Global Business Travel Insurance Provisions of the CITGO Petroleum Corporation Medical, Dental, Vision, & Life Program for Hourly Employees

Summary Plan Description

January 1, 2018

The Summary Plan Description, including announcement letters and other communications such as a summary of material modifications issued after the effective date of this Summary Plan Description, and the global business travel insurance contract between the Company and the Insurer are the governing Program documents. In the event of a discrepancy between this Summary Plan Description and the actual insurance contract, the insurance contract will control.

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PURPOSE

Global business travel insurance (the "Program") is designed to provide supplemental coverage for medical expenses incurred while you are traveling out of your country of permanent residence or assignment for business purposes. The Program is insurance coverage with respect to planned travel and is supplemental to other major medical coverage. The Program is not a major medical or comprehensive medical policy.

The Program is an insured benefit program under the CITGO Petroleum Corporation Medical, Dental, Vision and Life Insurance Program for Hourly Employees (the "Plan"). UnitedHealthcare Insurance Company (the "Insurer"), which is the insurer for the Program, has prepared a Certificate of Coverage (the "Certificate") that provides detailed information about these benefits. The Certificate should be the first place you look for questions regarding the Program. This Summary Plan Description includes information regarding the Program that is not contained in the Certificate.

> *If you have not received a Certificate or if you have questions regarding your coverage, you should contact UHC Member Services at 1-866-870-3475. If you are not able to obtain answers to your questions, please contact the CITGO Benefits Helpline at 1-888-443-5707.*

ELIGIBILITY

Employees Who Are Eligible

You are eligible to participate in the Program if you satisfy the requirements described below under "Procedure for Requesting UHC Global Business Travel Insurance Welcome Kit" and you satisfy all of the following requirements:

- You are a Regular Full-Time Employee of the CITGO Petroleum Corporation (the "Company");
- You are carried on a U.S. dollar payroll;
- You are required to travel outside of your country of permanent residence or assignment on the business of the Company;
- You are covered under a collective bargaining agreement which provides for coverage under the Program; and
- You are not listed in the section below titled "Employees Who Are Not Eligible."

For this purpose, the term "Regular Full-Time Employee" means an employee of the Company who is regularly scheduled to work at least 40 hours per week.

Eligibility for benefits is further limited by the terms and conditions described in the Certificate. Please review the Certificate closely for specific information about the benefits that are available and the conditions applicable to those benefits.

Employees Who Are Not Eligible

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

- You are employed on any basis other than as a Regular Full-Time Employee of the Company (for example, a part-time, 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 not in a class of employees covered by a collective bargaining agreement which provides for coverage under the Program;
- 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 upon a final determination of your status by the Plan Administrator.

Procedure for Requesting UHC Global Business Travel Insurance Welcome Kit

When you become aware that you will be required to travel out of the country on CITGO business, you must complete the UHC Global Business Travel Insurance Request for Welcome Kit form and have it signed by your manager. You should submit the completed form to the Benefits Department at **Benefits@CITGO.com.**

It is a requirement that this form be completed, submitted and approved each time you travel out of the country on CITGO business.

When completed forms are received, a representative from the Benefits department will confirm the information submitted. If any questions arise, you will be contacted for clarification.

The UHC Global Business Travel Insurance Welcome Kit will be emailed to you, along with the UHC Global Business Travel ID card**.** **(**Please note that this card is separate from your regular UHC member ID Card.) Print the card and take it with you on your CITGO business trip. The ID card will provide all the information you will need to contact UnitedHealthcare Global Services and access their assistance.

Please obtain a list of direct settlement providers in the country of your travels prior to your departure.

If you encounter date changes to your travel after having submitted the completed form, please send an email to **Benefits@CITGO.com** along with your revised travel dates.

DESCRIPTION OF BENEFITS

The Program pays only the benefits provided under the global business travel insurance contract between the Company and the Insurer. The Certificate tells you:

- what types of benefits are provided under the Program;
- how the Insurer determines how much it will pay;
- cost-sharing rules, including when you are required to pay any deductible, coinsurance or co-payment amount;
- your benefit limits, including any annual or lifetime caps or other benefit limits;
- any rules requiring preauthorization or utilization review as a condition to obtaining a benefit or service under the Program; and
- when a claim for benefits must be filed and how the Insurer handles claims and appeals.

The Program limits or excludes payment for certain expenses or events. Read the Certificate to learn about:

- when the Program will not pay for expenses for services and supplies; and
- specific types of expenses or events excluded from coverage under the Program.

TERMINATION OF COVERAGE

Your coverage with respect to a specific trip will end when you return from that trip. Your eligibility for the Program generally will end on the date you cease to satisfy the eligibility requirements described above or, if earlier, the earliest termination date described in the Certificate.

BENEFIT CLAIMS AND APPEALS

The Insurer administers all benefit claims and appeals with respect to the Program. The Insurer has the authority, in its discretion, to interpret the terms of the documents describing the Program, decide questions of eligibility for benefits and make any related findings of fact. All decisions made by the Insurer are final and binding on all persons covered under the Program to the full extent of the law.

