Dental Plan Provisions Of The CITGO Petroleum Corporation Medical, Dental, Vision, & Life Program For Hourly Employees

Summary Plan Description
and Formal Plan Text
as in effect January 1, 2007

The Summary Plan Description, including announcement letters issued subsequent to the publication date, is the governing Plan Document.

COMPANY DENTAL PLAN
HIGHLIGHTS

Eligibility

Regular Full-Time and Regular Part-Time Employees covered under a collective bargaining agreement which has negotiated for the Plan.

Enrollment

You may enroll yourself and your eligible dependents within 31 days of your hire date, or when becoming eligible (if later).

Cost/Funding

Your pre-tax contributions depend on the total cost of coverage, less the Company's contribution, and the level of coverage you select. A schedule of contributions is published annually.

Benefits

Covered Services	Coverage You Pay	Deductible
Preventive and Diagnostic Two oral examinations per year, routine cleaning and scaling, and X-rays. For dependents under age 19, fluoride applications and space maintainers. Sealants for children age 14 and under.	**You pay 0%**	**No**
General Fillings, extractions, oral surgery, general anesthetics, drugs, periodontics (treatment of gums) and endodontics (root canals)	**You pay 20%**	**Yes**
Prosthetic Crown and gold restorations, bridges and dentures and replacement of damaged bridges and dentures	**You Pay 50%**	**Yes**
Orthodontic Braces and other appliance therapy and surgical therapy to correct malocclusion	**You Pay 50%**	**No**

Deductible

$50 per person per year

Maximum Benefit

The maximum benefit limits are:

- $1,250 per person per calendar year for preventive and diagnostic, general and prosthetic services, and
- $1,250 per person per lifetime for orthodontia

CIGNA Preferred Provider Program (PPO)

CIGNA has developed a network of dentists who provide their services at reduced rates. This program is entirely voluntary and yet allows you to maximize your benefits through the use of preferred dentists.

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PURPOSE

The Dental provisions of the CITGO Petroleum Medical, Dental, Vision and Life Insurance Program for Hourly Employees ("Plan" or "Dental Plan") is offered to you and your eligible dependents to provide financial assistance towards expenses for necessary dental services. One of the key benefits of the Plan is 100% coverage for most routine preventive and diagnostic services. This benefit not only helps you reduce your out-of-pocket expenses now, but can help you lower any future expenses by promoting good dental hygiene and preventing or minimizing future problems that can be painful, both physically and financially.

The Plan has been designed so that both the Company and the participants share the cost of the Plan. The Plan is intended to pay a portion of participants' dental expenses and participants are responsible for payment of contributions, annual deductibles, their covered percentage, charges in excess of reasonable and customary limits, and charges for goods and services not covered under the Plan.

This Summary Plan Description describes the benefits available under the Plan, as well as the Plan's limitations and exclusions. As a participant of the Plan, you may be asked to comply with certain provisions of this Plan, which could affect the benefits you receive. You should acquaint yourself with these provisions; failure to comply may result in a penalty, a reduction in benefits, or even the denial of benefits.

ELIGIBILITY

Active Employees

Who is Eligible

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

(1) You are a Regular Full-Time Employee or a Regular Part-Time Employee compensated on an hourly basis covered under a collective bargaining agreement which has been negotiated for the Plan; and

(2) You are carried on a U.S. dollar payroll of the Company.

Employees who would otherwise be eligible but who are on an authorized leave of absence will be eligible for the Plan.

Who is Not Eligible

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

(1) You are a member of a collective bargaining unit which has negotiated for a group dental plan other than the Plan;

(2) You are a part time employee who is a member of a collective bargaining unit which has negotiated for the Plan and has completed less than 1,000 hours of service during a calendar year or during a twelve-month period that began on the date employment began;

(3) You are a part time employee who is not covered by a collective bargaining agreement;

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

(5) You provide services to the Company under an independent contract between yourself and the Company or under an independent contract between the Company and a third party;

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

(7) You are employed by a related company or any subsidiary or affiliate which has not adopted the Plan; or

(8) You are a nonresident alien.

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

Dependents

When you enroll in the Plan, you can also enroll your dependents as outlined in the chart below:

Type of Dependents	Coverage	
	Eligible	Not Eligible
Your spouse, if you are not legally separated	X	
Your unmarried children who are under age 19 or under age 25, if full-time students at an accredited school or university, including: • Your biological children • Stepchildren living with you • Adopted children (see below) or foster children • Children who depend on you for support and live with you as though in a regular parent-child relationship. The birth parent of the child cannot live in the home.	 X X X X	
Your dependent children if mentally retarded or become physically or mentally disabled prior to the end of the month in which the child attains the limiting age, either 19 or 25, as applicable.	X	
Adopted children, as explained previously in this chart, regardless of whether the adoption has become final. An adopted child will be eligible for coverage when the child is placed for adoption, but in no event earlier than the date of the employee's coverage. A child is considered being placed 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.	X	
Common law marriage. Requires application and approval.	X	
Parents or grandparents, even if living with you and dependent upon you for support		X
Married children		X
Grandchildren, unless they depend on you for support and live with you as though in a regular parent-child relationship. The birth parent of the grandchild cannot live in the home.		X
Stepchildren who do not live with you		X
Brothers-in-law, sisters-in-law, aunts, uncles, cousins, nieces or nephews (unless they qualify as unmarried children who depend on you for support and live with you as though in a regular parent-child relationship as explained previously in this chart).		X
Dependents actively serving in the armed forces of any country		X
Your domestic partner		X

Proof of Dependent Status
Proof of dependent status satisfactory to the Company may be requested for any individual being enrolled or already covered under the Plan as a dependent.

Disabled Child Eligibility Guidelines

Your unmarried, disabled child is eligible for continued dental coverage ***if*** the child is mentally retarded or becomes physically or mentally disabled prior to the end of the month in which the child attains the limiting age, either 19 or 25, as applicable. A Dependent Disabled Handicapped Application must be submitted to the Plan Administrator for approval, within 31 days from the end of the month in which the child would otherwise cease to be eligible, or within 31 days after you become eligible for the Plan if the child was disabled prior to your employment. The proof must show that the child meets all of the following conditions. He or she:

- is mentally retarded or is physically or mentally disabled;
- is incapable of self-sustaining employment;
- is primarily dependent upon you for support; and
- was disabled prior to the end of the month is which the child attained either age 19 or 25, as applicable.

Dual Company Coverage

If both you and your spouse work for the Company and are eligible for any Company-sponsored dental plan, you may be covered **either** as an employee **or** as a dependent - but not both - under the Plan. If both you and your spouse work for the Company and you have one or more dependent children, only one of you may cover the eligible children.

If divorced birth parents both work for the Company, dependent children may be covered by each parent.

Retired Employees

Coverage Under the Plan: You will be eligible to continue coverage for yourself and your eligible dependents under the Plan after you retire, if you:

(1) retire directly from employment with the Company under the provisions of the Retirement Plan of CITGO Petroleum Corporation and Participating Subsidiary Companies; or

(2) are eligible to retire under the provisions of the Pension Plan for Hourly Employees of CITGO Refining and Chemicals; or

(3) are eligible to retire under the provisions of the Pension Plan for Hourly Employees of UNO-VEN.

Additional retirement eligibility provisions may apply as approved by the Company or the Plan Administrator.

Your coverage after retirement will continue 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 dental 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.

If you waive coverage, you may re-enroll at a later date in accordance with the Late Enrollment provisions on page 7.

If you are a retiree, your coverage can be cancelled due to non-payment and **you will not be eligible to re-enroll at a later date.** (see *Termination of Coverage* on page 34).

Dependents: If you are eligible for retiree dental coverage, you may continue to cover each of your eligible dependents after you retire, provided that:

- You are covered under the Plan as a retiree;
- The dependent continues to meet the eligibility requirements under the Plan; and
- You pay any required contribution.

You may elect to add new dependents to your coverage in conjunction with an "eligible family status change" or at any subsequent Annual Election Period. 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 may change your level of coverage in accordance with the eligible Status Change rules on page 76.

If both you and your spouse are eligible for Plan benefits at retirement, at any Annual Election Period or eligible Status Change, you may elect to be covered under the Plan **either** as a dependent **or** as a retiree – but not both.

Effect of Eligibility when age 65

Active Employees

Active employees age 65 and over: Coverage under the Plan is available to eligible active employees aged 65 and over, under the same conditions available to active employees under age 65. If you are covered under the Plan as an employee when you reach age 65, you will continue to be covered while you are an employee.

ENROLLMENT

Level of Coverage

You may apply for the following coverage levels available to participants in the Plan:

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

If both you and your spouse are eligible to enroll in the Plan as employees and you both wish to be covered

- Each of you may enroll for "Employee Only" coverage;
- One of you may enroll for "Employee and Spouse" or "Employee and Family" coverage; or
- One of you may enroll for "Employee and Child(ren)" and the other may enroll for "Employee Only".

