

**CITGO Petroleum Corporation
Long Term Care Insurance Program
for Salaried and Hourly Employees**

Summary Plan Description
as in effect January 1, 2006

The Summary Plan Description (SPD), including announcement letters issued subsequent to the publication date, and the Long Term Care Insurance Contract between the Company and the Insurer are the governing Plan Documents. In the event of a discrepancy between this Summary Plan Description and the actual insurance contract, the insurance contract will control.

LONG TERM CARE INSURANCE PLAN

HIGHLIGHTS

Eligibility	Regular Full-Time and Regular Part-Time Employees and eligible Retirees
Enrollment	Anytime
Cost/Funding	Paid in full by the Participant
Benefits	Provides Long Term Care benefits to assist with the expenses associated with a Nursing Home or other extended custodial services.

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PURPOSE

The Long Term Care Insurance Plan (“Plan”) is designed to provide coverage for necessary or medically necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community, or in the home via a plan of care prescribed by a licensed health care practitioner.

The group policy provides coverage for covered long term care expenses, subject to a maximum daily benefit amount (DBA).

This Summary Plan Description (SPD) describes the benefits available under the Plan, as well as the Plan’s limitations. 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, for failure to comply may result in a reduction in benefits, or even the denial of benefits.

ELIGIBILITY

Who is Eligible

You are eligible to participate in the Long Term Care Insurance Plan if you meet the following requirements:

- (1) You are a Regular Full-Time Employee or a Regular Part-Time Employee; and
- (2) You are carried on a U.S. dollar payroll; or
- (3) You are a retiree of the Company meeting the eligibility requirements for retirement.

Dependent Coverage

The following dependents are eligible for coverage:

- An Employee's or Retiree's spouse. However, any such spouse who is insured under this Plan (or eligible for benefits because of prior insurance under this Plan) as an Employee or Retiree is not a dependent.
- The parents of an Employee or Retiree and the parents of an Employee's or Retiree's spouse.

A parent must be named by the Employee or Retiree and must be: the natural parent of the Employee or Retiree or the Employee's or Retiree's spouse; a person who legally adopted the Employee or Retiree or the Employee's or Retiree's spouse; or any other person who at one time was married to the natural or adoptive parent of the Employee or Retiree or the Employee's or Retiree's spouse.

- The grandparents of an Employee or Retiree and the grandparents of an Employee's or Retiree's spouse.

A grandparent must be named by the Employee or Retiree and must be: the natural parent of the Employee's or Retiree's parent or the parent of the Employee's or Retiree's spouse; a person who legally adopted the Employee's or Retiree's parent or the parent of the Employee's or Retiree's spouse; or any other person who at one time was married to the natural or adoptive grandparent of the Employee or Retiree or the Employee's or Retiree's spouse.

- The adult children and their spouses, if any, of an Employee or Retiree.

An adult child must be at least age 20 years of age and must be: the biological child or the legally adopted child of the Employee or his or her spouse; or the biological child or the legally adopted child of the Retiree or his or her spouse.

- The siblings and their spouses, if any, of an Employee or Retiree and the siblings and their spouses, if any, of an Employee's or Retiree's spouse.

A sibling must be at least 20 years of age and must be: the natural sibling of the Employee or his or her spouse; or related to the Employee or his or her spouse by means of adoption; the natural sibling of the Retiree or his or her spouse; or related to the Retiree or his or her spouse by means of adoption.

No person may be covered both as a dependent and an Employee or Retiree; and no person may be covered as a dependent of more than one Employee or Retiree.

Surviving Spouses of Retirees

A person who is a surviving spouse of a deceased Retiree on the Effective Date of the Plan is eligible. A surviving spouse is not eligible for any dependent coverage.

Who is Not Eligible

You are not eligible for the Long Term Care Insurance Plan if you meet **any** of the following conditions:

- (1) You are employed on any basis other than as a Regular Full-Time or Regular Part-Time Employee of the Company (for example, on a temporary or seasonal basis);
- (2) 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;
- (3) You provide services to the Company under a leasing arrangement between the Company and a third party;
- (4) You are employed by a related company which has not adopted the Plan; or
- (5) 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.

ENROLLMENT

If you are an active Employee eligible to participate in the Plan, you may enroll for coverage within 60 days of your hire date with no medical underwriting or at any later date, subject to completing a medical questionnaire. Eligible Retirees or Dependents may enroll at any time, subject to completing a medical questionnaire.

When you enroll, you will make the following choices:

- Your Daily Benefit Amount (DBA) (see page 6)
- Your Lifetime Maximum (see page 7)
- If you want the Non-Forfeiture Benefits option (see page 11)

You can enroll by completing the appropriate forms that you obtain from the Insurer. The form is available at www.aetna.com/group/citgo or by calling the Aetna Hotline at 1-800-537-8521.

Effective Date of Insurance

Generally, your coverage under the Plan is effective on the first day of the month following enrollment or on the first of the month following the date on which you are approved for coverage, if medical underwriting is necessary; provided, if you are an Employee, you are Actively at Work on that date. You are eligible to rescind or cancel coverage within 30 days of receiving your coverage certificate for a full refund of any premiums paid.

If you are an Employee and not Actively at Work on the day coverage is scheduled to begin, your coverage will not go into effect until the first day of the month following the date you return to active employment for at least 5 consecutive working days.

An Employee will be considered to be actively at work on any of the Employer's scheduled work days if, on that day, the Employee:

- is performing all the usual and customary duties of his or her occupation on a regular full time basis; and
- is reporting for work at his or her usual place of employment or other location to which the Employer's business requires the Employee to travel.

