

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

Summary Plan Description
as in effect January 1, 2007

The Summary Plan Description, including announcement letters issued subsequent to the publication date, and the formal text of the CITGO Petroleum Corporation Medical, Dental, Vision and Life Insurance Program for Hourly Employees (the “Program”) are the governing Plan Documents. In the event of a discrepancy between this Summary Plan Description and the formal text of the Program, the formal text will control. You can receive a copy of the formal text from the Plan Administrator upon written request (see *Additional Information* on page 103 for the Plan Administrator’s address).

COMPANY MEDICAL PLAN HIGHLIGHTS

Eligibility Eligible Regular Full-Time and eligible 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 of the date you first become eligible, if later.

Cost to You Your pretax cost depends on the total cost of the coverage, less the Company's contributions, and the type of coverage and dependent option you select. A schedule of contributions is published annually.

Basic Benefits (see pages 23 - 31 for detailed information)

Medical

Network Area Benefits		
Choice EPO	Choice Plus	
In-Network Only	In-Network	Out-of-Network
\$25 per office visit for primary care; \$35 per office visit for specialty care; You pay 10% no deductible	\$25 per office visit for primary care; \$35 per office visit for specialty care; \$250 deductible (\$750 max.-family); You pay 20% after deductible	\$1,000 deductible (\$3,000 max.-family); You pay 40% after deductible

Non-Network Option for Non-Network Areas	High Deductible Health Plan
\$600 deductible (\$1,800 max.-family); You pay 20% after deductible	\$1,500 deductible for employee only (\$3,000 for all other levels); You pay 20% after deductible

Prescriptions

	Retail Pharmacy Program*	Mail-Order Program*
For Short-Term and Immediate Prescriptions	Up to a 31 day supply. You pay 30% with \$10 minimum for tier 1 and tier 2. You pay 40% with \$10 minimum for Tier 3.	Not applicable
For Long-Term and Maintenance Medications		You pay for up to a 90 day supply: <ul style="list-style-type: none"> • \$25 for Tier 1 • \$50 for Tier 2 • \$75 for Tier 3

- These benefits would apply after the \$1,500 or \$3,000 deductible has been met under the HDHP option.

Who to Call for Information

This summary is designed to provide overall guidance on who to contact

<p style="text-align: center;"><u>Benefits HelpLine</u> 1-888-443-5707 Benefits @Citgo.com</p>	<p style="text-align: center;"><u>Medical</u> <u>UnitedHealthcare Customer</u> <u>Service Center</u> 1-866-317-6359 www.myuhc.com</p>	<p style="text-align: center;"><u>Mental Health/Substance Abuse</u> <u>UnitedHealthcare – United</u> <u>Behavioral Health</u> 1-866-317-6359; Option 3 www.liveandworkwell.com</p>	<p style="text-align: center;"><u>Prescription Services</u> <u>UnitedHealthcare - Medco</u> <u>Health</u> 1-866-317-6359; Option 4 www.myuhc.com or www.365WellSt.com</p>
Enrollment or termination of coverage for you or dependents including eligibility questions	Medical coverage needs, ID cards or questions	Mental health and substance abuse coordination of benefits	Retail prescriptions
Changes in coverage	Approved medical facilities	Notification	Mail order or maintenance prescriptions
Forms	Covered and non-covered expenses, medical treatments; claim status	Substance abuse treatment and planning	Participating pharmacies
Eligible status changes	Notification of pending hospital admission or other specialty care – Care Coordination	Behavioral health questions	Prescription drug claim problems or questions
Claim problems or questions	Network or non-network provider and hospitals guidance	Denial of claims-mental health and substance abuse	Preferred Drug List
Absences and other events affecting coverage	Medical Denial of claim appeals	Network or non-network providers guidance	Prescription drug information and costs
Information about COBRA	Authorization for non-participating providers	Problems with a Behavioral health network provider	
Flexible Spending Accounts	Flexible Spending Accounts	Emergency and crisis help	
Over-age dependent & student questions	Disease Management Programs	Working Solutions Program – see the Employee Assistance Program SPD for more information.	
	Provider directories: www.provider.uhc.com/citgo		

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PURPOSE

The Medical provisions of the CITGO Petroleum Medical, Dental, Vision and Life Insurance Program for Hourly Employees (“Plan” or “Medical Plan”) are intended to help pay medical expenses incurred by you and your family for the diagnosis and treatment of an illness, injury or pregnancy. This coverage is available to employees, retirees, and their dependents that meet the eligibility requirements of this Plan.

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' medical 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, as 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 Plan if you meet **all** of the following requirements:

- (1) You are a Regular Full-Time Employee or a Regular Part-Time Employee and compensated on an hourly basis covered under a collective bargaining agreement which has negotiated for the Plan; and
- (2) You are carried on the U. S. 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 medical, dental and prescription drug 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 as soon as administratively practicable following 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: <ul style="list-style-type: none"> 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 your home. 	X X X X	
Your unmarried 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 child, 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 your 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.

If your dependents' Primary Plan is another group health plan (other than Medicare) they are not eligible for the Prescription Drug Program (page 62). To determine if the Plan is your dependent's Primary Plan, refer to *Coordination of Benefits* on page 94.

Disabled Child Eligibility Guidelines

Your unmarried, disabled child is eligible for continued medical 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 first 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;
- is disabled prior to the end of the month in 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 health care or medical 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.
- (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

ELIGIBILITY

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 medical coverage prior to your retirement, coverage for you and any eligible dependents who are covered as of the date you retire will continue automatically and you will be billed monthly for your contributions.

If you waive coverage, you may re-enroll at a later date in accordance with the Late Enrollment provisions on page 9.

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 74).

Dependents: If you are eligible for retiree medical 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 at any subsequent Annual Election Period. You may continue to cover all your eligible dependents even when you become eligible for Medicare. 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 Status Change rules on page 71.

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 for Medicare

Active Employees

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

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

Your coverage under the Plan will be considered primary until your retirement, and Medicare coverage will be secondary. You will continue to be eligible for the same benefits under this Plan as employees who are not eligible for Medicare.

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

- The employee notifies the Company within 31 days of the spouse's 65th birthday, or within the Plan Year or during the Annual Election Period that he or she does not want the spouse's coverage to continue;
- The spouse otherwise ceases to be eligible for coverage for a reason that would also make a spouse under age 65 ineligible for coverage;
- The employee notifies the Company within 31 days of the dependent becoming eligible for Medicare, or during the Annual Election Period that he or she does not want the dependent's coverage to continue; or
- The dependent otherwise ceases to be eligible for coverage under the Plan.

As long as you are actively employed, coverage under the Plan will be considered primary and Medicare coverage will be secondary for your dependents that are eligible for Medicare.

Retirees and Disabled Participants

Medicare eligible participants: After you cease employment with the Company and you become eligible for Medicare by reason of age or disability, your medical coverage can be continued under the Plan but Medicare will become your Primary Payor. If you are eligible by reason of disability – you must be eligible for or receiving disability retirement benefits and be totally and permanently disabled. You and your dependents will no longer be eligible for the Network benefits; however you and your eligible dependents will be enrolled in Non-Network benefits. If you are eligible for Medicare due to age, Non-Network benefits for you and your dependents are effective the first of the month in which you turn 65. If you are eligible due to disability, call the Benefits HelpLine for the effective date of your Non-Network benefits. Available options are discussed further under the *Benefit Options* on page 14.

Covered Dependents eligible for Medicare: If you are retired, under age 65 and you have a dependent eligible for Medicare by reason of age or disability, the Plan will be your Primary Payor and Medicare will be the Primary Payor for your dependent.

Medicare as Primary

The Plan is not a supplement to Medicare when Medicare becomes your Primary Plan. Medicare Parts A and B must be elected because any medical benefits payable under the Plan will be offset or reduced by any amount that you are receiving or would be eligible to receive under Medicare whether or not you are enrolled in Medicare. This means that the Medicare benefits will be “carved out” of the Plan’s benefits so that the total benefit from Medicare and the Plan will always be at least as much as the Non-Network Option would have paid in the absence of Medicare. You are not eligible to continue in the CITGO plan if you elect supplemental Medicare Part D (prescription drug) coverage.

ENROLLMENT

Level of Coverage

Regardless of when you enroll, the coverage levels available to participants in the Plan are as follows:

- 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 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.

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 wish to enroll for coverage in the Plan:

- More than 31 days after your employment date;
- More than 31 days after first becoming eligible to enroll (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 Changes, see page 71*); 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 employee coverage is effective.

If you want to cover any of your eligible dependents under your medical 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. (*For details about eligible Status Changes, see page 71*).

If you do not meet either of the deadlines listed above you will not be able to enroll your eligible dependents until the next Annual Election Period, or another 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 child 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 3) 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 3) 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 Annual Election 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. If you do not make this change, the dependent(s) will not be eligible for coverage under

the Plan for the duration of the Plan Year. 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 and Spouse” coverage during the Annual Election Period. Several months later, her first child is born. Sally needs to change her level of coverage to “Employee and Family” coverage. If Sally does not change her coverage within 31 days, her child will not be covered for the duration of that Plan Year.

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. 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 canceled within 31 days of the Status Change, coverage will be canceled retroactive to the end of the month in which the dependent lost 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 Medical 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 medical 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 include the following:

- (1) Changing your or your family's coverage from one option under the Plan to another option;
- (2) Changing level of coverage by dropping dependents or adding dependents who meet eligibility requirements; or
- (3) 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 medical benefits under the Plan for that Plan Year unless you have an eligible Status Change.