- **You cannot obtain the coverage only for your dependents.**

When to Enroll

Regular Enrollment

You may enroll yourself and your eligible dependents in the Plan within 31 days of your employment date, or within 31 days of the date you first become eligible for the Plan (if later). You must complete, sign, date and return your enrollment forms to your Authorized Company Representative. You can obtain the proper enrollment forms from the Benefits HelpLine at 1-888-443-5707.

If you enroll within 31 days of first becoming eligible, your coverage is effective as of the date you were first eligible for coverage. For example, if your date of hire is July 5 and you submit your enrollment by August 5, your coverage will be effective July 5.

Late Enrollment

If you enroll for coverage into the Company Dental Plan:

- More than 31 days after your employment date;

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

then you may enroll:

- Within the Plan Year after an eligible Status Change *(For details about eligible Status Change, see page 26)*; or
- During the next Annual Election Period.

You are not permitted to enroll at any other time.

Enrolling Your Dependent(s)

Current Dependents

Dependent coverage is not effective until or unless employee or retiree coverage is effective.

If you want to cover any of your eligible dependents under your dental coverage, you need to enroll them within 31 days after:

- Your employment date;
- You first become eligible to join the Plan (if later); or
- The date your dependent first becomes eligible for coverage.

Coverage for your eligible dependent is effective on the date of eligibility or the date of the Status Change, if the change is within the Plan Year. (For details about eligible Status Changes, see page 31).

If you don't meet either of the deadlines listed above, you will not be able to enroll your eligible dependents until the next Annual Election Period, unless you have a subsequent eligible Status Change.

New Dependent(s)

Newborns: If you are covered under the Plan, your newborn infant will be eligible for benefits on the date of birth provided you enroll your newborn within 31 days of birth.

Foster children or any other child who depends on you for support: a foster child or any other child who depends on you for support becomes eligible on the date you establish a parent-child relationship provided you enroll them within 31 days. In order to cover your grandchild, the birth parent(s) of the child cannot live in your home.

Adoption: an adopted child who is eligible for coverage, as defined in the section entitled *Eligibility – Dependents* (page 4), may be covered under the Plan under the same conditions applicable to children of eligible participants regardless of whether the adoption has become final. An adopted child will be eligible for coverage when the child is placed for adoption, but in no event earlier than the date of your coverage, provided you enroll them within 31 days.

Marriage: You may enroll a spouse who is eligible for coverage as defined under the section entitled *Eligibility – Dependents* (page 4) on the effective date of the marriage. You are required to notify the Benefits HelpLine at 1-888-443-5707 within 31 days from the date of marriage; otherwise you must wait until the next Annual Election Period or another eligible Status Change.

Adding Coverage for Dependents

Current Coverage Level Includes Dependents: If you are enrolled in a level of coverage that includes dependent child(ren), any newly eligible dependent child(ren) added to your family will be covered. However, claims for expenses for the new dependent will not be processed until you contact the Benefits HelpLine at 1-888-443-5707 with the dependent information needed to add them to your coverage. Once the Benefits HelpLine has your records updated, the Claims Administrator will be notified in order to pay claims. The Claims Administrator will process claims for your new dependent retroactive to the date of eligibility. Failure to provide dependent changes in a timely manner could result in the delay of claim processing.

> ***Example: Adding a Dependent Without a Level of Coverage Change***
> Tom elects "Employee and Family" coverage during the Annual Election Period. Several months later, his third child is born. Tom does not need to change his level of coverage. He does, however, need to provide information about the dependent to the Benefits HelpLine so that eligible expenses for his new dependent can be processed.

Current Coverage Level Does Not Include Dependents: If the addition of a dependent means that you must change your level of coverage (for example, from "Employee Only" to "Employee and Spouse" or "Employee and Child(ren)" or from "Employee and Spouse" to "Employee and Family" coverage), then you must change your level of coverage within 31 days of the Status Change. You will be required to wait until the next Annual Election Period or eligible Status Change to request coverage for your new dependent(s).

> ***Example: Adding a Dependent With Change in Coverage Level***
> Sally elects "Employee Only" coverage during the Annual Election Period. Several months later, she marries. Sally needs to change her level of coverage to "Employee and Spouse" coverage.

Dropping Coverage for Dependents

You must have an eligible Status Change if you wish to drop coverage for a dependent(s) during the Plan Year. If dropping coverage for a dependent results in a change in your level of coverage, the change will be effective as of the end of the month in which you contact the Benefits HelpLine at 1-888-443-5707. If, however, it is determined that a dependent ceased to meet eligibility requirements (for example, a dependent over age 19 who ceases to be a full time student) and yet coverage for that dependent was not cancelled within 31 days of the Status Change, coverage will be cancelled retroactive to the end of the month in which the dependent loses eligibility. There will be no refunding of employee contributions paid if this results in a change in your level of coverage. Further, the Claims Administrator will require reimbursement for any expenses paid after the retroactive loss of coverage date.

> ***Example: Dropping a Dependent After Loss of Eligibility***
> Chad has "Employee and Family" coverage under the Dental Plan. Chad's only child, Mary, graduates from college on June 5 when she is age 21. Chad does not notify the Benefits HelpLine of Mary's loss of eligibility until the Annual Election Period in November. Upon notification in November, Mary's coverage is canceled retroactive to June 30. Even though this reduces Chad's coverage level to "Employee and Spouse", Chad does not get a refund of any contributions. He will start paying the lower contribution for "Employee and Spouse" coverage effective December 1. Also, Chad must reimburse the Claims Administrator for any expenses incurred by Mary that were paid by the Plan after June 30.

Annual Election Period

Changes if You are Currently Covered

Each year during a specified time period, you have the opportunity to change your dental coverage. Changes elected during this period will be effective for the following Plan Year (January 1 - December 31). This period is the Annual Election Period.

The changes you can make during the annual election period include the following:

(1) Changing level of coverage by dropping dependents or adding dependents who meet eligibility requirements; or

(2) Terminating or waiving coverage.

During this period, under certain circumstances you may be required to submit an election form. You will be notified if you are required to make an election. If you are not required to make an election, your current coverage will continue unless you choose otherwise or your elections are automatically changed to coverage that is available under a revised Plan design.

If you are required to submit an election, it must be properly completed, signed, dated, and returned within the specified time limits. If you do not complete and return the required elections within the specified time limits, you and your eligible dependents will not be eligible for any dental benefits under the Plan for that Plan Year unless you have an eligible Status Change.

Dropping Dependent Coverage During Annual Election: You do not need an eligible Status Change to drop coverage for dependents during the Annual Election Period. Coverage changes elected during the Annual Election Period are effective on January 1 unless a dropped dependent ceases to meet eligibility requirements prior to that date.

> ***Example: Dropping a Dependent During Annual Election Period***
> Tom has "Employee and Family" coverage under the Dental Plan. Tom's wife, Sarah, accepts employment July 1 and elects to be covered under her employer's group dental plan. Tom may drop Sarah's coverage under the Plan as of the Status change. If Tom elects to drop Sarah's coverage, the change will be effective at the end of the month he contacts the Benefits HelpLine. During the period that Sarah has coverage under her employer's plan and the Company Dental Plan, her employer's plan will be the Primary Plan for her and the Company Dental Plan will be secondary in accordance with the Coordination of Benefits rules on page 43.

Changes if You Are Not Currently Covered

If you are not covered under the Plan because you waived coverage initially or during an Annual Election Period, you may enroll for coverage during a subsequent Annual Election Period. Your coverage under this Plan will become effective on January 1 of the following year.

Transfers from Salaried to Hourly

If you are a salaried employee and are transferred to hourly status and were enrolled in the salaried dental plan, you will automatically be enrolled in this Plan based upon your enrollment choice in the salaried dental plan. For example, if you had elected "Employee and Family" coverage in the salaried dental plan, you will automatically be enrolled for "Employee and Family" coverage in this Plan upon transferring to hourly status. You will, however, have the option to change coverage (see *Status Change* page 26).

OVERVIEW OF BENEFITS

To assist you and your family, the Plan is designed to promote and encourage preventive dental care, to provide benefits for services that are essential to the proper care of teeth, and to help defray a portion of the dental expenses incurred by you and your family members.