In addition, an Employee will be considered to be actively at work on the following days:

- any day which is not one of the Employer's scheduled work days if the Employee was actively at work on the preceding scheduled work day.
- an Employee's normal vacation day.

This "Actively at Work" requirement also applies to any increase in an Employee's DBA for which an Employee makes written request.

Changes In Coverage Amounts

A covered person may elect to increase his or her Daily Benefit Amount anytime. The Insurer must give its written consent before such an increase may take effect. Coverage may be increased up to the maximum Daily Benefit Amount in force (currently \$300).

An increase of less than \$10 in a covered person's DBA may not be chosen. The increased DBA will take effect on the date agreed to by the Insurer and CITGO. In no event will such an increase become effective without the Insurer's written consent.

Increases with the Insurer's written consent will not always be available. A participant may not purchase added coverage:

- When he or she is in a Benefit Period; or
- If contributions have not been made or premiums have not been paid on his or her behalf for any reason.

The premium rate for increased coverage amounts with the Insurer's written consent will be based on the participant's age as of the date the Insurer receives the request for the increased coverage amount.

You may elect to decrease your DBA anytime. The Insurer must be given written notice. You may not decrease your DBA:

- by less than \$10; or
- To an amount less than the Plan minimum of \$75.

DESCRIPTION OF BENEFITS

DESCRIPTION OF BENEFITS

Long Term Care insurance benefits are intended to provide coverage for necessary or medically necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services, and maintenance or personal care services, provided in a setting other than an acute care unit of a hospital, such as a nursing home, in the community, or in the home via a plan of care prescribed by a licensed health care practitioner. If you die from any cause while coverage is in force, benefits will be paid up to the amounts of premiums paid to your designated beneficiary.

The group policy provides coverage for covered long term care expenses, subject to maximum daily benefit amounts (DBA), lifetime maximums, policy exclusions, limitations and a deductible period for chronically ill individuals. "Chronically Ill" individual means that the covered person has been certified by a licensed health care practitioner as: (i) being unable to perform (without substantial assistance) at least two Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity; or (ii) requiring substantial supervision to protect him or herself from threats to health and safety due to Impairment of Cognitive Ability.

Daily Benefit Amount

The Daily Benefit Amount (DBA) is the maximum dollar amount or daily benefit chosen by a covered person that the Plan will pay for any one day of covered services. It is an amount equal to any whole multiple of \$1 with a

- Minimum of \$75
- Maximum of \$300. The maximum is subject to change.

Schedule of Coverage	
Benefit	Percent of DBA
Nursing Care Facility DBA	100%
Assisted Living Facility DBA	100%
Community Based Services DBA	75%
Informal Care DBA	25%

Deductible Period

On the date a covered person suffers such a qualifying eligible loss, a deductible period of 90 days will begin. A covered person must suffer an eligible loss for 90 days before benefits will be payable. No benefits will be paid during the deductible period. The deductible period needs to be satisfied only once during a covered person's lifetime. The number of days used to meet the deductible period do not need to be consecutive days.

DESCRIPTION OF BENEFITS

Lifetime Maximum

When you enroll, you will elect the number of Plan benefit years for coverage from the following:

- 3 Years
- 5 Years
- 10 Years

The total lifetime maximum benefit is the total dollar amount of benefits you can receive under the Plan during your lifetime for any combination of nursing home care, adult day care, home health care, homemaker services and respite care. The lifetime maximum benefit is determined by multiplying your elected DBA by the number of Plan benefit years selected by 365.

<p>Example: \$150 Daily Benefit Amount for three years</p> $\$150 \times 3 \times 365 = \$164,250 \text{ lifetime benefit maximum}$

Restoration of Benefits: The lifetime maximum benefit will be restored by the amount charged against it if one Benefit Period has closed as to a covered person and a new Benefit Period has begun in accordance with the terms of the Plan, and the coverage of that covered person is not extended under the optional Non-Forfeiture Benefits provision (page 11).

Eligibility for Payment of Benefits

Certain conditions apply before any benefits will be paid under this plan. A covered person must suffer an eligible loss. Generally, this is the inability to perform, without the substantial assistance (i.e. hands-on or standby assistance) of another person, two of the six designated activities of daily living (bathing, transferring, dressing, toileting, continence and eating) or the Impairment of Cognitive Ability, as established by the clinical diagnosis of a licensed health care practitioner. Such diagnosis shall include the covered person's history, and neurological, psychological and/or psychiatric evaluations and laboratory findings. The Deductible Period must be met and a plan of care prescribed by a licensed health care practitioner must be obtained in order to qualify for benefits.

“Impairment of Cognitive Ability” means the deterioration or loss in intellectual capacity requiring substantial supervision for protection of self or others, as established by the clinical diagnosis of any licensed practitioner in the state authorized to make such a diagnosis. Such diagnosis shall include the patient history and physical, neurological, psychological and/or psychiatric evaluations and laboratory findings.

DESCRIPTION OF BENEFITS

The Insurer decides when sufficient documentation of an eligible loss has been received and may consider information from the covered person, his or her attending physician and other health care providers when making that decision. A person will not be determined to have suffered an eligible loss without the certification, within the preceding 12 month period, of a licensed health care practitioner.

Covered Services:

The group policy provides the benefits described in this section. Once the above requirements are satisfied, the plan provides benefits for the following:

Transitional Care Benefit: A Transitional Care Benefit is payable to assist in meeting immediate needs resulting from the onset of an eligible loss. Only one such benefit is payable to a covered person during his or her lifetime. The amount of the benefit payable is equal to three times the DBA selected. The Transitional Care Benefit will not count toward the reduction of the Lifetime Maximum Benefit amount.