Each year prior to the Annual Election Period, the Network Benefits Zip Code List is updated to show the zip codes that are mandatory Network Areas for the following Plan Year. If you are enrolled in a medical option and your eligibility for the Network options changes as a result of this update, generally your medical option will be automatically changed to an option that is available in that area effective on January 1. You may elect an option other than the automatic selection provided you do so during the Annual Election Period.

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 Medical Plan. Tom's wife, Sarah, accepts employment July 1 and elects to be covered under her employer's group medical plan. Tom may drop Sarah's coverage under the Plan as a result of the Status Change. If Tom elects to drop Sarah's coverage during the Plan Year, 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 Medical Plan, her employer's plan will be the Primary Plan for her and the Company Medical Plan will be secondary in accordance with the Coordination of Benefits rules on page 94.

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.

Pre-Existing Condition Limitations

The Plan does not contain any pre-existing condition limitations.

Transfers from Salaried to Hourly

If you are a salaried employee and are transferred to hourly status and were enrolled in the salaried medical plan, you will automatically be enrolled in this Plan based upon your enrollment choice in the salaried medical plan. For example, if you had elected “Employee and Family” coverage under the Choice EPO in the salaried medical plan, you will automatically be enrolled for “Employee and Family” coverage in the Choice EPO in this Plan upon transferring to hourly status. You will also, however, have the option to change coverage (see *Status Change* page 71).

BENEFIT OPTIONS

Eligibility for medical benefit options is determined by the zip code where you live. Employees and non-Medicare eligible participants who live in a UnitedHealthcare Network area, as defined by the Claims Administrator, are eligible to choose among two network options, the Choice EPO or the Choice Plus, or they can choose the High Deductible Health Plan (HDHP) Option. Participants who live in Non-Network areas are eligible to choose from the Non-Network option or the HDHP. Employees and non-Medicare eligible participants who live in Non-Network areas may also elect to “opt-in” to one of the network options if they are willing to travel to a network provider to obtain any non-emergency care. Retirees or disabled participants who are Medicare eligible are eligible for the Non-Network option only.

Whether you are in the Choice EPO or Choice Plus Options, the provider network for the Plan is the UnitedHealthcare Choice Network, which provides access to a large, nationwide network of Physicians. To determine whether you live in a UnitedHealthcare Choice Network area, the zip code list is available through the CITGO Internet and intranet sites or by calling UnitedHealthcare’s Customer Service or the Benefits HelpLine.

Information about participating providers in the UnitedHealthcare Choice Network may be obtained through the CITGO intranet, at <http://www.provider.uhc.com/citgo/> or by calling UnitedHealthcare’s Customer Service. Provider directories are furnished to you when you first become eligible and are also available by calling the Benefits HelpLine at 1-888-443-5707.

UnitedHealthcare Customer Service:
1-866-317-6359

Provider Directory:
<http://www.provider.uhc.com/citgo/>

If you are in the Choice EPO or the Choice Plus Option, to assure proper charges are submitted by your provider and there is no unnecessary delay in processing your claim, it’s important you present your identification card and identify yourself as a Choice Network member at the time you visit your provider.

When you select a benefit option, that option applies to all your covered dependents, including those living outside of the Network area. Your eligible dependents living outside your Network area may be able to access a network in the area where they live.

Choice EPO

Under the Choice EPO, you **must** receive all services from an in-network provider. The Choice EPO is best suited for individuals who want a cost-effective plan and are **always** willing to obtain their care from network provider. The Choice EPO does not offer out-of-network benefits except in the case of an emergency, or if you obtain an authorization to see an out-of-network specialist because there are no contracted doctors in that specialty available in your geographic area, as defined by the Claims Administrator. The Prescription Drug Program is automatically included.

The Choice EPO uses the UnitedHealthcare Choice network, which provides you access to a large, nationwide network of Physicians.

If you are in the Choice EPO and you are located in a network area that does not include an In-Network specialist in a certain field, you may call UnitedHealthcare to get an exception to see a Non-Network provider. This is called a Network Exception.

Choice Plus

Under the Choice Plus option, you may choose an in-network provider and pay a lower deductible, covered percentage and coinsurance maximum. Alternatively, you may choose an out-of-network provider but you will pay a higher deductible, covered percentage and coinsurance maximum. Out-of-Network providers are providers who are not part of the Choice Network and have not agreed to accept negotiated and discounted rates. The Prescription Drug Program is automatically included.

The Choice Plus option is best suited for individuals who want freedom of choice and who want the ability to use non-network providers. If you are in Choice Plus and you obtain any services, other than emergency care, from a non-network provider or facility, you will receive the out-of-network benefit.

Non-Network Option

The Plan also includes a Non-Network Option. The Non-Network Option provides coverage for those participants whose place of residence is in an area where UnitedHealthcare does not provide reasonable access to Choice Network providers, as determined by comparing the zip code of the participants' home address against the zip codes of network provider locations. The Non-Network Option also provides coverage for retirees or disabled participants who are Medicare eligible, whether they live in a Network area or not. If you are retired and in a Network option, your coverage will be transferred to the Non-Network Option the first day of the month in which you turn 65. Participants on disability retirement should call the Benefits HelpLine for the effective date of the transfer to the Non-Network Option.

The Non-Network Option is a traditional medical option with most eligible expenses subject to deductible and your covered percentage. You pay an initial amount (the deductible) towards medical care for you or your dependents and then the Plan begins to cover a portion of the eligible covered expenses and you pay the remainder. Once the amount that you pay reaches a coinsurance maximum, the Plan will pay 100% of eligible covered expenses. The Non-Network Option has a \$300 per person per year preventative care benefit and the Prescription Drug Program is automatically included.

Participants enrolled in the Non-Network Option who use a Choice network provider will continue to receive the Non-Network Option benefits; however the charges will be based on the lower, discounted network fee.

High Deductible Health Plan (HDHP)

The HDHP is available whether you live in or out of a network area. The HDHP option is best suited for individuals who don't expect to need major medical care in the coming year but want to have basic protection for unexpected catastrophic events or for individuals who wish to participate in a Health Savings Account (HSA). See HDHP and the Health Savings Account on page 26.

The HDHP is a medical option with all eligible care subject to a deductible and a covered percentage. Once the amount that you pay reaches an out-of-pocket maximum, the Plan will pay 100% of eligible covered expenses.

Participants enrolled in the HDHP option who use a UnitedHealthCare Choice network provider will continue to receive the HDHP benefits; however the charges will be based on the lower, discounted network fee.

HDHP Deductibles

The deductibles for the HDHP work differently from what you are accustomed to. Instead of a single and family deductible, the deductible for the HDHP is determined by the level you are enrolled in ("Employee Only", "Employee and Spouse", "Employee and Child(ren)", and "Employee and Family"). See *Deductibles under the High Deductible Health Plan (HDHP)* on page 18 for more information.

Prescription drugs under the HDHP

The HDHP includes the Prescription Drug Program; however, prescriptions are **included in the deductible** for both retail and mail order drugs. Therefore, you will pay the full discounted network cost of any prescription drug until your deductible is met. Once your deductible is met, then you will pay the costs as described in the Prescription Drug Program (see page 64 for details). In addition, the cost of your prescription drugs will be applied to your annual out-of-pocket limit.

HDHP and the Health Savings Account

The HDHP option has been added to the CITGO medical options to give you an opportunity to participate in a Health Savings Account (HSA) of your own. A HSA is a trust or custodial account established exclusively to receive tax-favored contributions (much like an IRA) on behalf of eligible individuals and their spouses and dependents, who are enrolled in a HDHP. Amounts contributed to a HSA accumulate on a tax-free basis and are not subject to tax if it is used to pay for eligible medical expenses. Eligible medical expenses also include COBRA, Medicare, and retiree group medical premiums. Contributions can be rolled over from year to year – in other words, **those contributions made in one year and not used to pay expenses in that year, may be used to pay eligible medical expenses in later years.**

BENEFIT OPTIONS

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

1. be enrolled in an eligible HDHP;
2. not be enrolled at the same time in a non-HDHP plan; and
3. not be entitled to benefits under Medicare.

The maximum annual contribution to a HSA for 2007 is \$2,850 for “Employee Only”, \$5,650 for all other levels.

CITGO is not sponsoring or administering a HSA. You do not have to participate in a HSA to enroll in the HDHP option. The HDHP is offered so you will be able to take advantage of a HSA if you so desire. Please refer to a Service Representative at a bank or insurance company that offers HSAs to learn more information about this tax-savings program.

OUT-OF-POCKET EXPENSES

Deductibles

Individual Deductible

The annual individual deductible is the initial amount of covered medical expense you must pay for each covered person before the Plan pays any benefits. The amount you pay is determined by the option you select. The annual deductible does not apply to the Choice EPO option (see page 19) and is handled differently for the HDHP option (see below). The annual deductible applies to hospital and medical expenses, certain services described in this summary, mental health and substance abuse program charges. Once a family member has met his or her deductible, reimbursement can be made from the Plan for his or her own covered expenses in excess of the deductible, regardless of whether other family members have incurred any covered expenses.

Expenses for prescription drugs are covered under the Prescription Drug Program (see page 62) and are separate from other medical benefits.

Family Deductible

The annual family deductible is met by combining individual family member deductibles for the year. Once the family deductible has been met, all family members can begin receiving benefits for covered expenses without satisfying any additional deductible.