Summary

COVERED SERVICES	COVERED PERCENTAGE		DEDUCTIBLE	MAXIMUM BENEFIT
	You Pay	Plan Pays		
Preventive & Diagnostic Two oral examinations per year, routine cleaning and scaling, and X-rays. For dependents under age 19, fluoride applications and space maintainers. For dependents under age 19, sealants.	0% plus R&C Excess	100% (of R&C charges)	No	**$1,250 per person per calendar year** **No lifetime maximum**
General Fillings, extractions, oral surgery, general anesthetics, drugs, repair or re-cementing of crowns, dentures, etc., periodontics (treatment of gums), and endodontics (root canals).	20% plus R&C Excess	80% (of R&C charges)	Yes ($50 per person per year)	
Prosthetic Crown and gold restorations, bridges and dentures, and replacement of damaged bridges and dentures.	50% plus R&C Excess	50% (of R&C charges)	Yes ($50 per person per year)	
Orthodontic Braces and other appliance therapy, and surgical therapy to correct malocclusion.	50% plus R&C Excess	50% (of R&C charges)	No	**$1,250 per person lifetime maximum**

The chart is intended to summarize the benefits of the Dental Plan. You should refer to the appropriate sections of this SPD for more detailed explanations of the information discussed in this chart.

Key Terms

Deductible

The annual calendar year deductible is the initial amount of covered dental expense you must pay for each covered person before the Plan pays any benefits. The annual deductible applies to all expenses except charges for Preventive services and for covered Orthodontic services described in this summary. Once you meet your deductible, the deductible is satisfied for the year, regardless of the number of claims submitted.

Covered Percentage

You and the Company share the cost of your covered dental expenses. The percentage you pay is your covered percentage. After the deductible is met, the Plan begins paying its share of covered dental expenses.

Maximum Benefit

Each individual enrolled for Plan coverage is eligible to receive up to a maximum of $1,250 in benefits (including Preventive, General and Prosthetic covered services) each calendar year. There is no dollar limit on the amount of benefits any one individual can be paid over his lifetime. However, there is a separate $1,250 lifetime maximum for Orthodontia treatment for you and each covered dependent.

COVERED EXPENSES

Benefits payable under the Plan 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 Plan will pay only the applicable allowance for the *less* expensive procedure.

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

(1) Preventive and Diagnostic Services;
(2) General Services;
(3) Prosthetic Services; and
(4) 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 Plan.

Some limitations and exclusions of coverage may apply to particular services and supplies, as outlined in this summary. Please refer to the sections entitled *Limitations (page 20)* and *Not Covered Expenses (page 22)* for listings of certain expenses that are not covered under this Plan.

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 Plan will be paid for the expenses of the dental service.

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

- Is necessary in terms of generally accepted dental standards; and
- Is qualified for benefits under the Plan.

In most cases, care prescribed by your dentist is considered necessary dental services, as defined by this Plan. However, there are exceptions which are not eligible for coverage under this Plan; for example, treatment considered to be experimental or investigational because it does not meet generally accepted standards of dental practice in the U.S.

Reasonable & Customary (R&C) Charges

The Plan will reimburse a portion of covered expenses up to an amount determined by the Claims Administrator to be reasonable and customary (R&C) for that service. The R&C charge for a service or supply is the lower of the provider's usual charge or the prevailing charge in the geographic area where it is furnished - as determined by the Claims Administrator. The Claims Administrator takes into account the complexity, degree of skill needed, type or specialty of the provider, range of services provided by a facility and the prevailing charge in other areas. A charge is considered reasonable and customary if it falls at or below 9 out of 10 other charges for that procedure surveyed (90% rule) in a geographic area.

This doesn't mean that a charge, which exceeds the R&C limit, is unreasonable or that you've been overcharged. There are many reasons why one provider may charge more than another. However, the Plan accepts the industry standard for determining R&C charges by the 90% rule. In most cases, the average charge will fall below the 90th percentile and within the R&C limit. By using this standard, only 10% of all provider charges will fall above these R&C limits.

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

Pre-Determination of Benefits

The Predetermination of Benefits feature of the Plan coverage allows you to find out what portion of the dentist's charges for your specific treatment will be covered under the Plan before you start treatment. This may help you get a better idea of the out-of-pocket cost involved for the recommended treatment.

When the estimated cost of a recommended dental treatment exceeds $250, the dental treatment should be submitted to the Claims Administrator for review before treatment begins. Your dentist can receive a pre-treatment estimate online or over the phone in minutes detailing what services the Plan will cover and at what payment level. The dentist can contact CIGNA at 1-800-244-6224 or online at, www.mycigna.com. The Claims Administrator will notify the patient and the dentist of the benefits payable based on the treatment plan. In determining the benefits payable, consideration will be given to

any alternative procedures that may accomplish a professionally satisfactory result. 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. Any pre-determination of benefits is subject to Plan limits at the time services are rendered and therefore does not guarantee payment of estimated benefits.

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 the least costly procedure that the Claims Administrator determines will produce a professionally satisfactory result.

Description of Benefits

Preventive and Diagnostic Services

To encourage preventive care and detect small problems before they become larger dental and financial concerns, the Plan 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 dependent children under age 19, but not more than twice each calendar year.
- **Space Maintainers:** Must replace prematurely lost primary teeth for dependent children 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 dependent children 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

After the $50 annual deductible per person has been satisfied, the Plan pays 80% of R&C charges for covered general services, as outlined below:

- **Fillings:** Includes amalgam, silicate, acrylic, synthetic porcelain and composite filling restorations to restore diseased teeth. Covers "white" or cosmetic resin fillings for front 6 teeth on the top and front 6 teeth on the bottom. Covers amalgam fillings for first and second molars. White or cosmetic resin fillings are considered cosmetic when used on first or second molars.
- **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 planning, 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.

Prosthetic Services

After you satisfy your annual deductible, the Plan pays 50% of R&C charges for covered prosthetic 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 Plan 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.

  Replacement of an existing denture or bridgework that is at least 60 months old and is no longer serviceable. 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.
- **Bruxism:** see *General Services*, page 17).

Normally, partial dentures will be replaced by partial dentures, but if a result consistent with generally accepted standards of dental practice can be achieved only with bridgework, the Reasonable and Customary charge for such bridgework will be a covered dental expense.

Orthodontic Services

The Plan pays 50% of the R&C charges for covered orthodontic services up to the maximum lifetime benefit of $1,250 for each covered Participant. 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.

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. 25% percent of the usual, necessary, and customary charges for the entire course of treatment will be considered by the Claims Administrator to be the initial charge and will be paid under the Plan at 50% as an orthodontic expense. The remaining 75% of the usual, necessary, and customary 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 Plan at 50% 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 Plan ceases, or the Lifetime Maximum of $1,250 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: $145.83 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. Orthodontic Services are reimbursed at 50%, so the monthly benefit paid by insurance will be $62.50, until the lifetime orthodontia maximum of $1,250 is reached.

Remember that the initial payment also goes against the maximum.

Therefore, $1,250 minus the $500 Initial Payment leaves $750 to apply towards the monthly claims. $750 divided by $62.50 (the monthly insurance payment) equals 12 months to exhaust your total $1,250 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 Flexible Spending Account Plan. (Toll free at 1-866-317-6359). Health Care Spending Account information is available in a separate SPD under Flexible Spending Accounts.

Limitations

The following limitations apply to the Plan:

Restorations

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 Plan as being the standard for determining the maximum benefit for specified teeth.

Name of Teeth	**Standard Material for Maximum Benefits Under the Plan**
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 Plan will be based on the usual, necessary, and customary charge for the material used.

Prosthodontics

If a standard partial denture meets accepted standards of dental practice in determining the benefits payable under the Plan, 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 Plan. The balance of the cost will not be considered to be a covered dental expense.

Effective Date of Coverage

Dental expenses that you or your family members incur will be covered under this Plan, 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 Plan.

Claims for a course of treatment that was started prior to a person's coverage under the Plan but is completed after the effective date of coverage under the Plan will be evaluated to determine how much of the charge applies to treatment received while covered under the Plan. Only that portion of the charges which are covered under the Plan 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 Plan 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.

In the case of orthodontia treatment a “full” $1,250 benefit allotment will be available, regardless of prior coverage and reimbursements.

