plan Year)	December 31
Final filing date during next Plan Year for claims incurred in the prior Plan Year	90 days after the end of the Plan Year (March 31, except in Leap Years) (claims must be received by UHC on or before this date)
Date when unused funds (if any) roll over and are available in the account	Mid-April of the next Plan Year (approximately 10 business days after the final filing date at the end of March)

If you don't provide this information to the Claims Administrator within the above timeframe, your claim will not be eligible for reimbursement, even if there are amounts credited to your RRA. This time limit does not apply if you are legally incapacitated.

The balance of your credited Benefit Dollars is available while you are a Participant in the Plan. You can request reimbursement for your Eligible Premiums Expenses or Eligible Healthcare Expenses up to the balance of your Benefit Dollars credited to your RRA as soon as such expenses have been incurred. You can submit a *Retiree Plan Claim for Reimbursement Form* at any time and reimbursements will be made weekly.

Required information for filing a claim

For reimbursement from your RRA, you must include proof of the expenses incurred. For Eligible Healthcare Expenses, proof can include a bill or an invoice that describes the date of the expense and the nature of the services. An explanation of benefits (EOB) from the applicable UnitedHealthcare AARP Medicare Product under which you are covered will also be sufficient to describe the service. In such cases, an EOB will verify what your out-of-pocket expenses were after payments under other plans.

CLAIM DENIALS AND APPEALS

If your claim is denied

If a claim is denied in part or in whole, you may call UnitedHealthcare at 877-298-2305 before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your

satisfaction over the phone, you have the right to file a formal appeal as described below.

How to appeal a denied claim

If you wish to appeal a denied claim, you or your authorized representative must submit your appeal in writing within 180 days of receiving the denial. This written communication should include:

- The patient's name.
- The provider's name.
- The date of health service or expense.
- The reason you disagree with the denial.
- Any documentation or other written information to support your request.

If you wish to request a formal appeal of a denied claim for reimbursement, you should call 877-298-2305 to obtain the UnitedHealthcare address where the appeal should be sent.

Review of your appeal

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- Appropriate individual(s) who did not make the initial benefit determination.
- A health care professional who was not consulted during the initial benefit determination process.

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial with instructions on how to request copies of all the information that was reviewed to formulate the determination.

Filing a second level appeal

The Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from the Plan Administrator within 60 days from receipt of the first level appeal determination. The Plan Administrator must notify you of the benefit determination within 30 days after receiving the completed appeal.

Important Note: Upon written request and free of charge, any covered persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. Claims will be reviewed by the Plan Administrator in accordance with the rules established by the U.S. Department of Labor. The Plan Administrator's decision will be final.

The table below describes the time frames which you and UnitedHealthcare are required to follow:

Claim Denials and Appeals*	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	30 days
You must then provide completed claim information to UnitedHealthcare within:	45 days after receiving an extension
If UnitedHealthcare denies your initial claim, they must notify you of the denial:	
If the initial claim is complete, within:	30 days
After receiving the completed claim (if the initial claim is incomplete), within:	30 days
You must appeal the claim denial no later than:	180 days after receiving the denial
UnitedHealthcare must notify you of the first level appeal decision within:	30 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
The Plan Administrator must notify you of the second level appeal decision within:	30 days after receiving the second level appeal

*UnitedHealthcare may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

Limitation of action

You cannot bring any legal action against the Plan Administrator or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all available reviews of your claim have been completed. After completing that process, if you want to bring a legal action against the Plan Administrator or the Claims Administrator you must do so within three years of the date you are notified of our final decision on your appeal or you lose any rights to bring such an action against the Plan Administrator or the Claims Administrator.

ADMINISTRATIVE INFORMATION: ERISA

This section includes information on the administration of the Plan, as well as information required of all Summary Plan Descriptions by ERISA as defined in the *Glossary Section*. While you may not need this information for your day-to-day participation, it is information you may find important.