Nursing Care Facility Benefit: A daily benefit is payable if a covered person is confined in a nursing care facility. The amount for any one day is the lesser of:

- The Nursing Care Facility DBA; or
- The charges made for that day by the nursing care facility for qualified long term care services.

Assisted Living Facility Benefit: A daily benefit is payable if a covered person is confined in an assisted living facility. The amount of the benefit for any one day is the lesser of:

- The Nursing Care Facility DBA; or
- The charges made for that day by the assisted living facility for qualified long term care services.

Adult Day Care Benefit: A benefit is payable for each day a covered person incurs charges made by an Adult Day Care Center. The amount of the benefit payable for any one day is the lesser of:

- The Community Based Services DBA; or
- The charges for that day by the adult day care center for qualified long term care services.

DESCRIPTION OF BENEFITS

Home Health Care Benefit: A benefit is payable for each day a covered person incurs charges made by a home health care agency for qualified long term care services provided to such family member in his or her home. Covered services include: Care by an R.N., L.P.N. or L.V.N, Home Health Aide for patient care, Homemaker Services and physical, occupational, speech or respiratory therapy. The amount of the benefit payable for any one day is the lesser of:

- The Community Based Services DBA; or
- The charges made for that day by the home health care agency.

Hospice Care Benefits:

While Confined

A benefit is payable for each day a covered person is confined in a hospice facility for hospice care. The amount of the benefit payable for any one day is the lesser of:

- The Nursing Care Facility DBA; or
- The charges made for that day by the facility for qualified long term care services.

Community Based Care

A benefit is payable for each day a covered person incurs charges made by a hospice care agency for qualified long term care services which are provided at home. The amount of the benefit payable for any one day is the lesser of:

- The Community Based Services DBA; or
- The charges made for that day by the hospice care agency.

Bed Reservation Benefit: If a covered person is receiving benefits in connection with a confinement in a nursing care facility, assisted living center or hospice facility and his or her stay is temporarily interrupted due to hospitalization or he or she is absent from the facility for any reason, this Plan continues benefit payments if he or she is incurring charges to reserve a bed in such facility, up to a maximum of 21 days per calendar year.

The Bed Reservation Benefit will not be payable if the covered person has not satisfied the deductible period. However the number of days a charge is made by a facility to reserve a bed will be applied to satisfy the deductible period.

Respite Care Benefit: A cash benefit is payable for each day of a covered person's respite care, up to a maximum of 21 days during a calendar year. The benefit for any one day is equal to the Community Based Services DBA. It is payable in addition to other benefits payable on that day, subject to the maximum DBA. The amount payable for the Respite Care Benefit will not count toward the reduction of the Lifetime Maximum.

DESCRIPTION OF BENEFITS

Home Modification Benefit: A benefit is payable when a covered person incurs a charge for any home modification necessary to allow the covered person to continue to stay in or return to his or her home to receive qualified long term care services. The benefit will pay for all charges incurred for home modifications up to a maximum benefit of ten times the Nursing Care Facility DBA selected, but not less than the Home Modification Minimum Benefit of \$1,000. This benefit is payable without regard to any other long term care benefits payable.

Assistive Equipment and Technology Benefit: If a covered person is not confined in a covered facility, a benefit is payable when he or she incurs a charge for rental, lease purchase or installation of an emergency alert system or other assistive equipment used to provide qualified long term care services. This benefit will also pay a benefit for the repair or replacement of the purchased equipment if the person's condition warrants such replacement. The monthly benefit amount is equal to the lesser of:

- The Community Based Services DBA; or
- The charges made for that month for the rental, lease, purchase, installation or repair or replacement of the assistive equipment or emergency alert system.

This benefit is payable without regard to any other long term care benefits payable.

Alternate Care Benefit: If, according to an alternate plan of care, a covered person needs qualified long term care services for which the policy would not otherwise pay a benefit, a benefit may be payable at the discretion of the Insurer. The benefit amount is the lesser of:

- Nursing Care Facility DBA or the Community Based Services DBA, depending on the Insurer's determination of which Long Term Care Benefit, as defined under this Plan, most closely relates to the provider rendering the care, or
- The charges made for the alternate care.

An "alternate plan of care" must be a written plan provided by or with a licensed health care provider and must be agreed to by the covered person, his or her attending physician and the Insurer.

However, this Alternate Care Benefit will not be payable in connection with expenses incurred for any services rendered by a member of the covered person's immediate family or a person who resides in the covered person's home.

Informal Care Benefit: A cash benefit is payable on any day, up to a maximum of 50 days per calendar year, that a covered person receives care in his or her home only from an informal caregiver; provided that a statement that the care has been given is signed by the informal caregiver and given to the Insurer. The amount payable for each day is the Informal Care DBA. The amount payable for the Informal Care Benefit will not count toward the reduction of the lifetime maximum benefit amount.

DESCRIPTION OF BENEFITS

Informal Caregiver Training Benefit: A benefit is payable if a covered person incurs expenses for training an informal caregiver to care for the covered person at home. The benefit is the lesser of:

- Three times the Nursing Care Facility DBA; or
- The charges for the training.

This benefit is payable without regard to any other benefits payable. Not more than one such benefit is payable in connection with any one benefit period. The amount payable for the Informal Caregiver Training Benefit will not count toward the reduction of the lifetime maximum benefit amount.