NOT COVERED EXPENSES

The following list of **Not Covered Expenses** is not all-inclusive. Other specific expenses may be determined to be not covered under the Plan 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 Plan include, but are not limited to:

1. Charges in excess of the reasonable and customary fees (R&C Excess) as determined by the applicable schedule of the Claims Administrator;
2. Treatment for accidental dental injury which results in a hospital confinement or emergency room treatment (covered by medical Plan);
3. Services rendered to a person prior to the effective date of that person's coverage under the Plan;
4. Services rendered to a person after the termination of the person's coverage, except those services started prior to termination (see *Treatment in Progress on Effective Date of Coverage* sub-heading SPD page 21);
5. Services not specifically included in the Plan;
6. 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 Plan, 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;
7. Services or supplies that are cosmetic in nature, unless a newborn defect, including personalization or characterization of dentures;
8. Harmful habits except bruxism – grinding of teeth;
9. 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 Plans;
10. Fees charged for the completion of a claim form;
11. The replacement of a lost, missing, or stolen prosthetic device;
12. Replacement or repair of an orthodontic appliance;
13. Any duplicate prosthetic device or any other duplicate appliance;
14. 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;
15. Services rendered through a medical department, clinic, or similar facility provided or maintained by a patient's employer;

16. Services or supplies for which no charge is made that the person covered under the Plan is legally obligated to pay or for which no charge would be made in the absence of dental expense coverage;
17. Services or supplies which are not necessary, according to generally accepted standards of dental practice as determined by the Claims Administrator;
18. 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;
19. Expenses for bridges, crowns, and dentures for which impressions were made prior to the effective date of a person's coverage under the Plan even though the installation of such prosthesis may take place after the effective date of the person's coverage;
20. 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 Plan or to replace congenitally missing natural teeth;
21. Services or supplies received as a result of dental disease, defect, or injury resulting from an act of war, declared or undeclared;
22. Treatment of a covered person for an injury or illness resulting from a felony committed by that person;
23. Instructions concerning oral hygiene and diet;
24. A plaque control program (a series of instructions on the care of teeth);
25. Implantology (an implant and the setting of it firmly or deeply into or onto the part of the bone that surrounds and supports the teeth);
26. Appliances or restorations used to alter vertical dimension or restore occlusion;
27. Periodontal splinting;
28. Cast restorations for teeth which are restorable by other means (for example, by amalgam, silicate or composite filling), or for the purpose of periodontal splinting or changes in vertical dimension;
29. 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;
30. Repetition of a periodontal procedure, including scaling and root planing and gingival curettage, in the same area of the mouth within the indicated limits;
31. Services to the extent that coverage for such services is provided under any other group plan except the group Medical Plan to which the Company makes contributions on behalf of employees;
32. Myofunctional therapy;
33. Services caused by attrition and wearing down of teeth; and

34. 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 Plan 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 Plan be utilized before benefits are available under the governmental plan.

CIGNA PREFERRED PROVIDER PROGRAM (PPO)

You have a choice of accessing network dentists under CIGNA's Preferred Provider Program (PPO). The Company Dental Plan provides for access to CIGNA's PPO organization network of dental offices to help you save money for yourself and the Plan. This program is entirely voluntary. The CIGNA Preferred Provider Program provides several cost and quality advantages to you:

- Savings from using network dental offices;
- Dentists whose credentials are verified and whose practice patterns are monitored; and
- Speedy and accurate claims processing.

You can maximize your Plan benefits through the use of preferred dentists. You are not required to use a preferred dentist. The Plan will pay the same percentage for a preferred dentist or a non-preferred dentist. If you choose not to use a preferred dentist, there is no penalty; however you will not receive the benefit of the network discounts. You do not have to select a primary dentist nor do you need an ID card or referrals for specialty care.

Following is more information about the CIGNA's Preferred Provider Program:

Participating Dentists

To participate in the CIGNA PPO, every dentist must meet CIGNA's strict qualification standards under their Quality Management Program. These standards include such things as license review, infection control compliance and 24-hour coverage arrangements. It also includes a review of each prospective PPO dentist's background and malpractice and sanction history. Once dentists begin participation, CIGNA carefully monitors their practice patterns to make sure they remain within acceptable norms, and work with them to develop their practice. All participating dentists are re-credentialed every 2 years.

To find a
Preferred Provider Program
Network dentist, call
1-800-244-6224
or visit the website at
www.mycigna.com

Cost Savings

Participating dentists have contracted with CIGNA for discounted fees. A lower cost results in lower out-of-pocket expense for you, and lower Plan costs for the Company, helping prevent premium increases. Participating dentists also extend lower, negotiated fees on services not covered by the Plan.

EVENTS AFFECTING COVERAGE

Status Change

Because your contributions for coverage are taken on a "pre-tax" basis, tax regulations do not allow you to increase or decrease your level of coverage, terminate coverage, or change your contribution during the year, unless you have a **Status Change** in:

- Your family status; or
- Your or your spouse's employment status.
- To be eligible, the Status Change must affect your (or your family's) eligibility under an Employer's Dental Plan.

An eligible Status Change in your family status includes:

- Marriage;
- Divorce, annulment or legal separation from your spouse ;
- Birth, adoption or placement for adoption of a dependent child;
- Death of a spouse or a dependent child;
- Loss of dependent eligibility;
- Acquiring a dependent who was not eligible for coverage during the previous Annual Election Period and later becomes eligible during a Plan Year;
- You or your dependents lose dental coverage from your spouse's employer through no action on your or your spouse's part, as a result of an eligible status change under that plan, or as a result of an election made during an annual election period under that plan when that plan has a different period of coverage than the Plan Year (January 1 – December 31);
- Court Order resulting from a divorce, legal separation, annulment, or change in legal custody that requires dental coverage for a dependent child;
- Beginning or losing eligibility for you, your spouse, or a dependent child under a group dental insurance plan;
- Any event as determined by the Plan Administrator which is not inconsistent with laws and regulations applicable to the Plan.

An eligible Status Change in employment status includes:

- A Company authorized transfer requiring a change in your work location or relocation of your residence;
- The employment or unemployment of you, your spouse, or a dependent child;
- You, your spouse or a dependent child changes residence or worksite; or

- You, your spouse or a dependent child changes work schedule (i.e. a reduction or increase in hours, a switch between part time and full-time, strike or lockout, commencement or return from unpaid leave of absence).

In addition to those above, losing eligibility for you, your spouse, or a dependent child because of attaining age 65 will be considered an eligible Status Change. An eligible Status Change allows you to make a change in your level of coverage. If your change does not meet the Status Change criteria above, you cannot change or terminate your coverage under the Plan for the remainder of the Plan Year. You must wait until the next Annual Election Period.

If you have waived coverage under the Plan and have an eligible Status Change during the Plan Year, you may apply for coverage under the Plan for yourself and your dependent, in accordance with the Status Change rules.

Changes in your benefit coverage on any date other than January 1 will only be permitted if the change is consistent with the eligible Status Change and applies to the specific person or situation affected by the Status Change.

Example: Eligible Status Change
During the Annual Election Period, James, an unmarried employee with two dependent children, elects "Employee and Child(ren)" coverage for himself and his two children. During the following Plan Year, he marries and decides to add his wife to his coverage. James can change his level of coverage to "Employee and Family" during the Plan Year within 31 days after his marriage.

Example: Ineligible Status Change
During the Annual Election Period, Shelly elects "Employee and Family" coverage. During the following year, she wants to cancel her dependent coverage to reduce expenses although she still has eligible dependents. Because this is not an eligible Status Change, Shelly cannot change her election until the next Annual Election Period.

If you have an eligible Status Change, you may request to change your coverage only if you contact the Benefits HelpLine at 1-888-443-5707 within 31 days after the Status Change. The change becomes effective on the date of the event.

Any change in your required contributions to the Plan resulting from the addition or dropping of a dependent will be applied as follows:

Change occurs:	**1st day of month**	**2nd – 16th**	**From 17th through last day of month**
Change in contributions begin	first pay period for that month	second pay period for that month	first pay period of following month

Absences

During any Company-approved absence with full or part pay, your contributions will continue to be deducted from your paycheck, and your dental coverage will remain in force. You are eligible to continue coverage under the Plan as long as you continue to be an eligible employee and are receiving a check from the Company; or as long as you continue to be an eligible employee and your status falls into one of the categories listed below:

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

Your coverage will continue if you make any required contributions within the 30-day grace period unless you qualify for waiver of contributions as explained below. You must notify the Benefits HelpLine at 1-888-443-5707 if you wish to waive coverage.

Payment of Contributions While on Leave

If payments are not made within the 30-day grace period, coverage may be terminated once final written notice has been given. If you are on FMLA or military leave you will be notified in writing at least 15 days before the date the coverage will terminate. Also, if you do not return to employment when your leave of absence expires, your coverage will terminate on the last day of the month in which the leave expires, provided the required contributions have been made.

If you lose coverage under the Plan, you may be eligible to receive COBRA continuation of coverage in certain situations. See *COBRA Continuation Coverages* (page 31) for more details.

Waiver of Contributions While on Leave

You may be eligible for a waiver of contributions for your dental benefits 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.

Reinstatement of Coverage

Absence Due to Leave of Absence or Disability - If coverage is terminated due to non-payment of required contributions during your leave or absence due to disability and you return to active employment, you will be eligible to enroll during the next Annual Election Period.

Absence Due to Family Medical Leave (FMLA), or Military Leave - If coverage is terminated during your leave for any reason and you return to active employment, you will be entitled to reinstate the dental coverage you had prior to your leave. 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 Plan.