Deductibles under the High Deductible Health Plan (HDHP)

The deductibles for the HDHP work differently than those under the Choice Plus and Non-Network Option. Instead of an individual and family deductible, the deductible for the HDHP is determined by the level you are enrolled in (“Employee Only”, “Employee and Spouse”, “Employee and Child(ren)”, or “Employee and Family”). The “Employee Only” level has a deductible of \$1,500 and all of the other levels have a deductible of \$3,000. For all levels other than the “Employee Only”, there is no individual deductible, the full deductible of \$3,000 must be met as a group (in total or by an individual) before any benefits will be paid for you or your dependents.

Expenses for prescription drugs **are included in the deductible** for both retail and mail order drugs under the HDHP option. Therefore, you will pay the full discounted network cost of any prescription drug until your deductible is met. Once your deductible is met, then you will pay the cost as outlined under the Prescription drug Program (see page 63).

OUT-OF-POCKET EXPENSES

Summary of Deductibles					
	Choice EPO Option	Choice Plus Option		Non- Network Option	High Deductible Health Plan (HDHP)
		In- Network	Out-of- Network		
Individual Deductible	Not Applicable	\$250 per person	\$1,000 per person	\$600 per person	\$1,500 for Employee Only
Family Deductible		\$750 per family	\$3,000 per family	\$1,800 per family	\$3,000 for all other levels

Covered Percentage

You and the Plan share the cost of your covered medical expenses. The percentage you pay is your covered percentage. The amount of covered percentage you pay is determined by the option you select. After the deductible is met, if applicable, the Plan begins paying its share of covered medical expenses.

Summary of Covered Percentage					
	Choice EPO	Choice Plus		Non- Network Option	HDHP
		In- Network	Out-of- Network		
You Pay	10%	20%	40%	20%	20%
Plan Pays	90%	80%	60%	80%	80%

Coinsurance Maximum (Out-of-Pocket Maximum)

Individual Coinsurance Maximum

There is a limit to the amount of covered expenses you must pay out-of-pocket in any calendar year. The coinsurance maximum provision, also known as the out-of-pocket maximum, protects you from extreme financial loss in the event of catastrophic medical expenses. After you have paid your deductible (if applicable) and your out-of-pocket costs for covered expenses have reached your coinsurance maximum, the Plan will pay 100% of the **additional eligible medical expenses** you incur during the remainder of that calendar year.

OUT-OF-POCKET EXPENSES

Important: The following out-of-pocket expenses *will not* be credited toward the coinsurance maximum or be paid at 100% after you reach your coinsurance maximum:

- Copays (\$25 or \$35) you pay for network primary and specialty care office visits;
- Copays you pay for hospital admissions (inpatient/outpatient), emergency room, urgent care, mental health and substance abuse inpatient and outpatient admissions, if applicable (copays vary by option);
- The \$300 preventive care maximum in the Non-Network and HDHP Option;
- Expenses for outpatient mental & nervous or substance abuse problems above allowed day or visit limits;
- Any expenses you pay for services not covered under the Plan;
- Any expenses you pay for charges over reasonable and customary charges - R&C Excess (see *Reasonable and Customary (R&C) Charges* on page 33);
- Any prescription drug expenses (except for the HDHP) except those administered while hospitalized. **If you are in the HDHP option, the cost of prescription drugs will be applied to your annual out-of-pocket maximum;**
- Any expense that is not a covered health service or not an eligible expense;
- Any required Plan deductibles; and
- Any notification penalties assessed.

Family Coinsurance Maximum

As with the annual deductible, the coinsurance maximum will be determined separately for each individual. The family coinsurance maximum amount is met by combining individual family member coinsurance maximums for the year. Once the family coinsurance maximum has been met, the Plan will pay 100% of the additional eligible medical expenses for the remainder of that calendar year for all covered family members.

Summary of Coinsurance Maximum					
	Choice EPO	Choice Plus		Non-Network Option	HDHP
		In-Network	Out-of-Network		
Individual Coinsurance Maximum	\$2,500	\$2,500	\$7,500	\$4,000	\$5,000
Family Coinsurance Maximum	\$5,000	\$5,000	\$15,000	\$8,000	\$10,000

Deductibles are not counted toward fulfillment of the coinsurance maximum.

OUT-OF-POCKET EXPENSES

Copayments

Copayments or copays are another type of payment for medical services if you are enrolled in the Choice EPO or the Choice Plus Option. The amount of your copay is determined by the option you select and the services you receive. There are copayments for office visits, urgent care, hospital services, hospital emergency room and treatment for mental and nervous conditions and substance abuse.

Please review the *Summary of Covered Expenses* Charts on pages 23 - 31 for copayments that may apply to you.

Lifetime Maximum Benefit

You and each of your eligible dependents have a lifetime maximum benefit of **\$2,000,000**. As you receive benefits, your maximum is reduced by the amount of Plan benefits paid. On the first day of January of each year, the unused portion of your Lifetime Maximum benefit will increase automatically by the lesser of either \$10,000 or the amount necessary to increase the remaining benefit to the applicable Lifetime Maximum benefit.

Cross-Application

Deductible Between Choice Plus In-Network and Choice Plus Out-of-Network

- If a participant satisfies the Choice Plus out-of-network deductible (\$1,000) and then sees a Choice Plus network provider, the \$250 in-network deductible would be satisfied.
- If a participant incurs expenses from an in-network Choice Plus provider first and satisfies the \$250 in-network deductible, and then sees a non-network provider, they would also have to satisfy the deductible that applies to Choice Plus out-of-network (\$1,000). In this case your total deductibles would be \$1,250.

Out-of-Network Maximum between Choice Plus Network and Choice Plus Out-of-Network

- If a participant satisfies the Choice Plus out-of-network coinsurance maximum (\$7,500) and then sees a Choice Network provider, the \$2,500 in-network coinsurance maximum would be satisfied.
- If a participant incurs expenses from an in-network Choice Plus provider first and satisfies the \$2,500 in-network coinsurance maximum, and then sees a non-network provider, they would also have to satisfy the additional coinsurance maximum that applies to Choice Plus out-of-network (\$7,500). In this case your total coinsurance maximum would be \$10,000.

OUT-OF-POCKET EXPENSES

Lifetime Maximum between In-Network and Out-of-Network

The \$2,000,000 out-of-network Lifetime Maximum does apply to the network \$2,000,000 Lifetime Maximum. In no instance will you be entitled to more than \$2,000,000 in lifetime benefits.

Transfers from Salaried to Hourly

If you are a salaried employee and transfer to hourly status, any deductibles, co-payments or other payments you made under the salaried medical plan during the Plan Year that you transfer will be credited to you under this Plan. Further, any benefits paid or used under the salaried medical plan in the Plan Year that you transfer will be applied to any Plan Year maximum benefits provided under this Plan. Finally, all benefits paid under the salaried medical plan throughout your service as a salaried employee will be applied to any maximum lifetime benefits provided under this Plan when you transfer.

COVERED EXPENSES

Summary of Covered Expenses

(The following charts are not intended to be all-inclusive)

Please refer to footnotes and the rest of the *Covered Expenses* section for additional information and details

	Choice EPO Network only – there are NO Out-Of-Network Benefits
Annual Deductible	You pay \$0 per person, \$0 per family
Covered Percentage	You pay 10%. Plan pays 90%
Annual Out-of-pocket Maximum after deductible⁽¹⁾	You pay \$2,500 per person; \$5,000 per family
Maximum lifetime benefit	\$2 Million
Allergy Tests, Treatment & Injections	You pay a \$25 or \$35 office visit copay, as applicable; no separate charge for injections; You pay 10% for testing.
Ambulance <ul style="list-style-type: none"> • Emergency Only (air or ground) Must be licensed service to nearest hospital where emergency health services can be performed. • Non-Emergency⁽²⁾ Transportation by regularly scheduled airline, railroad or air ambulance, to the nearest medical facility qualified to give the required treatment. Ground transportation must be by professional ambulance to and from a medical facility. 	<p>You pay 0%</p> <p>You pay 10%</p>
Bereavement Counseling	You pay 10%; Plan pays a maximum of \$500 per person per incident
Chiropractic Care and Spinal Treatment	You pay 10%; Plan pays \$2,500 maximum per year
Durable Medical Equipment⁽²⁾ (Includes necessary repairs as required and replacement once every 3 years for the most cost effective equipment) Care Coordination will decide if equipment should be purchased or rented. You must purchase or rent the equipment from the vendor Care Coordination identifies.	You pay 10%
Emergency Care⁽²⁾ (Hospital emergency room)	You pay \$100 copay per visit (waived if admitted to hospital)
Home Health Care⁽²⁾ (Includes necessary supplies and services supplied and billed by Home Health Care agency)	You pay 10%
Hospice Care⁽²⁾ 6 month lifetime maximum per person	You pay 10%
Injections (including allergy) received in a Physician's office	You pay \$25 or \$35 copay; no copay if no Physician charge

(1) Excludes certain expenses, including expenses for hospital copayments, network office copayments, and prescription drug expenses – see page 19.

(2) Notification may be required – see page 42.