Refund of Contributions

Plan coverage provides for a refund or partial refund of premium contributions upon the death of a covered person. The covered person's age at death will determine the availability of any refund of contributions. Payment of any contribution due to be refunded under this provision, less any benefits previously paid, will be made to the designated beneficiary (see page 17) upon satisfactory proof of death from any cause.

No refund of contribution will be made if contributions or premium payments have been discontinued for any reason unless such payments were discontinued because the covered person was receiving benefits under the Plan.

Until the covered person reaches age 65, the refund will equal the contributions paid on the covered person's behalf. However, starting on the date that the covered person reaches age 65, the refund available will reduce by 10% per year. If a covered person enrolls on or after the date he or she reaches age 65, the 10% annual reduction will start on the date of enrollment. Refund of contribution amounts will no longer be available on the ninth anniversary after the reduction starts.

Non-Forfeiture Benefits (Optional)

The Non-forfeiture Benefit is available as an election on an optional basis. When coverage of a covered person, who has made premium contributions under the Plan for at least three years, terminates because of failure to make the required contributions when due, he or she will receive the Shortened Benefit Period non-forfeiture benefit (see below).

The Shortened Benefit Period non-forfeiture benefit will also apply:

- when decreasing a covered person's DBA; and
- when surrendering a covered person's coverage in the case of an Employee or Retiree who surrenders coverage but remains eligible, or the dependents of such a person.

Coverage will be extended under the Shortened Benefit Period feature without future contributions.

DESCRIPTION OF BENEFITS

Shortened Benefit Period Feature

This feature allows for extended coverage with no reduction in the applicable DBA, but with a change in the Lifetime Maximum Benefit. The new Lifetime Maximum Benefit will be an amount equal to the greater of:

- The amount of the sum of all premium contributions made on the covered person's behalf on the date premium contributions cease; or
- 30 times the applicable Daily Benefit Amount.

Eligibility for benefits will terminate at the first to occur of:

- The death of the covered person; or
- The date the new Lifetime Maximum Benefit is reached.

In no event will a benefit be paid under the Shortened Benefit Period feature after a person has exhausted his or her Lifetime Maximum Benefit.

As of the date a covered person's coverage is extended under the Shortened Benefit Period feature, the following shall apply:

- No benefit changes will be allowed.
- No refund of contributions will be available.

Benefit Exclusions or Limitations

Pre-existing Conditions: The plan does not exclude the payment of benefits for losses caused by pre-existing conditions.

Non-eligible Facilities: The plan does not pay benefits on any day a covered person is confined in a hospital (except as covered under the Bed Reservation Benefit), or a government institution which makes no charge to the covered person.

The plan does not pay benefits for:

- A loss which is caused by war or act of war, whether declared or undeclared.
- A loss which is caused by a suicide attempt, while sane or insane, or any intentionally self-inflicted injury.
- Any day on which benefits for the charges incurred by a covered person are provided or required because of past or present service in the armed services of a government.
- Services for which no charge is normally made in the absence of insurance or charges that a covered person is not legally obliged to pay.

DESCRIPTION OF BENEFITS

- Any day on which benefits for the charges incurred by a covered person are provided or required under any state or federal law or governmental program.
- Any day the covered person is outside the United States, its territories, or Canada.
- Any charges incurred while outside the United States, its territories, or Canada.
- Any day of a confinement in a governmental institution; unless a charge is made which the covered person is required to pay.
- Any charges incurred by a covered person for which benefits are payable under Medicare when Medicare is the primary payer (including benefits that would be payable except for the application of Medicare's deductible or coinsurance features).

YOUR POLICY MAY NOT COVER ALL OF THE EXPENSES ASSOCIATED WITH YOUR LONG TERM CARE NEEDS.

Cost/Funding

Plan benefits are made available under the provisions of the CITGO Petroleum Corporation Long Term Care Insurance Program for Salaried and Hourly Employees. The costs of the Plan benefits provided from the Insurer are paid from Participant contributions remitted directly to the Insurer. Premiums may be paid on a monthly, quarterly or annual basis.

Payment of Contributions

Contributions for the cost of long term care coverage must be paid directly to the Insurer. Contributions must be paid in advance at the Insurer's home office or to its authorized agent on the designated due date. Insureds may designate a third party to be notified by the Insurer when:

- Contributions are 30 days late; or
- Coverage has been terminated.

Spousal Discount

If an Employee, Retiree or eligible dependent requests coverage for his or her dependent spouse, a 10% discount may be applied to the coverage of the Employee, Retiree, or eligible dependent, and his or her dependent spouse.

However:

- The discount will not be applied and will not take effect until the date that coverage is in force for both the Employee, Retiree, eligible dependent and his or her spouse.
- The discount will cease to apply on the date that either the Employee, Retiree or eligible dependent, or his or her spouse ceases to be a covered person; except that: in the event of the death of the Employee, Retiree or eligible dependent or his or her spouse, the discount will continue to apply to the survivor.

DESCRIPTION OF BENEFITS

- The discount will cease to apply on the date that either the Employee's, Retiree's or eligible dependent's coverage or his or her spouse's coverage, is being extended under the "Non-Forfeiture Benefit" provision (see page 11).

Waiver of Premiums/Contributions

After a covered person has satisfied the applicable Deductible Period, benefits will be paid for that covered person in accordance with the terms of this Plan without further payment of any premiums or contributions. Payments of premiums or premium contributions shall resume at the end of each Benefit Period.

While the terms of this provision are in effect for a covered person, the terms of the "Non-Forfeiture Benefits" provision (page 11) will not apply.

Return of Unearned Premium Contributions

If premium contributions have been paid for a period of coverage which extends beyond:

- a covered person's death; or
- The date the covered person's coverage is surrendered for any reason,

then any unearned premium contributions will be refunded to the covered person, his or her designated beneficiary, if any, or to his or her estate.