Coverage will be effective on the date you return to active employment. You will only be eligible for benefits that you would have had if you had not been absent on a leave. If the Plan has changed during your leave, you will be entitled to the coverage that is applicable.

Termination of Coverage

Unless you are eligible to continue coverage as explained under the major heading *Continuation of Coverage* on page 31, your coverage under the Plan will terminate at the end of the month in which the earliest of the following occurs:

- You cease to be an employee meeting the eligibility requirements;
- You terminate employment for any reason and are not eligible to continue coverage as a retiree;
- You become eligible for other dental care coverage to which the Company makes contributions on behalf of employees (i.e., the salaried dental plan);
- You elect to waive coverage during Annual Election or with an eligible Status Change;
- The Plan terminates; or
- Contributions fail to be made in a timely manner.

If you have dependent coverage under the Plan, the coverage for your dependent(s) will terminate at the same time your coverage under the Plan terminates. In addition, your dependent's coverage will also terminate at the end of the month in which the dependent no longer meets the eligibility requirements.

Coverage can be terminated for failure to pay any required contribution once final written notice has been given. **If you are a covered retiree, and your coverage is cancelled**

due to non-payment, you will not be eligible to re-enroll in retiree dental at a later date.

If you are rehired, however, then you may re-enroll while you are an active employee at the next Annual Election. When you retire again, you will not be eligible for coverage as a retiree due to your previous cancellation due to non-payment.

CONTINUATION OF COVERAGE

Upon Retirement

Upon your retirement you may be eligible for continued dental coverage. Please refer to the section entitled *Eligibility-Retired Employees* page 5 for further information.

If you are not eligible for retiree dental, you and your dependents' dental coverage will terminate at the end of the month in which you retire. At that time, you can continue coverage under COBRA.

COBRA Continuation Coverage

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (known as "COBRA"), you and your covered dependents may extend your present dental coverage if it is lost due to certain "qualifying events."

The following chart describes the COBRA qualifying event for you and your covered dependents:

	Qualifying Event
You, the employee	• Termination of employment, except for gross misconduct • Reduction in hours resulting in loss of coverage
You, the retiree	• A bankruptcy proceeding in a case under Title 11 of the United States Code with respect to the Company.
Eligible dependents	• Termination of your employment, other than for gross misconduct • Reduction in your hours worked that results in loss of coverage • Your death • Your divorce or legal separation, • Your dependent child's eligibility for coverage ends, or • A bankruptcy proceeding in a Title 11 case is commenced with respect to the Company.

If you and/or your covered dependents lose coverage under the Plan as a result of one of these qualifying events, you and/or your covered dependents will be eligible to elect

COBRA continuation coverage. In the case 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 bankruptcy proceeding commences.

In addition to the qualifying events previously described, you, your spouse or your dependent(s) may have a COBRA qualifying event if all of the following conditions are met:

1. You, your spouse or dependent(s) is covered under the Plan on the day before the first day of a leave of absence under the Family and Medical Leave Act of 1993 (FMLA leave) or becomes covered under the Plan during the FMLA leave;
2. You do not return to employment with the Company at the end of the FMLA leave; and
3. You, your spouse or dependent would, in the absence of COBRA continuation coverage, lose coverage under the Plan before the end of what would be the maximum coverage period.

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

The maximum coverage period is measured from the last day of the FMLA leave unless coverage is lost at a later date, in which case the maximum coverage period is measured from the date the coverage is actually lost.

Continued Coverage

Depending on the qualifying event, coverage may continue for up to **18, 29 or 36 months** from the date coverage would otherwise end. Continuation coverage will be identical to the coverage provided to active employees. You will have the same rights as an active participant, including the right to enroll eligible dependents. In addition, evidence of insurability is not required in order to continue coverage.

COBRA Qualifying Event	How Long Coverage May Continue	
	You	**Dependents**
You terminate employment (except for gross misconduct)	18 months (may be extended an additional 11 months – if you or your dependents are determined under the Social Security Act to be disabled at any time within the first 60 days of continuation coverage and the applicable notice requirements are satisfied.	18 months (may be extended an additional 11 months – if you or your dependents are determined under the Social Security Act to be disabled at any time within the first 60 days of continuation coverage and the applicable notice requirements are satisfied.
Your hours are reduced, resulting in a loss of coverage	18 months (may be extended an additional 11 months – if you or your dependents are determined under the Social Security Act to be disabled at any time within the first 60 days of continuation coverage and the applicable notice requirements are satisfied.	18 months (may be extended an additional 11 months – if you or your dependents are determined under the Social Security Act to be disabled at any time within the first 60 days of continuation coverage and the applicable notice requirements are satisfied.
You die	N/A	36 months
You and your spouse divorce or legally separate	N/A	36 months
Your child is no longer eligible	N/A	36 months

Second Qualifying Events

Your total coverage under COBRA is limited to 36 months from the date of the first qualifying event. You may be eligible for an additional period of coverage (within the 18-month period) if a second qualifying event occurs while you are receiving continued coverage under COBRA. You must notify the Benefits HelpLine at 1-888-443-5707 within 60 days after the second qualifying event.

Notification

If you or a covered spouse or dependent loses coverage under this Plan due to **divorce, legal separation, or loss of dependent eligibility,** it is your responsibility to notify the Benefits HelpLine within 60 days of the qualifying event or within 60 days of the date benefits would be lost as a result of the qualifying event. If the notice is sent to the Benefits HelpLine more than 60 days after the later of the date of one of the qualifying

events described above or the date of loss of coverage because of the qualifying event, you may not be entitled to elect COBRA continuation coverage. The Plan Administrator is already notified if the event that causes loss of coverage is your death, termination, reduction in hours or bankruptcy proceedings.

Enrollment

The Company has retained Ceridian's COBRA Services (CobraServ) for the administration of COBRA. The Plan Administrator will notify CobraServ when a qualifying event has occurred and CobraServ will send a package of information to the individual(s) who are entitled to continuation coverage that explains the right to continue coverage and includes plan costs and an election agreement. The materials will include instructions on how to elect COBRA. You must comply with these instructions in order to elect continuation coverage.

You will have 60 days from the date that benefits were lost as a result of a qualifying event (or the date you are notified of your right to extend these benefits, if later) to inform the Benefits HelpLine that you want COBRA continuation coverage. Each eligible dependent may independently elect COBRA coverage. You or your spouse, however, may elect COBRA coverage on behalf of all the eligible dependents. 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 dependent(s) meet all of the other conditions for continuation of coverage and the required contributions are paid on a timely basis.

If you have any questions about the election materials or COBRA rules and regulations, call:

Ceridian's COBRA Services
(CobraServ)
1-800-877-7994

You and your dependents may participate in the Annual Election Period each year to the extent you and/or your dependent(s) remain eligible for COBRA continuation.

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

Disability

You and your dependents may be eligible to extend your COBRA coverage an additional 11 months from the original 18-monthCOBRA period, if you or your dependent qualifies for disability 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 of continuation coverage. To receive this extension, notice of the determination of disability under the Social Security Act must be provided in writing to CobraServ within 60 days of the date of the Social Security Administration's award notice, but before the end of the original 18-month period of COBRA coverage. The 11-month extension will continue so long as you or your dependent remains eligible for disability benefits under the Social Security Act, but not for more than 29 months of coverage from the date of the qualifying event.

If you and/or your dependent(s) are enrolled in COBRA continuation coverage and are determined to be disabled under the Social Security Act, you should contact CobraServ immediately or read the back of any invoice for additional information and instructions on the requirements for extension of coverage.

If you receive a determination from the Social Security Administration that you or your dependent is no longer considered disabled, you must notify CobraServ within 30 days of this determination. If the date of 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,

Cost of Coverage

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

If you or your dependent is receiving an additional 11 months of COBRA coverage because of disability (see the previous heading - *Disability*), the cost for each of those additional 11 months is 150% of the full monthly cost.

The required contribution or premium must be paid on a timely basis. Generally, payments are timely if they are paid within 30 days after the due date. However, no payment of contributions or premiums may be required until 45 days after the date of your election of COBRA continuation coverage. Your coverage is not reinstated until CobraServ receives your first payment. The first payment made is generally applied to the COBRA continuation coverage period beginning immediately after the date coverage is lost or the period beginning with the effective date of your COBRA continuation coverage, if later. If COBRA is elected, CobraServ will send monthly invoices with the cost and date payment is due.