COVERED EXPENSES

Summary of Covered Expenses

	Choice EPO (cont'd)
Inpatient hospital services⁽²⁾ <ul style="list-style-type: none"> • Semi-private room and board • Intensive/cardiac care • Routine newborn care • Miscellaneous hospital services & supplies • Surgeon • Anesthesia and administration • Physicians hospital visits 	You pay a \$250 copay per confinement & 10% after the copay
Lab/X Ray (Outpatient) including outpatient surgery, preadmission testing and diagnostic services	You pay 0%
Mammogram	You pay 0%
Maternity & Pregnancy Related Expenses <ul style="list-style-type: none"> • Physicians office • Hospital-Inpatient Stay⁽²⁾ 	You pay \$25 copay (no copay for prenatal care after 1 st visit) You pay 10% after the \$250 inpatient hospital copay
Mental Health and Substance Abuse <ul style="list-style-type: none"> • Inpatient⁽²⁾ • Outpatient 	You pay \$250 copay per confinement. You pay 10% up to 30 days confinement per year; 60 days lifetime maximum You pay \$35 copay; limit of 25 visits per year
Outpatient Surgery <i>(Includes operating and recovery room, services and supplies, facilities and surgeon fees)</i>	You pay a \$200 outpatient facility copay per admission and 10% after the copay
Physician services <i>(includes routine diagnostic testing and lab work)</i> <ul style="list-style-type: none"> • Office visits: Network Primary Care • Office visits: Network Specialty Care 	You pay a \$25 copay per office visit You pay a \$35 copay per office visit
Preventive care <ul style="list-style-type: none"> • Periodic physicals • Well-baby, child, woman and man care • Immunizations 	You pay a \$25 copay, as applicable, per visit
Prosthetic Devices <i>(includes necessary repairs as required and replacement once every 5 years)</i> <i>Repairs to rental equipment not covered</i>	You pay 10%
Reconstructive procedures, surgery, or services⁽²⁾	You pay 10%
Rehabilitation Services – Outpatient Therapy. <i>Includes Physical, Occupational and Speech Therapy</i>	You pay 10% Plan pays \$2,500 maximum per therapy per year
Skilled Nursing Care Facility/Extended Care Facility⁽²⁾	You pay 10%. Limited to 100 days per year.
TMJ Treatment Non-surgical procedures and treatment	You pay 10%. Plan pays \$1,000 lifetime maximum.

(2) Notification may be required – see page 42.

COVERED EXPENSES

Summary of Covered Expenses

	Choice EPO (cont'd)
Transplantation Services⁽²⁾⁽³⁾	You pay 10%
Urgent Care⁽²⁾	You pay \$50 copay

(2) Notification may be required – see page 42.

(3) Special URN benefits – see page 54

COVERED EXPENSES

Summary of Covered Expenses

	Choice Plus	
	In-Network	Out-of-Network
Annual Deductible	You pay \$250 per person, \$750 per family	You pay \$1,000 per person, \$3,000 per family
Covered Percentage	You pay 20%. Plan pays 80%	You pay 40% of eligible charges. Plan pays 60%
Annual Coinsurance Maximum after deductible⁽¹⁾	You pay \$2,500 per person; \$5,000 per family	You pay \$7,500 per person; \$15,000 per family
Maximum lifetime benefit	\$2 Million	\$2 Million
Allergy Tests, Treatments & Injections	You pay a \$25 or \$35 office visit copay, as applicable, no separate charge for injections; You pay 20% for testing, after deductible.	You pay 40% of eligible charges after deductible
Ambulance <ul style="list-style-type: none"> • Emergency Only (air or ground) Must be licensed service to nearest hospital where emergency health services can be performed. • Non-Emergency⁽²⁾ Transportation by regularly scheduled airline, railroad or air ambulance, to the nearest medical facility qualified to give the required treatment. Ground transportation must be by professional ambulance to and from a medical facility. 	<p>You pay 0%</p> <p>You pay 20%, after deductible</p>	<p>You pay 0%</p> <p>You pay 40% of eligible charges after deductible.</p>
Bereavement Counseling (combined limits in- & out-of network)	You pay 20%, after deductible; Plan pays \$500 per person per incident	You pay 40% of eligible charges after deductible; Plan pays \$500 per person per incident
Chiropractic Care and Spinal Treatment (combined limits in- & out-of network)	You pay 20% after deductible; Plan pays \$2,500 maximum per year	You pay 40% of eligible charges after deductible; Plan pays \$2,500 maximum per year
Durable Medical Equipment⁽²⁾ (Includes necessary repairs as required and replacement once every 3 years for the most cost effective equipment) Care Coordination will decide if equipment should be purchased or rented. You must purchase or rent the equipment from the vendor Care Coordination identifies.	You pay 20%, after deductible	You pay 40% of eligible charges after deductible
Emergency Care⁽²⁾ (Hospital emergency room)	You pay \$100 copay per visit (waived if admitted to hospital)	You pay \$100 copay per visit (waived if admitted to hospital)

(1) Excludes certain expenses, including expenses for annual deductible, hospital copayments, network office copayments, and prescription drug expenses – see page 19.

(2) Notification may be required for in-network and always required for out-of-network– see page 42.

COVERED EXPENSES

Summary of Covered Expenses

	Choice Plus (cont'd)	
	In-Network	Out-of-Network
Home Health Care⁽²⁾ <i>(Includes necessary supplies and services supplied and billed by Home Health Care agency)</i>	You pay 20%, after deductible	You pay 40% of eligible charges after deductible. Limited to 60 visits (8 hours per visit) per person per year
Hospice Care (in-patient and in-home)⁽²⁾	You pay 20% after deductible; 6 month lifetime maximum per person	You pay 40% of eligible charges after deductible; 6 month lifetime maximum per person
Injections (including allergy) received in a Physician's office	You pay \$25 or \$35 copay; no copay if no Physician charge	You pay 40% of eligible charges after deductible
Inpatient hospital services⁽²⁾ <ul style="list-style-type: none"> • Semi-private room and board • Intensive/cardiac care • Routine newborn care • Miscellaneous hospital services & supplies • Surgeon • Anesthesia and administration • Physicians hospital visits 	You pay a \$250 copay per confinement & 20% after the copay and the deductible	You pay a \$250 copay per confinement & 40% of eligible charges after the copay and the deductible
Lab/X Ray <i>(Outpatient) includes outpatient surgery preadmission testing and diagnostic services</i>	You pay 0%	You pay 40% of eligible charges after deductible
Mammogram	You pay 0%	You pay 40% of eligible charges after deductible
Maternity & Pregnancy Related Expenses <ul style="list-style-type: none"> • Physicians office • Hospital-Inpatient Stay⁽²⁾ 	<p>You pay \$25 copay (no copay for prenatal care after 1st visit)</p> <p>You pay 20% after the \$250 inpatient hospital copay and deductible</p>	<p>You pay 40% of eligible charges after deductible</p> <p>You pay 40% of eligible charges after \$250 inpatient hospital copay and deductible</p>
Mental Health and Substance Abuse <ul style="list-style-type: none"> • Inpatient⁽²⁾ • Outpatient <i>(combined limits in- & out-of network)</i>	<p>You pay \$250 copay per confinement; 20% after the copay and deductible, up to 30 days confinement per year; 60 days lifetime maximum</p> <p>You pay \$35 copay; limit of 25 visits per year</p>	<p>You pay \$250 copay per confinement; 40% of eligible charges after the copay and deductible, up to 30 days confinement per year; 60 days lifetime maximum</p> <p>You pay 40% of eligible charges after deductible; limit of 25 visits per year and 150 visits per lifetime</p>

(2) Notification may be required in-network and always required out-of-network— see page 42.

COVERED EXPENSES

Summary of Covered Expenses

	Choice Plus (cont'd)	
	In-Network	Out-of-Network
Outpatient Surgery <i>(Includes operating and recovery room, services and supplies, facilities and surgeon fees)</i>	You pay a \$200 outpatient facility copay per admission and 20% after the copay and deductible	You pay a \$250 outpatient facility copay per admission and 40% of eligible charges after the copay and deductible
Physician services <i>(includes routine diagnostic testing and lab work)</i> <ul style="list-style-type: none"> • Office visits: Primary Care • Office visits: Specialty Care 	You pay a \$25 copay per office visit You pay a \$35 copay per office visit	You pay 40% of eligible charges after deductible You pay 40% of eligible charges after deductible
Preventive care <ul style="list-style-type: none"> • Periodic physicals • Well-baby, child, woman and man care • Immunizations 	You pay a \$25 or \$35 copay, as applicable, per visit	Not Covered
Prosthetic Devices <i>(includes necessary repairs as required and replacement once every 5 years)</i> <i>Repairs to rental equipment not covered</i>	You pay 20%, after deductible	You pay 40% of eligible charges after deductible
Reconstructive procedures, surgery or services⁽²⁾	You pay 20%, after deductible	You pay 40% of eligible charges after deductible
Rehabilitation Services – Outpatient Therapy. Includes Physical, Occupational and Speech Therapy <i>(combined limits in- & out-of network)</i>	You pay 20%, after \$250 deductible; Plan pays \$2,500 maximum per therapy per year	You pay 40% of eligible charges after \$1,000 deductible; Plan pays \$2,500 maximum per therapy per year
Skilled Nursing Care Facility/Extended Care Facility⁽²⁾ <i>(combined limits in- & out-of network)</i>	You pay 20%, after deductible. Limited to 100 days per year	You pay 40% of eligible charges after deductible. Limited to 100 days per year
TMJ Treatment Non surgical procedures and treatment	You pay 20%, after deductible. Plan pays \$1,000 lifetime maximum	You pay 40% of eligible charges after deductible. Plan pays \$1,000 lifetime maximum
Transplantation Services⁽²⁾⁽³⁾	You pay 20%, after deductible	You pay 40% of eligible charges after deductible
Urgent Care⁽²⁾	You pay \$50 copay	You pay 40% of eligible charges after deductible

(2) Notification may be required in-network and always required out-of-network– see page 42.