Future Purchase Inflation Protection Increases

Because the cost of long term care services will likely increase over time, you may want to consider whether and how the benefits of this plan may be adjusted. The Plan provides an inflation protection feature.

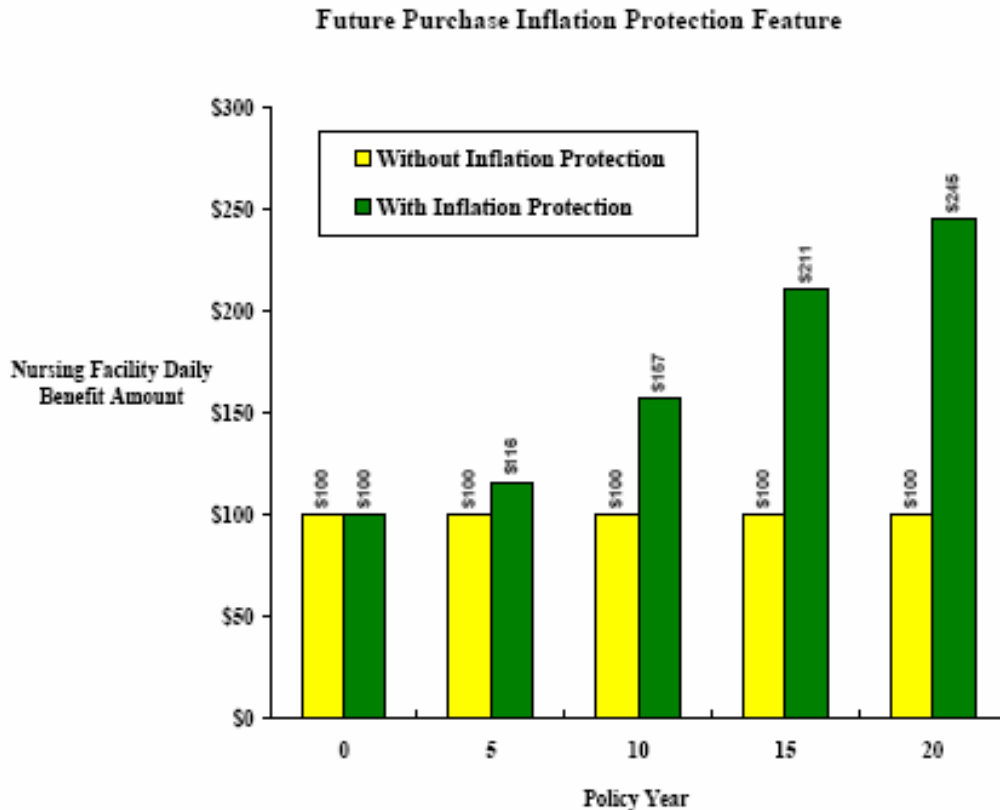
Every three years from the initial Effective Date of the Plan, which is November 1, 2005, you can buy additional amounts of coverage without completing a medical questionnaire required by the Insurer. You may apply for additional amounts of coverage in other years, but the Insurer will then require you to complete a medical questionnaire. With any purchase of additional coverage, your premium will go up in a manner which reflects the additional coverage purchased and your age at the time of the purchase.

Once you refuse any additional amounts of coverage offered through the inflation protection offering, you will be ineligible for any subsequent inflation offerings while you are in a Benefit Period.

DESCRIPTION OF BENEFITS

The amount of additional coverage available on the chosen three year intervals will be equal to 5%, compounded each year, for each of the preceding three years, of the DBA in effect under the group policy on the third preceding policy anniversary.

The following graph illustrates the effect of inflation.



Future of the Plan

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

Terms Under Which Coverage May Be Continued in Force or Discontinued

The group policy, including your certificate, is guaranteed renewable to each covered person. This means you have the right, subject to the terms of your certificate, to continue this coverage as long as you pay your premiums on time. The Insurer cannot change any of the terms of your coverage on its own, except that, in the future, they MAY increase the premium that you pay.

DESCRIPTION OF BENEFITS

If the group policy discontinues as to new enrollees and is not replaced by a similar policy or the covered person loses membership in an eligible class, the covered person may continue coverage under the certificate. The continued coverage is the same coverage and cost as under the group policy, and the covered person does not have to submit any medical information to the Insurer to be eligible for continuation.

When a covered person begins to receive benefit payments for an eligible loss, the covered person does not have to pay further premiums in order to receive further benefits for that eligible loss. The DBA would remain fixed as of the beginning of the eligible loss. If the covered person recovers from the eligible loss, the covered person must then resume premium payments at the end of the benefit period.

Terms Under Which the Insurance Provider May Change Premiums

Premium rates for this coverage may change because of actual and expected group experience. Rate changes due to experience may only occur once every policy year. Rates may also change at any time benefits are modified under this Plan. Rates will not be changed solely because of any covered person's age or use of the long term care coverage; changes of this nature may only be made on a class basis. The Insurer will issue written notice regarding any premium increase at least 120 days prior to such increase.

NAMING YOUR BENEFICIARY

Long Term Care Insurance provides for Refund of Contributions (see page 11) if you die, even while in claim status. A named beneficiary will receive 100% of the contributions you have paid for long term care coverage. However the refund of contributions will be reduced by the either or both of the following :

- The amount of the refund is reduced 10% annually starting at age 65; and
- The amount of the refund is further reduced by the amount of the benefits already paid out.