Termination of COBRA Coverage

Extended coverage under COBRA cannot be terminated before the end of the applicable **18th-, 29th- or 36th-month**, unless:

(1) You or your dependent fails to pay the required contributions when due;

(2) You or your dependent becomes covered under a group dental plan of another employer. However, if the other employer's dental plan contains an exclusion or limitation with respect to any pre-existing condition, you or your covered dependent may continue COBRA coverage under the Plan to cover the exclusion or pre-existing condition only;

(3) The Company terminates dental coverage for all its active and/or retired employees; or

(4) In the case of extended coverage due to disability, the disabled individual ceases being disabled under the Social Security Act.

Eligibility for Reservists Called to Active Duty

In the event that you are a reservist in the Armed Forces of the United States and are called up to active duty and coverage for you and your dependents is not otherwise continued under the Plan, a qualifying event will occur and COBRA continuation coverage will be available for you and your dependents. You should contact the Benefits HelpLine if you have any questions concerning this situation.

Other Continuation of Coverage

In addition to the option to extend benefits under the provisions of COBRA, certain extensions of benefits are available due to an employee's or retiree's death.

Eligible Dependents of Deceased Active Employees not Eligible for Retiree Coverage

If you die as an active employee and you are not eligible for retiree coverage under the Plan, your dependents may continue coverage under the Plan **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;
- The end of the month following the date that your spouse remarries;
- The end of the month following the date that your dependent loses eligibility under the Plan; or
- The end of the month following the date coverage under the Plan terminates due to failure to make required contributions in a timely manner.

The above continuation of coverage will be offset with COBRA continuation coverage.

Eligible Dependents of Deceased Active Employees Eligible for Retiree Coverage or Deceased Retired Employees

If you die as an active employee and you are eligible for retiree coverage under the Plan or you die as an eligible retiree, your dependents may continue coverage under the Plan **until the earlier of:**

- The end of the month following the date that your spouse remarries;
- The end of the month following the date that your dependent loses eligibility under the Plan; or
- The end of the month following the date coverage under the Plan terminates due to failure to make required contributions in a timely manner.

Qualified Medical Child Support Orders (QMCSO's)

If you are getting divorced or legally separated, coverage for your dependent 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 dental coverage for your eligible children, regardless of whether:

(1) They are currently covered under the Plan,

(2) They are dependent on you for financial support, or

(3) You have legal custody of the children.

A medical child support order is any judgment, decree, order, or court-approved settlement agreement that:

1. Provides for child support or dental benefit coverage with respect to a child, is issued pursuant to a state domestic relations law, and relates to benefits under a group dental plan; or
2. Is issued pursuant to a law relating to medical child support with respect to a group dental plan.

However, the Plan Administrator is not required to comply with the order unless the order is a *Qualified Medical Child Support Order (QMCSO).*

A QMCSO is a medical child support order that creates or recognizes the right of a child (alternate recipient) to be covered under your Company-sponsored group dental care plan to the extent he or she would otherwise be eligible for participation under the provisions of the Plan. If the child is not already covered under the Plan, you will be allowed to enroll the child in the Plan as directed under the QMCSO, and the Plan's late enrollment provisions will not apply. Enrollment of this type is considered an eligible Status Change.

A QMCSO must meet specific legal requirements, as outlined in the Plan's written procedures for QMCSO's. A copy of these procedures is available upon request from the Benefits HelpLine, free of charge.

If you are going through a divorce or separation, you should ask your attorney to obtain a copy of the Plan's QMCSO procedures, which can be helpful in drafting the order. Your attorney should also send a draft of your proposed medical child support order to the Plan Administrator for review, before it is approved by the state court. This way, you will know in advance whether the order meets the requirements for a QMCSO and will avoid having to go back to the court later to amend the order.

Don't forget to send a final copy of the court-approved QMCSO to the Plan Administrator. Coverage of the child will begin as soon as administratively possible after receipt and approval of the QMCSO. Coverage cannot be effective retroactive to receipt of the QMCSO.

Once the Plan Administrator determines that an order is qualified, the Plan Administrator will take whatever actions are required to comply with the QMCSO.

Under current law, a QMCSO cannot require the Plan to pay a greater benefit than the benefit that would otherwise be paid from the Plan if no QMCSO existed. However, current law requires benefits to be paid directly to the child or the child's custodial parent or legal guardian, instead of to the Plan participant (you), who normally is the only family member entitled to payment of Plan benefits.

ASSIGNMENT OF BENEFITS

Benefits payable under the Dental Plan may not be assigned, other than to a service provider or the Company, subject to applicable law.

CLAIMS PROCEDURES

When to Submit Claims

Whenever you have dental expenses, your provider may file a claim for your benefits on your behalf. However, you are responsible for meeting the annual deductible and for paying your covered percentage at the time of service, or when you receive a bill from the provider. If you have met your annual deductible and paid your coverage percentage and still receive a bill from your provider, contact the Claims Administrator.

If your provider does not file your claim, you should file the claim yourself in a format that contains all of the information required, as described below.

Claims must be submitted for payment of benefits within two years after the date of service. If you don't provide this information within **two years** of the date of service, benefits for that dental service will not be considered for payment under the Plan.

Where to Submit Claims

Claims for dental services should be sent to:

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CIGNA Dental
P.O. Box 188037
Chattanooga, TN 37422-8037

With the following information:
Group number 3328457

Filing Initial Claims for Dental Benefits

When filing for dental benefits under the Plan, failure to submit a properly completed claim form will delay the processing of the claim while the necessary information is obtained. Therefore, you should read the instructions on the claim form carefully and make sure all of the requested information is filled in completely and accurately.

When submitting a dental claim form, you should attach all itemized bills for dental expenses. All dental bills sent to Claims Administrator should include the following information:

1. Name of the employee or retiree and address.
2. The patient's name, date of birth and relationship to the employee/retiree.

3. The group number.
4. The name and address of the provider of the service(s).
5. A diagnosis or procedure from the dentist.
6. An itemized bill from your provider that includes the Current Procedural Terminology (CPT) codes or a description of each charge.
7. Dates of Service.
8. A statement indicating either that you are, or you are not, enrolled for coverage under any other dental insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

You may obtain the necessary claim forms online through the CITGO intranet or at http://www.hr.CITGO.com or by phone through the Benefits HelpLine at1-888-443-5707. You must sign any release form required in order for benefits to be paid.

You should keep photocopies of each claim submitted for each of your covered dependents, as well as for yourself, so you can keep track of your reimbursements. If a claim is lost, simply submit a copy of the claim and write "Duplicate" on the front of your submission.

Payment of Claims

Regardless of whether your claim for benefits covers expenses incurred by you or one of your dependents, payment of the claim will be made directly to you, the active employee or retiree. The payment may be made to an alternate payee through a QMCSO, or to the provider because the provider notified the Claims Administrator your signature is on file, assigning benefits directly to that provider.

If you have any questions about your claim for dental charges, please call CIGNA's customer service:

Dental Claims
To contact CIGNA Customer Service, call toll-free:

1-800-244-6224

Customer Service representatives are available to take your call during regular business hours, Monday through Friday 8:00 a.m. to 6:00 p.m. EST.

Benefit Determinations

Within 30 days following receipt of a claim, the Claims Administrator will either:

- Pay all benefits payable,
- Deny the claim in whole or in part, or
- Request additional information.

The 30 day period may be extended one time for up to 15 days, provided that the extension is necessary due to matters beyond the control of the Claims Administrator and you are notified, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to render a decision. If the extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension shall describe the required information, and you shall have at least 45 days from receipt of the notice to provide the specified information.

After your claim has been processed, you will receive an *Explanation of Benefits* (EOB) statement.

The EOB shows all the charges that were submitted, what charges the Plan covered, and the amount that was actually paid. It also provides you with an explanation of how the benefit amounts were determined and the amount of payment, if any, you are responsible for paying.

How to Appeal a Claim Decision

In the event the claim is denied, the Claims Administrator will notify you of the reason for denial and provide the claim appeal procedures. If you have questions about the denial you can call Customer Service. If you disagree with the claim determination after talking with a Customer Service representative, you can ask the Claim Administrator to formally reconsider your claim.

If the appeal relates to a claim for payment, your request should include:

- The patient's name and the identification number.
- The date(s) of dental service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any new information to support your request for claim payment.

Your appeal review request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

Appeal Process

The Claims Administrator will appoint a qualified individual to resolve or recommend the resolution of the appeal. This individual will not be the person who made the initial denial that is the subject of the appeal, nor the subordinate of the individual. If your complaint is related to clinical matters, the review will be done by a dental care professional who was not involved in the initial determination with appropriate expertise in the field. The Claims Administrator may consult with, or seek the participation of,

dental experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent dental claim information.

Appeals Determinations

The Claims Administrator will send you written or electronic notification of its decision on claims within 30 days of the receipt of the claimant's request for review of the denial.

If the Claims Administrator denies your appeal and you are still not satisfied with this decision, you have the right to take your appeal to the Plan Administrator within 180 days of receipt of the denial.