(3) Special URN benefits – see page 54

COVERED EXPENSES

Summary of Covered Expenses

	Non-Network Option	HDHP
Annual Deductible	You pay \$600 per person, \$1,800 per family	You pay \$1,500 for Employee Only, \$3,000 for all other coverage levels
Covered Percentage	You pay 20% of eligible charges Plan pays 80%	You pay 20% of eligible charges Plan pays 80%
Annual Coinsurance Maximum after deductible⁽¹⁾	You pay \$4,000 per person; \$8,000 per family	You pay \$5,000 per person; \$10,000 per family
Maximum lifetime benefit	\$2 Million	\$2 Million
Allergy Tests, Treatments & Injections	You pay 20% of eligible charges after \$600 deductible	You pay 20% of eligible charges after applicable \$1,500/\$3,000 deductible
Ambulance <ul style="list-style-type: none"> • Emergency Only (air or ground) <i>Must be licensed service to nearest hospital where emergency health services can be performed.</i> • Non-Emergency <i>Transportation by regularly scheduled airline, railroad or air ambulance, to the nearest medical facility qualified to give the required treatment. Ground transportation must be by professional ambulance to and from a medical facility.</i> 	<p>You pay 20% of eligible charges after \$600 deductible</p> <p>You pay 20% of eligible charges after \$600 deductible</p>	<p>You pay 20% of eligible charges after applicable \$1,500/\$3,000 deductible</p> <p>You pay 20% of eligible charges after applicable \$1,500/\$3,000 deductible</p>
Bereavement Counseling	You pay 20% of eligible charges after \$600 deductible; Plan pays \$500 per person per incident	You pay 20% of eligible charges after applicable \$1,500/\$3,000 deductible; Plan pays \$500 per person per incident
Chiropractic Care and Spinal Treatment	You pay 20% of eligible charges after \$600 deductible; Plan pays \$2,500 maximum per year	You pay 20% of eligible charges after applicable \$1,500/\$3,000 deductible; Plan pays \$2,500 max per year
Durable Medical Equipment⁽²⁾ <i>(Includes necessary repairs as required and replacement once every 3 years for the most cost effective equipment)</i> <i>Care Coordination will decide if equipment should be purchased or rented. You must purchase or rent the equipment from the vendor Care Coordination identifies.</i>	You pay 20% of eligible charges after \$600 deductible	You pay 20% of eligible charges after applicable \$1,500/\$3,000 deductible
Emergency Care⁽²⁾ <i>(Hospital emergency room)</i>	You pay 20% of eligible charges after \$600 deductible	You pay 20% of eligible charges after applicable \$1,500/\$3,000 deductible
Home Health Care⁽²⁾ <i>(Includes necessary supplies and services supplied and billed by Home Health Care agency)</i>	You pay 20% of eligible charges after \$600 deductible; Limited to 60 visits (8 hours per visit) per person per year	You pay 20% of eligible charges after applicable \$1,500/\$3,000 deductible; Limited to 60 visits (8 hours per visit) per person per year

(1) Excludes certain expenses, including expenses for annual deductible and prescription drug expenses – see page 19.

(2) Notification may be required – see page 42.

COVERED EXPENSES

Summary of Covered Expenses

	Non-Network Option (cont'd)	HDHP (cont'd)
Hospice Care (both in-patient and in-home)⁽²⁾	You pay 20% of eligible charges after \$600 deductible; 6 month maximum per person	You pay 20% of eligible charges after applicable \$1,500/\$3,000 deductible; 6 month maximum per person
Injections (including allergy) received in a Physician's office	You pay 20% of eligible charges after \$600 deductible	You pay 20% of eligible charges after applicable \$1,500/\$3,000 deductible
Inpatient hospital services⁽²⁾ <ul style="list-style-type: none"> • Semi-private room and board • Intensive/cardiac care • Routine newborn care • Miscellaneous hospital services & supplies • Surgeon • Anesthesia and administration • Physicians hospital visits 	You pay 20% of eligible charges after the \$600 deductible	You pay 20% of eligible charges after the applicable \$1,500/\$3,000 deductible
Lab/X-Ray (Outpatient) includes outpatient surgery preadmission testing and diagnostic services	You pay 20% of eligible charges after the \$600 deductible	You pay 20% of eligible charges after the applicable \$1,500/\$3,000 deductible
Mammogram	The Plan pays \$300 maximum per person per year	You pay 20% of eligible charges after the applicable \$1,500/\$3,000 deductible
Maternity & Pregnancy Related Expenses <ul style="list-style-type: none"> • Physicians office • Hospital-Inpatient Stay⁽²⁾ 	You pay 20% of eligible charges after the \$600 deductible	You pay 20% of eligible charges after the applicable \$1,500/\$3,000 deductible
Mental Health and Substance Abuse Inpatient⁽²⁾	You pay 20% of eligible charges after \$600 deductible up to 30 days confinement per year; 60 days lifetime maximum	You pay 20% of eligible charges after applicable \$1,500/\$3,000 deductible; up to 30 days confinement per year; 60 days lifetime maximum
• Outpatient	You pay 20% of eligible charges after \$600 deductible; limit of 25 visits per year and 150 visits for lifetime	You pay 20% of eligible charges after applicable \$1,500/\$3,000 deductible; limit of 25 visits per year and 150 visits for lifetime
Outpatient Surgery, and Diagnostic Services (Includes operating and recovery room, services and supplies, facilities and surgeon fees)	You pay 20% of eligible charges after \$600 deductible	You pay 20% of eligible charges after applicable \$1,500/\$3,000 deductible
Physician services (includes routine diagnostic testing and lab work) <ul style="list-style-type: none"> • Office visits: Primary Care • Office visits: Specialty Care 	You pay 20% of eligible charges after \$600 deductible You pay 20% of eligible charges after \$600 deductible	You pay 20% of eligible charges after applicable \$1,500/\$3,000 deductible You pay 20% of eligible charges after applicable \$1,500/\$3,000 deductible

(2) Notification may be required – see page 42.

COVERED EXPENSES

Summary of Covered Expenses

	Non-Network Option (cont'd)	HDHP (cont'd)
Preventive care <ul style="list-style-type: none"> • Periodic physicals • Well-baby, child, woman and man care • Immunizations 	Plan pays \$300 maximum per person per year; no deductible	Plan pays \$300 maximum per person per year; no deductible
Prosthetic Devices <i>(includes necessary repairs as required and replacement once every 5 years)</i> <i>Repairs to rental equipment not covered</i>	You pay 20% of eligible charges after \$600 deductible	You pay 20% of eligible charges after applicable \$1,500/\$3,000 deductible
Reconstructive procedures, surgery or services⁽²⁾	You pay 20% of eligible charges after \$600 deductible	You pay 20% of eligible charges after applicable \$1,500/\$3,000 deductible
Rehabilitation Services – Outpatient Therapy. Includes Physical, Occupational, and Speech Therapy	You pay 20% of eligible charges after \$600 deductible; \$2,500 maximum per therapy per year	You pay 20% of eligible charges after applicable \$1,500/\$3,000 deductible; \$2,500 maximum per therapy per year
Skilled Nursing Care Facility/Extended Care Facility⁽²⁾	You pay 20% of eligible charges after \$600 deductible. Limited to 100 days per year	You pay 20% of eligible charges after applicable \$1,500/\$3,000 deductible. Limited to 100 days per year
TMJ Treatment Non-surgical procedures and treatment	You pay 20% of eligible charges after \$600 deductible. \$1,000 lifetime maximum	You pay 20% of eligible charges after applicable \$1,500/\$3,000 deductible. \$1,000 lifetime maximum
Transplantation Services⁽²⁾⁽³⁾	You pay 20% of eligible charges after \$600 deductible	You pay 20% of eligible charges after applicable \$1,500/\$3,000 deductible
Urgent Care⁽²⁾	You pay 20% of eligible charges after \$600 deductible	You pay 20% of eligible charges after applicable \$1,500/\$3,000 deductible

(2) Notification may be required – see page 42.

(3) Special URN benefits – see page 54

Important:

- (1) The Summary of Covered Expenses Charts are intended to summarize the benefits of the various options. You should refer to the appropriate sections of this Summary Plan Description for more detailed explanations of the matters referenced in these charts.
- (2) The \$25 or \$35 co-payment on in-network provider office visits will not be credited towards your coinsurance maximum or deductible, if applicable.
- (3) Choice Plus participants and their dependents have complete freedom of choice in selecting whether to use an in-network or out-of-network provider.

Conditions of Coverage

For purposes of this summary, all services described in the Plan **will not** be eligible for reimbursement unless they meet the definitions described in this section.

Covered Health Services

Plan benefits apply only to Eligible Expenses for Covered Health Services. (see *Definitions*, page 118, for definition of Eligible Expenses). Covered Health Services are those health services provided for the purpose of preventing, diagnosing or treating a sickness, injury, mental illness, substance abuse, or their symptoms. A Covered Health Service is a health care service or supply described in Covered Expenses as a Covered Health Service, which is not excluded under Not Covered Expenses, including Experimental or Investigational Services and Unproven Services.

Covered Health Services must be provided:

- When the Plan is in effect;
- Prior to the effective date of any of the individual termination conditions set forth in this Summary Plan Description; and
- Only when the person who receives services is a Covered Person and meets all eligibility requirements specified in the Plan.

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

Certain expenses are not covered under the Plan (see the section entitled *Not Covered Expenses on page 55*). Other Plan provisions are subject to limitations and maximums as described in other sections of this Summary Plan Description. Please refer to these sections for a better understanding of what the Plan will and will not cover.