Right of recovery

If a benefit is paid that is larger than the amount allowed by the Plan or if a claim is denied and it is determined that an overpayment was made, the Plan has a right to recover the excess amount. UnitedHealthcare and the Company must produce any instruments or papers necessary to ensure the right of recovery, unless prohibited by law, and present them to the person receiving benefits.

Right to amend or terminate the Plan

The Company intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice. If there should be an inconsistency between the contents of this Summary and the contents of the Plan, your rights shall be determined under the Plan and not under this Summary.

Plan sponsor

The Company is the Plan Sponsor of the Plan and has the discretionary authority to interpret the Plan. You may contact the Plan Sponsor at:

CITGO Petroleum Corporation
Attn: Benefits Department
1293 Eldridge Parkway
Houston, TX 77077

Plan administrator

The Company as the Plan Sponsor has appointed the Benefit Plans Committee ("Committee") as the Plan Administrator. You may contact the Plan Administrator at:

Benefit Plans Committee
CITGO Petroleum Corporation
1293 Eldridge Parkway
Houston, TX 77077

Agent for service of legal process

If you feel you have cause for legal action, petition for service of legal process may be presented to the Secretary of the Benefit Plans Committee at the address shown previously in this section for the Plan Administrator.

Other administrative information

This section of the Summary contains information about how the Plan is administered as required by ERISA.

Plan Name:	CITGO Petroleum Corporation Retiree Reimbursement Account
Employer ID:	73-1173881
ERISA Plan Number:	550
Plan Type:	Welfare benefits plan
Plan Year:	January 1 – December 31
Plan Initial Effective Date:	January 1, 2013
Plan Administration:	Self-Insured
Source of Plan Contributions:	Employer
Source of Benefits:	Assets of the Company

Claims administrator

UnitedHealthcare is the Plan's Claims Administrator. The role of the Claims Administrator is to handle the day-to-day administration of the Plan's coverage as directed by the Plan Administrator, through an administrative agreement with the Company. The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan.

The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan. You may contact the Claims Administrator at 877-298-2305 or in writing at:

UnitedHealthcare
Attention: EV Team
P.O. Box 30516
Salt Lake City, UT 84130-0516
Fax: 855-244-5016

Choice of provider and healthcare

The Plan's Benefits are administered by the Company, the Plan Sponsor. UnitedHealthcare is the Claims Administrator and processes claims for the Plan and provides first level appeal services; however, UnitedHealthcare and the Company are not responsible for any decision you or your eligible Spouse make to enroll in a UnitedHealthcare AARP Medicare Product or to receive treatment, services or supplies you receive from providers. UnitedHealthcare and the Company are neither liable nor responsible for the treatment, services or supplies you receive from providers.

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Your ERISA rights

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

- Receive information about Plan Benefits.
- Examine, without charge, at the Plan Administrator's office and at other specified worksites, all plan documents – including pertinent insurance contracts, collective bargaining agreements (if applicable), and other documents available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain copies of all Plan documents and other Plan information, including insurance contracts and collective bargaining agreements (if applicable), and the updated Summary, by writing to the Plan Administrator. The Plan Administrator may make a reasonable charge for copies.

You can continue health care coverage for yourself or eligible Spouse if there is a loss of coverage under the Plan as a result of a qualifying event. You or your eligible Spouse may have to pay for such coverage. Review the Summary and the Plan documents to understand the rules governing your COBRA continuation coverage rights.

You will be provided a certificate of creditable coverage in writing, free of charge, from the Company:

- When you lose coverage under the Plan.
- When you become entitled to elect COBRA.
- When your COBRA coverage ends.
- If you request a certificate of credible coverage before losing coverage.
- If you request a certificate of credible coverage up to 24 months after losing coverage.

You may request a certificate of creditable coverage by contacting the Plan Sponsor.