No refund/return of Contributions is paid if you have stopped paying premium, except if you are on premium waiver.

Your named beneficiary will also receive any Return of Unearned Premium Contributions; if applicable (see page 14).

At enrollment, you will designate a beneficiary. You may change the person named at any time by giving written notice to the Insurer. If no person has been named, or if the named person dies before you, then any Refund of Contribution amount available or Return of Unearned Premium Contributions will be paid to the executors or administrators of your estate.

EVENTS AFFECTING COVERAGE

Absences, Termination or Retirement

You are eligible to continue coverage under the Plan as long as you continue to remit premiums on a timely basis to the Insurer.

Termination of Coverage

Unless you continue to remit premiums on a timely basis, coverage for Long Term Care Insurance will terminate at the end of the month for which the last premium was received.

Before a covered person's coverage terminates for failure to make individual premium contributions when due, the Insurer will give notice of the intent to terminate coverage to the covered person and to any person, or persons designated by the covered person. The notice will be given at least 30 days before coverage will terminate. For the purpose of this provision, a notice will be deemed to have been given five days after the date it is mailed. The notice will be given by first class United States mail, postage prepaid.

The covered person's coverage will terminate at the end of the 30 day period following the date notice is given, if payment of the premium contribution is not made within the 30 day period.

Reinstatement of Coverage

If a person's coverage terminates for failure to make premium payments or premium contributions when due; and the person provides adequate proof to the Insurer that:

- the lapse is due to Cognitive Impairment or loss of functional capacity; and
- such impairment or loss occurred on or before the date of termination;

coverage may be reinstated; provided that:

- the request to reinstate coverage is made within five months of the date coverage terminated; and
- any past due premiums are paid.

If a person's coverage terminates for failure to make premium payments or premium contributions when due; and the lapse is not due to Cognitive Impairment or loss of functional capacity; coverage also may be reinstated; provided that:

- the request to reinstate coverage is made within 36 months of the date coverage terminated;
- the Insurer gives its written consent; and
- any past due premiums are paid.

If the Insurer's written consent is required to reinstate coverage, they will not give such consent unless each of the questions on the health statement is answered. Answering each question does not obligate them to give their consent and does not guarantee coverage.

CONTINUATION OF COVERAGE

If the Plan is Amended or Terminated

You may continue your coverage under this Plan if CITGO terminates its participation in this Plan, or if CITGO amends the Plan so that you are no longer eligible for coverage under this Plan.

Cost of Continued Coverage

If you decide to continue your individual policy, you will have to continue to pay the premiums for this insurance, at the same rates in effect as established by the Insurer.

Portability of Coverage

If a covered person's coverage would otherwise terminate because:

- the group policy discontinues as to the Eligible Employees or Retirees and it is not replaced by a like policy; or
- because the group policy discontinues as to Eligible Employees or Retirees and is replaced by like coverage, and the covered person does not become covered under the replacement coverage; or
- because the Employee or Retiree ceases to be in an Eligible Class; or
- because of the death or divorce of an Employee or Retiree; or
- because of the death of an Employee's or Retiree's spouse;

coverage for the covered person will continue under this Plan, provided premium payments are continued by means of direct payment to the Insurer.

The covered person may elect not to continue coverage by notifying the Insurer within 31 days of the event which would in the absence of this portability provision terminate coverage. Failure to remit premium to the Insurer within 31 days of the first premium due date following the continuation will result in termination of coverage.

A covered person who does not continue coverage under this Plan may be eligible for benefits as described in the "Non-forfeiture Benefits" section of this Plan, if applicable.

In no event may coverage of a covered person be continued under the terms of this "Portability" provision if coverage would terminate for non-payment of premiums or premium contributions on that person's behalf.

CLAIMS PROCEDURES

When and How to File a Claim

A covered person should keep complete records of all charges incurred during a Benefit Period. They will be required when a claim is made for payment of benefits. Records kept should include the dates expenses are incurred and copies of all bills and receipts.

A covered person must submit written notice of claim to the Insurer within 30 days after the start of any loss covered under this Plan, or as soon thereafter as is reasonably possible. Notice given by, or on behalf of, the covered person to the Insurer at its home office in Hartford, Connecticut or to its authorized agent, with information sufficient to identify the covered person, shall be deemed notice to the Insurer.

Upon receipt of a written notice of claim, the Insurer or its authorized agent will give the covered person such claim forms as are usually given for filing proof of loss. If such forms are not given within 15 days of the notice of claim, the covered person can send proof of loss without the form.

Proof of Loss

Written proof of loss must be furnished to the Insurer's home office within 90 days after the date of such loss. Failure to give such proof within the time required shall not affect any claim if it was not reasonably possible to give proof within such time. However, proof must be given as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time it was otherwise required. Otherwise, late claims will not be covered.

As part of proof of loss, the Insurer may also conduct an on-site assessment in order to evaluate the condition of the covered person.

The covered person must give proof of continued Eligible Loss at intervals requested by the Insurer. Such proof must be given within 30 days of the Insurer's request. If it is not possible for the covered person to give proof within such time, it must be given no later than one year after the time proof is otherwise requested.

Physical Exam

The Insurer will have the right to examine at its own expense, the person of anyone whose injury or disease is the basis of a claim when and as often as it may reasonably require before and during a Benefit Period.

Payment of Benefits

All benefits are payable to the covered person. However, the Insurer has the right to pay any benefits to the service provider. This will be done unless the covered person has told the Insurer otherwise by the time the claim is filed. Benefits will first be payable under this Plan within 60 days of receipt by the Insurer of proof of loss as described above.