Pre-Determination of Medical Benefits

If you have a question about whether treatment of a condition is payable under the Plan, you may call UnitedHealthcare Customer Service which will inform you of the extent of benefits payable under the Plan or you may submit a written description of the proposed medical treatment and its cost to the Claims Administrator. The submitted description must be completed by a Physician. Any notification is subject to other expenses which may have been submitted under the Plan and does not guarantee payment of the estimated benefits.

COVERED EXPENSES

Please note that written notification of benefits may take up to 30 days.

<p>UnitedHealthCare P.O. Box 740800 Atlanta, GA 30374-0800</p> <p>Customer Service: 1-866-317-6359</p> <p>Group Number: 229556</p>

Eligible Charges for Non-Network Providers

The Plan will reimburse a portion of covered expenses up to the lesser of billed charges amount or an amount determined by UnitedHealthcare to be reasonable and customary (R&C) for that service. All services except those relating to surgery will be based on billed charges. Surgeon fees and related surgical fees, such as assistant surgeon fees and anesthesiologist fees, will be based on R&C charges.

Billed Charges

Billed charges are the original amounts that the provider bills for services rendered.

Reasonable and Customary (R&C) Charges

The R&C charge for a surgical service is the lower of the provider's usual charge or the prevailing charge in the geographic area where it is furnished - as determined by UnitedHealthcare. UnitedHealthcare 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. For example, a charge is considered reasonable and customary if it falls at or below 8 out of 10 other charges for that procedure surveyed (80% rule).

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. The Choice Plus Option (for out-of-network services) accepts the industry standard for determining R&C charges by the 80% rule. In most cases, the average charge will fall below the 80th percentile and within the R&C limit. By using this standard, only 20% of all provider charges will fall above these R&C limits. The Non-Network Option and the High Deductible Health Plan (HDHP) use 90% R&C.

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

Therapeutic vs. Maintenance Care

Although the Plan covers chiropractic services and other therapies (for example, physical, occupational, and speech therapies), there may come a time in treatment when the care provided ceases to be "therapeutic" and instead is administered to "maintain" a level of functioning. Maintenance care does not satisfy the Plan definition of Covered Health Service (see page 32) and, therefore, is not covered under the Plan.

If you are receiving chiropractic, physical therapy, or other similar treatment, you should encourage your provider to submit these claims for reimbursement *as soon as possible*. There is a maximum amount covered for these treatments, so if claims are submitted promptly then you may avoid going over the limit.

Care Coordination

The Care Coordination program is designed to encourage an efficient system of care for you and your covered dependents by identifying and addressing possible covered health care needs that are not met. This may include admissions counseling, inpatient care advocacy, and certain discharge planning and disease management activities.

One of the most important services of Care Coordination is pre-admission and concurrent review of hospital care. Under this part of the program, you are **required** to call Care Coordination if you or any of your dependents are going to be hospitalized, receive home or hospice care, require durable medical equipment over \$1,000, or need reconstructive surgery under the out-of-network portion of the Choice Plus Option or under the Non-Network Option or HDHP. In these cases, if you do not notify Care Coordination it may result in a \$1,000 penalty. Please see the section titled *Notification Requirements* on page 42 for more information.

Care Coordination should be called whenever inpatient surgery is proposed. They can review the merits of getting a second opinion and help you identify and examine possible alternatives to surgery. If you and your Physician agree to treatment on an outpatient basis and plans change and an overnight stay is required, Care Coordination must be notified of the change.

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

Care Coordination

1-866-317-6359

Care Coordination can be called anytime you need more information before proceeding with medical care. They can be of valuable assistance to you in reaching important health care decisions. Examples of this include:

- If a prolonged hospital stay is proposed, is alternate care available?
- Do you need assistance finding a nurse to provide care at home after discharge from the hospital?

If you answered “yes” to any of these questions, contact Care Coordination for more information.

Alternatives to a Hospital Stay

Hospice

Hospice care, both inpatient and home hospice, is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill patient. Hospice services must be ordered/prescribed by a physician. The Plan pays the applicable covered percentage of eligible charges, after the deductible, if applicable, when services are rendered by a Hospice provider. Hospice care is limited to six months per lifetime. Please notify Care Coordination 72 hours before receiving the services (if you don't, your benefits will be subject to a \$1,000 penalty).

The Plan will also pay up to \$500 for **Bereavement Counseling** services provided by a licensed M.D., P.H.D., social worker or counselor for the patient's immediate family within six months after the patient's death.

Home Health Care

The Plan will pay the applicable covered percentage of eligible charges, after the deductible, if applicable, for Home Health Care provided by or supervised by a registered nurse in your home. The services from a Home Health Care agency must be ordered by a Physician. Benefits are available only when the Home Health Care agency services are provided on a part-time, intermittent schedule and when skilled home health care is required. Skilled home health care is skilled nursing, skilled teaching, and skilled rehabilitation services, it is not custodial care. If you are using non-network benefits, the coverage is limited to 60 visits per calendar year, with one visit equaling eight hours.

You must notify Care Coordination before receiving services (if you don't, your benefits will be subject to a \$1,000 penalty).

Private duty nursing care must be given on an outpatient basis by a licensed Nurse (R.N., L.P.N., or L.V.N.). Private duty nursing received on an inpatient basis is not covered.

COVERED EXPENSES

Skilled Nursing Facility Care/Extended Care Facility

The Plan will cover room and board accommodations and other services and supplies for up to 100 days per calendar year at an approved Skilled Nursing Facility or Extended Care Facility. The care must be rehabilitative in nature rather than care that is deemed custodial, which is a non-covered expense.

Please note that, in general, the intent of skilled nursing is to provide benefits to eligible participants who are convalescing from an injury or illness that requires an intensity of care or a combination of skilled nursing, rehabilitation and facility services which are less than those of a hospital but greater than those that are available in the home setting.

The Plan will pay the applicable covered percentage of eligible charges, of the facility's regular charge for a semi-private room. Care Coordination must be notified as follows:

- For elective admissions: 72 hours before admission;
- For emergency admissions: within two business days after admission; or
- For non-elective admissions: within two business days after admission.

If you don't notify Care Coordination, benefits will be subject to a \$1,000 penalty.

The following Covered Expenses are in alphabetical order for your convenience:

Assistant Surgeons

Although certain procedures sometimes require an assistant surgeon, in many cases, an assistant surgeon is not considered to be a Covered Health Service (see page 32). Covered Health Services for an assistant surgeon will be covered at 50% of the R&C amount or negotiated rate of the primary surgeon's fees.

Cancer Resource Services

The Plan offers you access to Cancer Resource Services, a program offered through UnitedHealthcare for all non-Medicare eligible participants. This program provides assistance, information and access to top cancer centers on an in-network basis if you or a covered dependent is diagnosed with cancer. Use of this program is voluntary, and there is no charge to take advantage of it.

Cancer Resource Services is intended to help you understand your cancer care options. It is not intended to offer medical advice – you still make the decision about what care to receive and where to receive it. Cancer Resource Services has agreements with many of the nation's leading cancer centers.

COVERED EXPENSES

By contacting Cancer Resource Services, you can determine the location of the nearest cancer resource center and be sure that your claims will be paid on an in-network basis. If you are in the Non-Network or HDHP Plan, you will continue to receive the benefits under your option, but your charges will be based on the lower, discounted network fees.

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

<p style="text-align: center;">UnitedHealthcare Cancer Resource Services 1-866-317-6359</p>
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Dental Expenses & Oral Surgery Charges

The Plan will pay the applicable covered percentage of eligible charges after the deductible, if applicable, for the following expenses:

- (a) Non-surgical treatment of Temporomandibular Joint (TMJ) disorders with a maximum of \$1,000 per lifetime;
- (b) Oral surgery and other dental restoration to natural teeth will be covered if required to correct fractures and dislocations resulting from an accident or injury which resulted in hospital confinement or hospital emergency room; and
- (c) Upper and lower jawbone surgery as required for direct treatment of acute traumatic injury or cancer. Orthognathic surgery, jaw alignment and treatment for the temporomandibular joint, as a treatment of obstructive sleep apnea.

All other dental and oral surgery charges are subject to the provisions of your dental plan.

Disease Management Program

The Plan offers a Disease Management Program that is offered through United HealthCare. The goal of this voluntary program is to assist you in managing the following conditions. As a participant, you will have access to a toll-free support line to contact experienced registered nurses with questions about your condition, symptoms, medications, or other health information. Complimentary educational materials will be sent to your home, and you will also have access to additional educational information on the Disease Management web site. The Disease Management Program has much to offer – and all at no cost to you.

**Disease Management
Program
1-866-317-6359**

All non-Medicare eligible participants of the Plan are eligible for this program. If you have any questions about the program or to find out how you can benefit from it, you can contact Disease Management through UnitedHealthcare.

Durable Medical Equipment

The Plan will pay for the most cost effective piece of equipment at the covered percentage, in accordance with the benefit option for durable medical equipment after the deductible, if applicable. Necessary required repairs of durable medical equipment are covered as well as one replacement every 3 years. However, one wig per lifetime is covered if due to loss of hair resulting from treatment of a malignancy, medical condition causing hair loss or permanent loss of hair from an accidental injury.

Care Coordination must be contacted for any single item that is over \$1,000 (either purchase price or cumulative rental). Care Coordination will decide if equipment should be purchased or rented. You must purchase or rent the equipment from the vendor Care Coordination identifies.

Emergency Care (Outpatient)

Emergency Care are services that are required to stabilize or initiate treatment in an Emergency. Emergency Care must be received on an outpatient basis at a hospital or alternate facility.