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

The Plan Administrator will review the facts of the case and will have the discretionary authority to make a final and conclusive determination of the claim. The Plan Administrator may consult with a dental care professional who has appropriate training and experience in the field involved in the judgment. The dental care professional will not be the individual who was involved in the denial of the first appeal. The Plan Administrator has the exclusive right to interpret and administer the Plan, and these decisions are conclusive and binding. Please note that the Plan Administrator's decision is based only on whether or not benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending dental service is necessary or appropriate is between you and your dentist.

The Plan Administrator's determination will be issued in writing within 30 days after receipt of your second and final written appeal.

Legal Actions

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

Coordination of Benefits (COB)

Many times, because both husband and wife are working or due to divorce or remarriage, members of a family may be covered under more than one group dental plan. In these situations, it's necessary to determine which plan has primary responsibility for the payment of benefits.

When COB Is Applicable

The benefits payable under the Plan are coordinated with benefits payable under other group dental plans not sponsored by the Company. "Other plans" are those which provide benefits or services in connection with dental care or treatment for which an employer pays all or part of this cost or for which an employer makes payroll deductions. This includes any government-sponsored plan, including Medicare and Medicaid.

The COB provision applies only where group dental plans are involved. It does not apply to benefits payable under any private dental insurance plans you or your dependents may have, nor does it apply to benefits payable under any other group insurance or dental care plan maintained by the Company.

The COB provision is applied whenever an individual who is covered under more than one group plan incurs an expense that is covered, partially or in full, under at least one of the plans. Benefits, related to that expense, will be paid with respect to the individual's coverage under the primary and secondary plans as determined under the COB provision. Under no circumstances will the sum of the benefits paid from each plan exceed the actual expense incurred.

What Happens When COB Is Applied

When an individual is covered under more than one group dental plan, one plan is determined to be the Primary Plan and the others are considered Secondary Plans. The Primary Plan pays benefits first and without consideration of the other plans. The Secondary Plans then consider the difference up to the total allowable expenses incurred.

No plan will pay more than it would have paid without this provision. In order to pay claims, the Claims Administrator must find out which plan is Primary and which plans are Secondary.

Determination of Primary Plan

If your spouse is covered under the Plan but is also covered under another group plan, your spouse's group plan will always be the Primary Plan for your spouse. Otherwise, generally, the Plan is the Primary Plan if:

- The expenses are for you, the Company employee,
- 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 person who may also be covering the child as a dependent under a group plan (known as the Birthday Rule), or
- The expenses are for your child, and you are separated or divorced, with custody of the child; or a court decree or Qualified Medical Child Support Order has established you as financially responsible for the child's dental expenses.

In order to avoid delays in claims processing, your claims should be submitted to the Primary Plan as soon as possible. You will have to give information about any other plans under which you are covered when you file your claim. After you receive an EOB from the Primary Plan, submit a copy of this statement along with an itemized statement of expenses, plus a claim form, if necessary, to the Secondary Plan for benefits consideration.

Rights of Recovery

Overpayment of Benefits

If you receive an overpayment of benefits under the Plan, you will be required to return the overpayment to the Claims Administrator.

Subrogation

If you or a covered dependent suffers an injury, illness or disability under circumstances which impose a legal obligation on a third party to pay the expenses of the treatment as damages, the Plan reserves the right to have the benefit payments made by the Plan reimbursed by the third party. By exercising its right of subrogation, the Plan will become a creditor in the action against the third party. "Subrogation" means the substitution of one person in the place of another regarding a legal claim or right.

By accepting payment of Plan benefits, you or your dependent(s) agree to execute and deliver any requested documents which secure this right, and you further agree not to execute any release or other document which will prejudice these rights.

ADMINISTRATION

The Company has entered into an Administrative Services Only (ASO) Agreement with the Claims Administrator. The Claims Administrator makes all payments of benefits under the terms of the Plan. The Claims Administrator does not insure the benefits described in this summary.

The Plan Administrator is responsible for the administration of the Plan and has final discretionary authority to interpret the Plan's provisions, to resolve ambiguities in the Plan and to determine all questions relating to the Plan, including eligibility for benefits. The decisions of the Plan Administrator will be final, conclusive and binding on all persons with respect to all issues and questions relating to the Plan. The Company's determination will be conclusive regarding rates of pay, periods of absence with or without full or part pay, length and continuity of service, and termination of employment.

The Plan 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.

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

COST/FUNDING

The Plan is a self-insured welfare benefit plan. This means that claims are not paid through insurance, purchased from an insurance company. Contributions made by the Company and the Plan participants are used to pay participant claims plus the operating expenses of the Plan. The primary reason the Company adopted this self-insured arrangement was to reduce Plan costs to you by avoiding certain costs associated with typical insurance plans, such as risk charges and insurance taxes.

The Plan Administrator, on behalf of the Plan, has contracted with CIGNA to act as the Claims Administrator - to process claims under the Plan and provide certain other administrative services. CIGNA, as the Claims Administrator, has no incentive to deny or delay claims – they are simply reimbursed for claims that are paid. The Claims Administrator is paid a fee out of Plan contributions to provide these services.

Each year, the Plan's financial experience is reviewed on the basis of total contributions paid into the Plan compared to paid claims plus operating expenses at the Plan.

Based on an actuarial analysis of Plan experience and projections of future dental costs, the Company will determine whether contribution rates should be adjusted. Normally, any change in contributions will become effective on January 1.

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 actuarially determined contributions by participants and the Company. Contributions to the Plan are held in the CITGO Employees' Benefit Trust. 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. 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.

Company Contributions

The Company currently contributes an amount each month toward the required contribution for eligible participants who are in active employment. The Company's contribution will be reviewed periodically and any increase or decrease will be based on several factors, including the Company's ability to continue making contributions. The Company does not calculate any Company contribution towards the required contribution for eligible retirees.

The Company's contributions are voluntary payments. The Company reserves the right to withhold or discontinue these contributions at any time.

The Company intends that the Plan qualify as a "cafeteria plan" under section 125 of the Internal Revenue Code of 1986, as amended, and that the coverage option that an employee elects under the Plan be eligible for exclusion from the employee's income for federal income tax purposes. Therefore, active employee contributions to the Plan will be made on a pre-tax basis.

Participant Contributions

All Plan participants are required to share in the cost of the Plan.

Contribution rate announcements are published annually during the Plan's Annual Election Period.

The contribution will be equally divided and deducted on a pre-tax basis from your normal semi-monthly payroll checks. If you are on a leave of absence without pay or otherwise not receiving payroll compensation from the Company, please see the section titled *Absences* on page 28.

"Pre-tax basis" means an amount equal to your monthly contribution will be deducted from your pay before taxes. After this amount has been deducted from your pay, taxes are withheld only on the remainder of your pay. You are not required to pay federal income tax and, in most cases, state and local taxes on the amount of this deduction. In addition you will pay less FICA Hospital Insurance taxes, and if you are earning less than the maximum taxable wage base for Old Age and Survivors Disability Insurance ("OASDI") Social Security, you will also pay less OASDI Social Security taxes.

Retirees will be billed monthly for their contribution amount. You may set up the contribution to be electronically transferred from your checking or savings account. Retirees may only contribute towards the cost of their coverage on an after-tax basis.

If you drop your dependent(s) coverage within 31 days of the loss of eligibility which results in a reduction in your level of coverage, you will be entitled to a refund. If you

fail to drop coverage for your dependent within 31 days of the loss of eligibility, you will not be entitled to a refund of contributions. Further, the Claims Administrator will require reimbursement for any expenses paid after the retroactive loss of coverage date.

Future of The Plan

The Plan is a voluntary plan. It is the Company's intention to continue to provide these benefits to participants of this Plan. However, the Company reserves the right to amend, modify, or terminate this Plan, in whole or in part, at any time and for any reason, including but not limited to discontinuing Company contributions and/or retiree benefits. Such actions will be effective as of any date designated by the Company.

Changes to the Plan, if any, will be applied to all Plan participants as of the effective date of the change.