Claim Denial

If the claim is denied because the Insurer did not receive sufficient information, the claims decision will describe the additional information needed and explain why it is needed.

When a claim is denied, the Insurer will explain why the claim has been denied and state the Plan provisions on which the denial is based. The notification will also include a description of the Plan review procedures and time limits, including a statement of your beneficiaries' right to bring a civil action if their claim is denied after an appeal. Your beneficiaries or their duly authorized representative may appeal the denial and request a final claim review.

Claim Appeal

Within a period of 60 days after the denial is received, the denial may be appealed, in writing, to the Insurer. The request must state the reasons why your beneficiary believes the claim was improperly denied and submit any written comments, documents, records or other information he or she deems appropriate. The Insurer will re-evaluate all the information, conduct a full and fair review of the claim and provide notification within 60 days after receipt of the written appeal (or within 120 days if special circumstances require an extension of time for processing). If an extension of time is required for the review, your beneficiary will be notified before the extension period begins. If an appeal is not made within the 60-day period, the denial will be considered final, conclusive and binding.

LEGAL ACTIONS

You may not pursue the claim in federal or state court until first exhausting the claims procedures under the Plan. You or your beneficiaries may not sue after three (3) years from the time the written notice is required to be furnished.

ADMINISTRATION

The Plan Administrator, on behalf of the Plan, has contracted with Aetna Life Insurance Company to provide coverage as the Insurer under the Plan.

The provisions of this Plan are subject to the terms and conditions of the Long Term Care Insurance Contract between the Company and the Insurer. The Insurer makes all payment of benefits under the terms of the Plan.

The Plan Administrator is responsible for the administration of this Plan

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

Agent for Service of Legal Process

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

ADDITIONAL INFORMATION

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 25. Other important information about the Plan is provided below:

Name of Plan: The CITGO Petroleum Corporation Long Term Care Insurance Program for Salaried and Hourly Employees

Type of Plan: Fully Insured Long Term Care Insurance 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, Oklahoma 74136

OR

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

Plan Number: 519

Plan's Effective Date: November 1, 2005

Plan Year: January 1 – December 31

Funding Method: Funded by Participant contributions under a fully insured arrangement with the Insurer

ADDITIONAL INFORMATION

Insurer: Aetna Life Insurance Company
Long Term Care Unit – RT52
151 Farmington Avenue
Hartford, CT 06156

www.aetna.com/group/citgo
1-800-537-8521

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, Texas 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.

ADDITIONAL INFORMATION

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order of medical child support order, you may file suit in Federal court. If it should happen that Plan Fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

DEFINITIONS

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

“Actively at Work” means that you are actually working for the Company at the Company’s place of business, or any other place that the Company requires you to go. An employee on vacation is considered Actively at Work, but an employee on a leave of absence or absent due to disability is not considered to be Actively at Work.

“Activity/Activities of Daily Living” an activity performed daily, for which you may require significant assistance performing. Activities of daily living under this LTC Plan are dressing, bathing, eating, transferring, toileting and continence.

- **Bathing:** Washing oneself by a sponge bath; or washing oneself in either a tub or shower, including the task of getting into or out of the tub or shower.
- **Transferring:** Sufficient mobility to move into or out of a bed, chair or wheelchair or to move from place to place, via walking, a wheelchair or other means.
- **Dressing:** Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
- **Toileting:** Getting to and from the toilet, getting on and off the toilet and associated personal hygiene.
- **Continence:** The ability to maintain control of bowel and bladder functions; or when unable to maintain control of bowel and bladder functions, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
- **Eating:** Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table), or by a feeding tube or intravenously.

“Adult Day Care” A program of social and health related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly, or other disabled adults who can benefit from care in a group setting outside the home.

“Adult Day Care Center” A community-based group program of health, social and related support services for participants in the LTC Plan living at home who cannot be left alone. The facility providing adult day care must meet the certification or licensing requirements of the state in which it is located. If the state does not certify or license adult day care centers, the facility must be certified by an accrediting agency recognized by the Insurer.

DEFINITIONS

“Alternate Care Benefit” a benefit that may be available to pay for care received from a provider who would not be included in the definition of a covered provider under the group policy.

“Alzheimer’s Disease” a progressive, degenerative form of dementia that causes severe intellectual deterioration.

“Assisted Living Facility (Residential Care Facility)” A facility that meets any applicable licensing requirements of the jurisdiction in which it is located and that it is operated pursuant to state and federal law. It is NOT a hospital, nursing care facility or similar establishment; or a place for drug addicts, alcoholics, mental retardates, educational care; or care of mental disorders.

“Assistive Equipment” This means tangible personal property with a useful life of at least one year, expressly designed and used for increasing interdependent functioning in specific tasks or activities of independent living in the home that directly results in a demonstrated decrease in need for assistance from another individual in performing certain tasks or activities. Assistive Equipment would include, but not be limited to:

- a wheelchair;
- blood pressure monitoring equipment;
- oxygen tank; and
- medication dispensing device.

“Bed Reservation” a claimant who resides in a nursing facility may have to temporarily leave the facility (i.e. to go to a hospital for surgery). In this situation, a benefit to reserve the insured’s place in the nursing facility is payable.

“Benefit Period” a period of days that begins when there is a certified covered loss. It includes the Elimination (Deductible or Waiting) Period, payment period and recovery period.

“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.

“Care Manager” a person who identifies the impairments that qualify a participant in the LTC Plan as having a qualified disability and develops a plan of care for services that meets the needs created by those impairments.