If you have creditable coverage from another group health plan, you may receive a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan. Without evidence of creditable coverage, Plan benefits for the treatment of a preexisting condition may be excluded for 12 months (18 months for late enrollees) after your enrollment date in your coverage. In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of the Plan. The people who operate your Plan, who are called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

If your claim for a Plan 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. See the *Claim*

Denials and Appeals Section, for details.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the plan document from the Plan, and do not receive it 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 for 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, and you have exhausted the administrative remedies available under the Plan, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court. 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.

If you have any questions about your 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 write to the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210. You may also obtain certain publications about your ERISA rights and responsibilities by calling the publications hotline of the Employee Benefits Security Administration at 800-998-7542.

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GLOSSARY

Many of the terms used throughout the Summary may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how benefits are paid. This section defines terms used throughout the Summary, but it does not describe the benefits provided by the Plan.

Benefits – Plan payments for Eligible Healthcare Expenses and/or Eligible Premium Expenses, subject to the terms and conditions of the Plan.

Benefit Dollars – The amount of notional credits the Company allocates for you into employee accounts for use while you are a Participant in the Plan as an eligible Retiree or eligible Spouse.

Claims Administrator – UnitedHealthcare and its affiliates, who provide certain claim administration services for the Plan.

Company – CITGO Petroleum Corporation.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – A federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

Eligible Healthcare Expense – An expense incurred by a eligible Retiree or eligible Spouse that is a "medical expense" as defined under Section 213(d), including those expenses not typically reimbursed by a health plan, for example: amounts paid to doctors, health labs, hospitals, pharmacies, and mental health centers that fall within the plan deductible or your share of the health expense, such as co-insurance (percentage of health expense that you pay) and co-payments but only to the extent that the Participant who incurred the expense is not reimbursed for the expense (nor is the expense reimbursable) through another benefit plan, other insurance, or any other accident or health plan.

Eligible Premium Expense – An expense incurred by an eligible Retiree or eligible Spouse as defined by the Plan, such as the premium expense for coverage under a UnitedHealthcare AARP Medicare Product and other healthcare insurance, but only to the extent that the Participant who incurred the expense is not reimbursed for the expense (nor is the expense reimbursable) through another benefit plan, other insurance, or any other accident or health plan.

ERISA – The Employee Retirement Income Security Act of 1974, as amended from time to time.

Healthcare – Defined as "medical care" under Section 213(d), means services and supplies for the diagnosis, cure, mitigation, treatment or prevention of disease, and for treatments affecting any part or function of the body. This definition is subject to change without notice to you.

Participant – An individual who participates in the Plan as an eligible Retiree or an eligible Spouse while enrolled in the Plan. References to "you" and "your" throughout this Summary are references to a Participant.

Plan – The CITGO Petroleum Corporation Retiree Reimbursement Account Plan.

Plan Administrator – CITGO Petroleum Corporation or its designee. The current designee is the CITGO Benefit Plans Committee.

Plan Sponsor – CITGO Petroleum Corporation.

Plan Year – January 1 through December 31 of each year.

Retiree – A Retiree who at the time of retirement met the eligibility criteria for retiree health coverage as defined by the health plan covering either Hourly or Salaried active employees.

RRA – Retiree Reimbursement Account is a limited purpose health reimbursement arrangement (HRA) for eligible Retirees and eligible Spouses. RRAs are individual accounts in the name of the Retiree or his/her eligible Spouse.

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. An otherwise eligible Spouse may participate as a surviving Spouse provided he/she continues to satisfy the eligibility criteria. "Spouse" includes your common law spouse of the opposite sex, if common law marriage is recognized in the state of which you were a legal resident when the marriage was established. You must submit the applicable documentation for your state of residence for review and approval by the Plan Administrator before coverage can begin for the Spouse.

UnitedHealthcare AARP Medicare Product – A Medicare Supplement insurance policy, a Medicare Advantage Plan policy or similar insurance program offered through AARP (the American Association of Retired Persons).