ADDITIONAL INFORMATION

As a participant or beneficiary under this Plan you have certain rights and protections as more fully described within the Statement of ERISA Rights on page 51. Other important information about the Plan is provided below:

Plan:	Dental provisions of the Medical, Dental, Vision and Life Insurance Program for Hourly Employees of CITGO Petroleum Corporation
Type of Plan:	Self-Insured Welfare Plan
Plan Sponsor:	CITGO Petroleum Corporation 1293 Eldridge Parkway Houston, Texas 77077
Plan Sponsor's Employer Identification No.:	73-1173881
Plan Administrator:	Benefit Plans Committee - Secretary CITGO Petroleum Corporation One Warren Place 6100 South Yale Tulsa, OK 74136 OR Benefit Plans Committee CITGO Petroleum Corporation 1293 Eldridge Parkway Houston, Texas 77077
Plan Number:	518
Plan's Effective Date:	January 1, 1984
Plan Year:	January 1 – December 31
Funding Method:	Funded by Employer and Employee, Retiree, and Surviving Spouse contributions under an Administrative Services Only (ASO) agreement with the Claims Administrator
Claims Administrator:	CIGNA P.O. Box 188037 Chattanooga, TN 37422-8037 CIGNA Customer Service 1-800-244-6224

Participating Provider Program (PPO)
1-800-244-6224

www.mycigna.com

Group Number: 3328457

COBRA Administrator: Ceridian's COBRA Services (CobraServ)
1-800-877-7994

Benefits HelpLine: 1-888-443-5707
Email Benefits @citgo.com

Benefits Department: The Benefits Department can be contacted as follows:

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

Telephone: 1-888-443-5707

Statement of ERISA Rights

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

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

Receive Information About Your Plan and Benefits

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

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

HIPAA - Health Insurance Portability and Accountability Act of 1996

This section applies to HIPAA and the regulations issued thereunder as set forth in 45 C.F.R. Parts 160, 162 and 164, as amended, (HIPAA Regulations).

Definitions

For purposes of this section, words and phrases not otherwise defined herein which are defined in the HIPAA Regulations shall have the meanings assigned therein when used herein. In the event of a conflict between the meaning of a word or phrase used herein with the definition given thereto in the Plan, the meaning given in this amendment shall control.

The Use and Disclosure of Protected Health Information.

Effective April 14, 2003, the Plan will use and disclose protected health information without an authorization from the individual only to the extent of and in accordance with the uses and disclosures permitted by HIPAA and the HIPAA Regulations, including the following uses and disclosures:

(1) Health care payment: For this purpose, health care payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of benefits under the Plan or to obtain or to provide reimbursement for the provisions of health care that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

(a) determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of benefit claims;

(b) risk adjusting amounts due based on enrollee health status and demographic characteristics;

(c) billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss coverage), and related health care data processing;

(d) review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;

(e) utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and

(f) disclosures to consumer reporting agencies of any of the following protected health information relating to collection or premiums or reimbursement: name and address, date of birth, social security number, payment history, account number, and name and address of health care provider and/or health plan.

(2) Health care operations: For this purpose, health care operations include, but are not limited to, the following activities:

(a) conducting quality assessment and improvement activities, including outcomes and evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities;

(b) conducting population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions that do not include treatment;

(c) reviewing the competence or qualifications of health care professionals, evaluation practitioner and provider performance, health plan performance, conducting training programs which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-healthcare professionals, accreditation, certification, licensing, or credentialing activities;

(d) underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance

of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance) provided certain requirements are met if applicable;

(e) conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance review programs;

(f) business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies; and

(g) business management and general administrative activities of the Plan, including, but not limited to:

(i) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements;

(ii) customer service, including the provision of data analyses for policyholders, plan sponsors or other customers, provided the protected health information is not disclosed to such policy holder, plan sponsor, or customer;

(iii) resolution of internal grievances;

(iv) the sale, transfer, merger or consolidation of all or part of the Plan with another Plan, or an entity that following such activity will become a covered entity and due diligence related to such activity; and or transfer of assets to a potential successor in interest; and

(v) consistent with the applicable requirements of 45 C.F.R. § 164.514, creating de-identified health information or a limited data set, and fundraising for the benefit of the Plan.

(3) Treatment: For this purpose, treatment means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

Disclosure to the Plan Sponsor.

(1) The Plan will disclose protected health information to the plan sponsor only upon receipt of a certification from the plan sponsor that the Plan documents have been amended to incorporate Sections D and E below. However, the Plan may disclose summary health information to the plan sponsor if the plan sponsor requests the summary health information for the purpose of obtaining premium bids from health plans for providing health insurance coverage under the Plan or modifying, amending or terminating the Plan. In addition, the Plan may disclose to the plan sponsor information on whether the individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

(2) The Plan participates in an organized health care arrangement with the following plan sponsored by the plan sponsor:

The CITGO Petroleum Corporation Medical, Dental, Vision and Life Insurance Program for Salaried Employees

Accordingly, the Plan and such plan may exchange protected health information for treatment, payment and health care operations purposes of such organized health care arrangement.

Additional Agreements of Plan Sponsor.

With respect to protected health information, the plan sponsor further agrees to:

(1) not use or further disclose the information other than as permitted or required by the plan document or as required by law;

(2) ensure that any agents, including a subcontractor, to whom the plan sponsor provides protected health information received from the Plan agree to the same restrictions and conditions that apply to the plan sponsor with respect to such information;

(3) not use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor unless authorized by an individual;

(4) report to the Plan any protected health information use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(5) make available protected health information to an individual in accordance with HIPAA's access requirements and 45 C.F.R. § 164.524;

(6) make available protected health information for amendment and incorporate any amendments to protected health information in accordance with HIPAA and 45 C.F.R. § 164.526;

(7) make available the information required to provide an accounting of disclosures in accordance with HIPAA and 45 C.F.R. § 164.528;

(8) make its internal practices, books and records relating to the use and disclosure of protected health information received from Plan available to the Secretary of the Department of Health and Human Services for the purposes of determining the Plan's compliance with HIPAA;

(9) if feasible, return or destroy all protected health information received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction not feasible; and

(10) ensure that adequate separation between the Plan and plan sponsor (as described below) is established.

(11) Effective April 20, 2005, implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives, maintains or transmits on behalf of the Plan (except with respect to enrollment or disenrollment information, summary health information or protected health information disclosed pursuant to an authorization under 45 C.F.R. § 164.508) and shall ensure that any agents (including subcontractors) to whom it provides such electronic protected health information agree to implement reasonable and appropriate security measures to protect such information; and

(12) Effective April 20, 2005, report to the Plan any security incident of which it becomes aware.

Adequate Separation between the Plan and the Plan Sponsor

In accordance with HIPAA and the HIPAA Regulations, only the following employees or classes of employees or other persons may be given access to protected health information to be disclosed:

(1) Plan Administrator;

(2) Human Resources employees within the Benefits Group;

(3) Human Resources employees with responsibility for investigating appeals and recommending decisions to the Plan Administrator;

(4) Human Resources employees with access to the data which is stored electronically;

(5) Employees within the Information Technology ("IT") Group which maintain the servers on which some protected health information may be stored or those IT employees who have access to systems such as email and voicemail;

(6) Employees in the area of Benefits Accounting;

(7) Employees in the Internal Audit Department; and

(8) In-house legal counsel.

The persons identified in this sub-section may only have access to and use and disclose protected health information for Plan administration functions that the plan sponsor performs for the Plan. If the persons identified in this Section E do not comply with the restrictions set forth in this Plan document and otherwise under HIPAA and the HIPAA Regulations, the plan sponsor shall respond to such noncompliance in accordance with the requirements of applicable law and the plan sponsor's policies, including as appropriate, the imposition of disciplinary sanctions. The plan sponsor will ensure that the provisions of this Section are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic protected health information.

Consistency with HIPAA and HIPAA Regulation

In the event any amendment of HIPAA or the HIPAA Regulations is adopted which renders any provision of this amendment inconsistent therewith, this amendment shall be deemed amended to be consistent therewith.

Other Uses and Disclosures of Health Information.

In addition to the above uses and disclosures, the Plan Sponsor may use and disclose protected health information to the fullest extent permitted under HIPAA or the HIPAA Regulations.

DEFINITIONS

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

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

"**Authorized Company Representative**" includes your Human Resources or Personnel representative as well as appropriate members of the CITGO Benefits Planning and Administration Department in Tulsa, Oklahoma and Houston, Texas.

"Benefits HelpLine" is a resource you may contact for assistance with any benefits related issues. The Benefits HelpLine is available toll free at 1-888-443-5707 or by email to Benefits@citgo.com.

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

"Family" when used to describe coverage options means the employee/retiree, an eligible spouse and at least one eligible child.

"Full-Time Student" means an eligible dependent child (under age 25) who is determined by an accredited university to be registered full-time and who is fully dependent on you for support.

"Panorex" means a full mouth series of X-Rays.

"Primary Plan or Payor" is the plan that considers eligible expenses before any other group plan.

"R&C Excess" means you pay 100% of any excess amount above the reasonable and customary (R&C) charges for non-network providers. The R&C charge for a service or supply is the lower of the provider's usual charge or the prevailing charge in the geographic area where it is furnished – as determined by the Claims Administrator. See page 15 for more information on reasonable and customary charges.

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

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

“Secondary Plan” is the plan that considers eligible expenses after another group plan.

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

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