“Chronically III” This means that a covered person has been certified by a Licensed Health Care Practitioner as: (i) being unable to perform (without substantial assistance) at least two Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity; or (ii) requiring substantial supervision to protect him or herself from threats to health and safety due to severe cognitive impairment.

DEFINITIONS

“Claims Administrator” Aetna is the Claims Administrator for the LTC Plan.

“Claims Specialist” Under the direction of the Care Manager, retrieves the documentation needed to certify the participants in the LTC Plan as having a qualifying disability and adjudicates contract provisions and makes the final authorization of benefits.

“Cognitive Impairment” a deficiency in a person’s short or long term memory; orientation to a person, place and time; deductive or abstract reasoning; or judgment as it relates to safety awareness.

“Community Based Care” services that are designed to help people stay independent in their own homes (i.e. as opposed to a nursing home).

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

“Emergency Alert System” Services designed to provide a 24 hour per day emergency communication link to assistance outside the home. This does not include a home security system.

“HIPAA” an acronym for the Health Insurance Portability and Accountability Act. HIPAA is federal law that provides for the tax favored treatment of certain long term care insurance policies.

“Home Health Care” Medical or non-medical services provided to ill, disabled or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living, respite care services, case management services, and maintenance or personal care services.

“Home Health Care Agency” An agency or organization which provides a program of home health care and which fully meets one of the following three tests:

- it is approved under Medicare; or
- it is established and operated as a home health care agency in accordance with applicable licensing laws or any other laws; or
- it is accredited as a home health care provider by the National League of Nursing, American Public Health Association or Joint Commission on Accreditation of Healthcare Organizations.

“Homemaker Services” household services performed for someone who, due to a physical or cognitive impairment, is unable to do so themselves.

DEFINITIONS

“Home Modification” Any modification made to a covered person’s place of residence that is necessary for that covered person to remain in or return to his or her residence to receive qualified long term care services. Such modifications include, but are not limited to the installation of:

- wheelchair ramp for doorway;
- shower grab bars;
- stair gliders; or
- widening of doorways.

“Hospice Care” care provided by or under arrangement with a Hospice Care agency or Hospice Facility to someone who is terminally ill.

“Impairment of Cognitive Ability” The deterioration or loss in the covered member’s intellectual capacity requiring substantial supervision by another person for the protection of the covered person and others as established by the clinical diagnosis of a Licensed Health Care Practitioner authorized to make such a diagnosis. Such diagnosis shall include the covered person’s history and neurological, psychological and/or psychiatric evaluations, and laboratory findings.

“Inflation Protection” an optional policy provision which, if elected, allows for periodic increases to the DBA to help protect against the potential impact of inflation in the costs of long term care.

“Informal Care” care that may be provided by family members, friends, neighbors or private caregivers.

“Informal Caregiver Training Benefit” a benefit that pays for the training of an informal caregiver to provide care for the insured member of the plan.

“Medicaid” a program that pays for health care for persons, regardless of age, whose incomes are below a certain level. The Medicaid program is jointly administered by the state and federal government.

“Medicare” a federal insurance program providing hospital and medical benefits to people age 65 and over, and to people of any age who are disabled. Medicare has very limited benefits for long term care services.

“Non-forfeiture Benefits” an insurance coverage option that provides for a limited amount of benefit if the coverage terminates due to non-payment of premium.

“Nursing Home” a facility which:

- is licensed by the state where it is located;
- provides nursing home care on an inpatient basis and under the supervision of a physician;
- has nursing services provided by or under the supervision of a RN, LVN or LPN;

DEFINITIONS

- keeps a daily medical record of each patient; and
- is either a freestanding facility, or a ward, wing, unit or swing bed of a hospital or other institution.

“Plan Administrator” means CITGO Petroleum Corporation

“Plan of Care” a written document detailing a program of care which is appropriate for your level of impairment. The plan of care is prepared either by the Insurer or a physician, RN, care manager or other qualified health professional approved by the Insurer. It must be in writing by your physician (psychiatrist or Ph.D.-level psychologist for mental or nervous disorders) and confirmed in writing at least once every 90 days.

“Plan Year” the calendar year, January 1 through December 31, on which the records of the LTC Plan are kept.

“Qualifying Disability” a disability due to an accidental injury, sickness or mental or nervous disorder that causes you or your covered relative to be dependent in at least two of six activities of daily living (dependent means the inability to perform the activity without personal assistance, directive assistance or supervision provided by another person); a severe, organically-based cognitive impairment (such as Alzheimer’s Disease or similar dementia) that impairs an individual’s cognitive function to a moderate or severe degree, so that substantial supervision is needed to protect the individual’s safety.

“Qualifying Waiting Period” the 90-day period following certification of a qualifying disability, during which no benefits are payable under the LTC Plan.

“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.

“Respite Care” services that provide temporary relief to certain of your caregivers upon whom you are dependent for activities of daily living.

“Restoration of Benefits” a benefit that restores the Lifetime Maximum by the amount of benefit that has been paid on the covered member’s behalf once they recover and are no longer in claim status.

“Standby Assistance” The presence of another person within arm’s reach of the individual that is necessary to prevent, by physical intervention, injury to the individual while the individual is performing the activity. For example, being ready to catch the individual if he or she falls while getting into or out of the bathtub or shower as a part of bathing; or being ready to remove food from the individual’s throat if he or she chokes while eating.

DEFINITIONS

“Transitional Care Benefit” an automatic cash payment that is designed to aid the covered person to meet the needs that arise during the transition phase (from being self-sufficient to requiring assistance) which occurs during the elimination period.

“Waiver of Premium” a provision within an insurance policy that relieves an insured of paying the premiums while they are receiving benefits.

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

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