The Certificate tells you when and how a claim for benefits must be filed, and how the Insurer handles claims and appeals. **Please review the Certificate closely for information regarding the claims and appeals processes. Your ability to appeal or bring an action in court with respect to a claim depends on your compliance with the applicable claims and appeals procedure.**

ADMINISTRATIVE INFORMATION

The Plan Administrator has contracted with UnitedHealthcare Insurance Company to provide coverage as the Insurer under the Program. The provisions of the Program are subject to the terms and conditions of the insurance contract between the Company and the Insurer (the "Insurance Contract"). The Insurer makes all payments of benefits under the Program.

The Insurer is responsible for individual claim determinations and has final discretionary authority to interpret the Insurance Contract's provisions, to resolve any ambiguities in the Insurance Contract and to determine all questions related to the Insurance Contract. Except for individual claim determinations, the Plan Administrator is responsible for the administration of this Program. The Plan Administrator has the authority to control and manage the operation and administration of the Program, including discretionary authority to establish and implement rules for the operation and administration of the Program; to construe and interpret the provisions of the Program; and to make factual determinations under the Program; provided that the Insurer is responsible for all functions associated with the administration of the Insurance Contract, such as adjudicating and paying benefit claims. Respectively, the decisions of the Insurer and the Plan Administrator will be final, conclusive and binding on all persons.

The Plan Administrator may delegate to other persons the responsibilities for performing the ministerial duties in accordance with the terms of the Program and may rely on information, data, statistics or analysis provided by these persons.

Payment of Benefits

No employee contributions are required or permitted. Program benefits paid by the Insurer are funded through an insurance policy purchased from the Insurer by the Plan Administrator on behalf of the Plan.

Agent for Service of Legal Process

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

Future of the Program

The Program is voluntary on the part of the Company. The Company reserves the right to amend, modify, or terminate this Program at any time, with or without advance notice, prospectively as well as retroactively, subject to applicable law. Such actions will be effective as of any date designated by the Company.

ADDITIONAL INFORMATION

As a participant or beneficiary under this Program and the Plan you have certain rights and protections as more fully described within the Statement of ERISA Rights on page 9. Other important information about the Plan is provided below:

Name of Plan:	CITGO Petroleum Corporation Medical, Dental, Vision and Life Insurance Program for Hourly Employees
Type of Plan:	Welfare Benefit Plan. The Global Business Travel Benefit is insurance coverage with respect to planned travel and is supplemental to other major medical coverage available under the plan. The Global Business Travel Benefit is not a major medical or comprehensive medical policy.
Plan Sponsor:	CITGO Petroleum Corporation 1293 Eldridge Parkway Houston, TX 77077
Plan Sponsor's Employer Identification Number:	73-1173881
Plan Administrator:	Benefit Plans Committee – Secretary Attn: Benefits CITGO Petroleum Corporation 1293 Eldridge Parkway, N5063 Houston, TX 77077
Plan Number	518
Plan Initial Effective Date:	January 1, 1984
Plan Year:	January 1 – December 31
Funding:	The Program benefits are provided by an insurance policy and the premiums paid to the Insurer are paid by the Company. Employees are not required to contribute to the cost of the coverage.
Insurer:	UnitedHealthcare Insurance Company 450 Columbus Avenue Hartford, CT 06115 1-866-870-3475

Contract Number: 908129

Benefits HelpLine Phone: 1-888-443-5707

Email: Benefits@citgo.com

Mail: CITGO Petroleum Corporation
Attn: Benefits
1293 Eldridge Parkway, N5063
Houston, TX 77077

The Plan is maintained pursuant to one or more collective bargaining agreements.

Statement of ERISA Rights

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

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The 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.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or 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.

Qualified Medical Child Support Order

The Plan complies with certain qualified medical child support orders ("QMCSOs") for group health benefits, if and to the extent applicable. To be a QMCSO, a child support order must be entered by a court of competent jurisdiction or issued through a state administrative process that has the force of law. The Plan follows certain procedures for the processing and administration of QMCSOs. You may obtain a copy of these procedures at no charge by calling the Benefits HelpLine at 1-888-443-5707.

No Promise of Continued Employment

No provision of the Plan shall give any employee the right to be retained by his or her employer, or affect the employer's right to terminate an employee's employment at any time.

Legal Actions

There are specific limitations on your right to file a lawsuit with respect to the Program. No civil action under ERISA § 502(a), or any other action at law or in equity, against the Plan, any participating employer, the Plan Administrator or any other fiduciary or party associated with the Plan with respect to a claim for benefits may be brought prior to the exhaustion of the internal claim and appeal process. In addition, the Insurance Contract imposes specific time limitations on the commencement of a legal action related to the Program. As of the date of this Summary Plan Description, the Certificate provides that, after completing the appeal process described in the Certificate, if you want to bring a legal action against the Insurer you must do so within three years of the date the Insurer notified you of its final decision on your appeal or you lose any rights to bring such an action against the Insurer. Please refer to the Certificate for more information regarding these limitations.