If you are in the Choice EPO or Choice Plus Option, to ensure prompt and accurate payment of your claim as a network benefit, notify Care Coordination within two business days after you receive outpatient Emergency Care at an in or out-of-network hospital or alternate facility.

Please remember that if you are admitted to a hospital, you **must** notify Care Coordination within two business days.

Maternity & Pregnancy-Related Expenses

Participant or Participant's Spouse: The Plan will cover expenses incurred by a participant or participant's spouse due to pregnancy, childbirth or pregnancy-related conditions in accordance with your benefit option. If you are in a network option, there is a \$25 copay for the mother's initial Physician visit. The Plan will then pay the applicable covered percentage of eligible charges after the deductible, if applicable, for the remaining eligible expenses including delivery fees and postnatal care. If you are out-of-network, then the Plan will pay the covered percentage after the deductible, if applicable, for all covered services. Services include tests that are considered Covered Health Services (see page 32) that your doctor may prescribe related to

COVERED EXPENSES

pregnancy, such as amniocentesis and sonograms. For example, an amniocentesis performed solely to learn the sex of the unborn child is not a Covered Health Service and, therefore, will not be covered.

Other Dependents: Expenses incurred by a dependent child due to pregnancy, childbirth or pregnancy-related conditions **are not covered** under this Plan, although complications resulting from pregnancy, childbirth or pregnancy-related conditions are covered for a dependent child on the same basis as any other illness.

Conditions of Coverage: Expenses relating to an abortion for yourself or your covered spouse will be covered when the procedure is a Covered Health Service (see page 32) or when the abortion is spontaneous (non-elective). Elective abortions are not covered, although complications resulting from an elective abortion are covered under the Plan.

The minimum authorized length of stay for the mother and newborn is 48 hours following a vaginal delivery and 96 hours following a cesarean delivery. However, the attending Physician, in consultation and agreement with the mother, may discharge the mother or newborn earlier than the 48 hours or 96 hours, as applicable. If an attending Physician wants the mother or newborn to stay longer than the minimum authorized length of stay, your Physician is required to call Care Coordination at 1-866-317-6359, as soon as reasonably possible.

Birthing Centers

Covered maternity and pregnancy-related services rendered at an approved Free-Standing Birthing Center, such as room and board and miscellaneous supplies and services, including anesthesia and its administration, will be payable under the Plan. In-network benefits will apply if you are in the Choice EPO and Choice Plus Option only if the birth center is contracted as a network facility. You can contact Care Coordination at 1-866-317-6359, to find out whether a particular Birthing Center is an approved facility.

Please refer to the *Definitions* section, page 119, for further clarification of a “Free-Standing Birthing Center”.

Midwife

The Plan will cover the services of a Midwife only if you are in the Choice EPO or Choice Plus Option and the Midwife is contracted as a network provider at a network facility. A midwife is not covered for out-of-network or non-network benefits.

Multiple Surgical Procedures

If more than one surgical procedure is performed on a participant during any one surgical operation on the same day, the maximum allowable covered medical expense for surgeons' charges will consist of the first procedure and will be based on the option's covered percentage for the primary surgical procedure, plus 50% of what would normally be considered the R&C or negotiated rate for the secondary surgical procedure, plus 50% of R&C or negotiated rate for any subsequent procedure. Criteria for providers who perform two or more surgical procedures through the same site during a single operation are subject to review.

Reimbursement for each procedure will be made at the lesser of billed charges or the percentage of the R&C or negotiated rate.

Newborn and Well Baby Care

Newborn coverage refers to services and supplies provided to a newborn infant during the initial hospital confinement. The following newborn charges will be covered under the Plan at the applicable covered percentage of eligible charges after the deductible, if applicable:

- (1) Hospital charges, including nursery care;
- (2) Doctor's charges for delivery and in-hospital visits; and
- (3) Physician's charges for circumcision.

See *Enrolling Your Dependent(s)*, page 9, for adding coverage for a newborn dependent.

Well Baby Care refers to the routine examinations and immunizations provided in the doctor's office. Well Baby Care is covered under the Plan for the in-network options (Choice EPO and the in-network benefit of the Choice Plus). The in-network benefit will cover Well Baby Care provided in an office setting and an immunization program covering childhood diseases for children at 100% after the applicable per office visit co-payment amount. Well Baby Care will only be covered if you are in the Non-Network Option for a maximum of \$300 per year.

COVERED EXPENSES

Notification Requirements

You or your network provider is required to notify Care Coordination, Customer Service or United Behavioral Health if you or any of your dependents receive the following services:

Service	Notification Requirement	Notify
Ambulance transfer – non-emergency	Pre-notification required	Care Coordination
Durable Medical Equipment or Prosthetic Device obtaining any single item of cost effective durable medical equipment or prosthetic device that costs more than \$1,000 (purchase price or accumulated rental cost)	Notify before obtaining the item	Care Coordination
Home Health Care	Notify before receiving services	Care Coordination
Hospice (inpatient and in-home care)	Notify 72 hours before receiving services	Care Coordination

COVERED EXPENSES

Service	Notification Requirement	Notify
Inpatient hospital stay	Elective admission: 72 hours before admission. Emergency admission: within two business days. Non-elective admission: within two business days.	Care Coordination
Inpatient hospital stay of a mother and/or the newborn that will be more than the time frames described below: <ul style="list-style-type: none"> • 48 hours for the mother and newborn child following a normal vaginal delivery • 96 hours for the mother and newborn child following a cesarean section delivery 	As soon as reasonably possible	Care Coordination
Mental health and substance abuse inpatient and outpatient services	Call UBH and obtain authorization to receive these benefits in advance of treatment	United Behavioral Health
Private Duty Nursing	Notify 72 hours before receiving services	Care Coordination
Reconstructive procedures	72 hours before receiving services. Care Coordination can verify that the service is a reconstructive procedure rather than a cosmetic procedure. Cosmetic procedures are always excluded from coverage	Care Coordination

COVERED EXPENSES

Service	Notification Requirement	Notify
Skilled nursing facility/Extended care facility	Elective admission: 72 hours before admission. Emergency admission: within two business days Non-elective admission: within two business days	Care Coordination
Transplantation Services	Notify as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center)	Care Coordination

Care Coordination 1-866-317-6359	Customer Service 1-866-317-6359	United Behavioral Health 1-866-317-6359
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This notification process is mandatory and your cooperation in making that initial phone call is essential to the success of the program. Failure to initiate this notification process by making the phone call to Care Coordination may result in a \$1,000 penalty.

In all cases of notification - Care Coordination, Customer Service or United Behavioral Health may be contacted by the patient’s representative - a family member, friend, doctor, hospital staff member or the Benefits HelpLine.

NurseLine Services

CITGO and UnitedHealthcare provide participants the opportunity to speak to an experience registered nurse 24 hours a day, every day of the year. The nurse can help you learn self-care techniques and understand what symptoms might mean at no cost to you.

Participants can access the NurseLine Services by calling toll free, 1-866-735-5686 or by logging onto the internet site: www.myuhc.com.

In addition to talking to a “live” nurse about issues such as choosing appropriate medical care, routine illness questions, minor injuries and treatment, chronic conditions, recognizing symptoms, medication safety, heart health issues and working with your doctor, there is also access to an extensive Health Information Library with over 1,100 prerecorded topics.

NurseLine Services

Available 24 hours a day – 7 days a week

1-866-735-5686

To reach a nurse – press 1

To reach the Health Information Library – press 2
and enter PIN 980

Preventive Care

Annual physical exams will be covered at the level in accordance with your benefit option based on current American Medical Association guidelines.

Well-baby, child, woman and man care, including immunizations, is covered under the Plan for the in-network options (Choice EPO and the in-network benefit for the Choice Plus) at the applicable copayment amount. The copayment for a routine annual well woman examination (including pap smears, pelvic examinations and mammograms) is \$25. Preventive care is covered under the HDHP option at the covered percentage.

Preventive care is generally not covered under the Choice Plus out-of-network. The office visits for mammograms and pelvic examinations will not be covered but the actual procedure will be covered at the appropriate covered percentage. The Plan will pay a \$300 maximum benefit per person per calendar year for preventive care if you are in the Non-Network or HDHP Option. The \$300 maximum is not subject to deductible.

Radiology, Anesthesiology and Pathology (RAP)

If you are in the Choice EPO or the Choice Plus, all RAP services will be paid at the network level regardless of whether the individual provider is in the network. All RAP services, except those received during a hospital stay, will be covered at 100%. RAP services received during a hospital stay will be covered at the appropriate covered percentage of your benefit option (90% or 80%).

Reconstructive Procedures

Services are considered reconstructive procedures when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function for an organ or body part. By improving or restoring physiological function means that the target organ or body part is made to work better. An example of a reconstructive procedure is a surgery on the inside of the nose so that a person's breathing can be improved or restored. If the services improve appearance without making an organ or body part work better than it is considered a cosmetic procedure. Cosmetic procedures are not covered. Care Coordination must be notified 72 hours before receiving reconstructive procedures.

COVERED EXPENSES

If you or your dependent receives benefits in connection with a mastectomy and elects breast reconstruction in connection with the mastectomy, the Plan shall also provide coverage for:

1. Reconstruction of the breast on which the mastectomy has been performed; and
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance.

Rehabilitation Services – Outpatient Therapy

Rehabilitation services or outpatient therapy include:

- Physical therapy,
- Occupation therapy,
- Speech therapy, or
- Vision therapy (only if due to injury or congenital)

The Plan pays the applicable covered percentage of eligible charges, after the deductible, if applicable, for rehabilitation services up to a maximum of \$2,500 per therapy per calendar year.

Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician. Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in your condition within two (2) months of the start of treatment.

The Plan will cover benefits for speech therapy only when the speech impediment or speech dysfunction results from Injury, stroke or a Congenital Anomaly.

Reproduction

Contraceptive devices are covered subject to the covered percentage, plus any deductibles, if applicable, and copayments for your benefit option.

Sterilization and reversals, tubal ligation and reversals and infertility diagnosis are covered as well.

Second Surgical Opinion

A "qualified" second surgical opinion is a second opinion that is obtained from a board-certified surgeon, who is not the surgeon originally scheduled to perform the surgery. Obtaining a second surgical opinion is voluntary on your part; it is not required. Covered charges include:

- Charges for consultation with the surgeon or surgeons, provided the surgeon examines the patient and furnishes a written report to the Claims Administrator, and
- Charges for laboratory and x-ray examinations and their diagnostic procedures in connection with or as a result of the consultation.

**To contact UnitedHealthcare
Customer Service, call toll
free:
1-866-317-6359**

Charges for a second surgical opinion are covered on any procedure you are considering at the appropriate copay or covered percentage of your benefit option. UnitedHealthcare can help you find a board-certified surgeon in your area for a second surgical opinion.

Transplantation Services

The Plan will cover, after the deductible, if applicable, and at the applicable covered percentage of eligible charges, services and supplies connected with a Plan participant who is a recipient of one of the following organ or tissue transplants:

- (1) Heart,
- (2) Heart/Lung,
- (3) Bone marrow,
- (4) Lung,
- (5) Kidney,
- (6) Kidney/pancreas,
- (7) Pancreas,
- (8) Cornea,
- (9) Liver/small bowel,
- (10) Liver, or
- (11) Small bowel

COVERED EXPENSES

Benefits are not available for the transplant if it is an Experimental or Investigational Service or Unproven Service. If a separate charge is made for a bone marrow/stem cell search, a maximum benefit of \$25,000 is payable for all charges made in connection with the search.

In any instance involving organ or tissue transplant, contact UnitedHealthcare.

**To contact UnitedHealthcare
call toll free:
1-866-317-6359**

United Resources Network Transplant Management (URN)

Transplantation services may be received at a Designated United Resource Network Facility (URN). URN is a group of hospitals that are highly specialized and are established leaders in the field of transplantation. They provide a high quality of care and have high success rates. In addition, they also report shorter hospital stays and fewer incidents of complications. URN is a voluntary program, however it would be beneficial to you to utilize these services because charges for services at a URN facility are covered at 100% (under the HDHP the applicable deductible must first be satisfied) and expenses are covered for travel, lodging and meals as listed below.

Benefits are also available for cornea transplants; however, they are not required to be performed at a Designated United Resource Network Facility. If you receive services by a Network Physician at a Network hospital then it will be covered as In-Network. The cornea transplant is not subject to the travel benefit due to not being part of URN services. This benefit is subject to the covered percentage plus any deductibles, if applicable, and copayments for your benefit option.

For organ or tissue transplant services provided by a Designated United Resource Network Facility, URN provides specialized services including:

- Referral to leading transplant institutions around the country;
- Special managed care services provided by a regional organ transplant coordinator;
- Negotiated discounts with network providers; and
- Assistance with travel-related expenses. **Expenses for travel, lodging and meals are available for in-network benefits only as follows:**
 - Transportation of the patient and one companion who is traveling on the same day(s) to and or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up.
 - Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the Designated United Resource Network Facility.

COVERED EXPENSES

- Eligible expense for lodging and meals for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to \$50 for one person or up to \$100 for two people.
- If the patient is an eligible dependent who is a minor child, the transportation expenses of two companions will be covered and lodging and meal expense will be reimbursed up to the \$100 per diem rate.

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

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

Urgent/Immediate Care

An Urgent Care center is a facility other than a hospital that provides services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen sickness, injury or the onset of acute or severe symptoms. If you are in the Choice EPO or Choice Plus you will have a copayment of \$50 for urgent care if you receive care at a network Urgent Care facility. If you are in the Choice EPO, to ensure payment of your claim as a network benefit, you must notify UnitedHealthcare's Customer Service within two business days after you receive urgent care if the facility is non-network. If you are in the Choice Plus and receive care at a non-network facility, you will pay 40% of the eligible charges after your \$1,000 deductible unless you had a true emergency (refer to the *Definitions* section, page 118, for further clarification of "Emergency Care").

**To contact UnitedHealthcare
call toll free:
1-866-317-6359**

Vision and Hearing

The Plan will cover eligible expenses for eye examinations and hearing screenings due to injury or medical condition in accordance with your benefit option.

All other vision charges are subject to the provisions of the vision plan.

MENTAL HEALTH/SUBSTANCE ABUSE PROGRAM

MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAM

The Plan has contracted with United Behavioral Health (UBH), to manage all aspects of your inpatient mental health needs through the Mental Health and Substance Abuse Program (MH/SA). UBH Total Care Management is an integrated, managed behavioral health program that provides management and oversight of outpatient mental health and substance abuse care to better service participants and improve their care. Remember, however, that you also have the Employee Assistance Program (EAP) for initial services. The EAP information is provided in a separate SPD.

Overview

The Mental Health and Substance Abuse Program is intended to provide you with the resources necessary for you and your covered dependents to get efficient and appropriate care for problems related, but not limited, to:

- depression,
- drug and alcohol abuse,
- marital or family problems,
- anxiety,
- stress,
- grief, or
- loss.

The key to the MH/SA Program is access to care and confidentiality. UnitedHealthcare and UBH have set up a network of providers through which you can get the care you require at reduced cost.

As with all goods and services covered under the Plan, only treatment that is determined to be a covered health service will be covered under the UBH program.

MENTAL HEALTH/SUBSTANCE ABUSE PROGRAM

Precertification

Before you receive inpatient or outpatient treatment, you must access a counselor at UBH Behavioral Health (UBH). The line is staffed 24 hours a day, seven days a week. The counselor will help match you to a UBH network provider with the clinical expertise, accessibility and any other special qualifications to meet your needs. You will receive the names, addresses and phone numbers of available providers in the UBH network. You must confirm your choice of provider with UBH prior to your first appointment. You will then call the UBH provider to schedule your first appointment. Tell the provider that you were referred by UBH and that you are covered under the CITGO Medical Plan. Your UBH provider will monitor your care to make sure it is medically necessary and appropriate. You will pay your share of the cost for the treatment and the UBH network provider will complete and submit all claim forms directly to UBH.

**To contact
United Behavioral Health (UBH)
call toll-free
1-866-317-6359**

Inpatient Care

To qualify for the higher in-network level of benefits under this program (see *Schedule of Benefits for Mental Health/Substance Abuse, page 54*), you must:

- (1) call UBH before treatment begins for precertification, and
- (2) follow the UBH-approved course of treatment.

Inpatient care for Mental Health and Substance Abuse is received in a hospital or alternate facility. All inpatient care must be authorized by UBH. Failure to contact UBH to authorize any inpatient treatment for mental health/substance abuse-type problems, in advance of any treatment, will result in a penalty of \$1,000.

Inpatient care is limited to 30 days confinement per year and 60 days per lifetime, whether in-network or out-of-network.

MENTAL HEALTH/SUBSTANCE ABUSE PROGRAM

Outpatient Care

To qualify for the higher in-network level of benefits under this program (see *Schedule of Benefits for Mental Health/Substance Abuse, page 54*), you must first call UBH for precertification.

Mental Health and Substance Abuse services received on an outpatient basis in a provider's office or an alternate facility include:

- Mental health, substance abuse and chemical dependency evaluations and assessment.
- Diagnosis.
- Treatment planning.
- Referral services.
- Medication management.
- Short-term individual, family and group therapeutic services (including intensive outpatient therapy).
- Crisis intervention.
- Psychological testing.

Outpatient care for both mental health and substance abuse is limited to 25 visits per year, whether in-network or out-of-network. However, if you are seeing a non-network provider, there is a lifetime limit of 150 visits.

**To contact United Behavioral Health
call toll-free**

1-866-317-6359

Emergency Care

For emergency care, the UBH counselor will direct you to the appropriate resource for care. In an emergency mental health or substance abuse situation, your priority is to get help as quickly as possible. If you cannot call UBH in an emergency and you are admitted to the hospital, you or a family member, the facility or the provider must call UBH no later than 48 hours after admission for authorization. Failure to contact UBH will result in a \$1,000 penalty.

An **emergency** is any situation in which failure to get immediate care may result in serious harm or danger to you, the patient, or to others.

**MENTAL HEALTH/SUBSTANCE ABUSE
PROGRAM**

To contact UBH, call toll-free

1-866-317-6359

MENTAL HEALTH/SUBSTANCE ABUSE PROGRAM

Out-of-Network Benefits

Out-of-network benefits (see *Schedule of Benefits for Mental Health/Substance Abuse, page 54*) are for the participants of the Non-Network Option, the HDHP and for those participants of the Choice Plus using the non-network providers.

You should keep in mind if you choose to use a non-network provider your benefits are substantially lower. In addition, remember both out-of-network inpatient care and emergency care requires you to call UBH to avoid a penalty reduction.

MENTAL HEALTH/SUBSTANCE ABUSE PROGRAM

Schedule of Mental Health/Substance Abuse Benefits					
At a Glance	Choice EPO	Choice Plus		Non-Network Option	HDHP
		In-Network	Out-of-Network		
Specific Benefits	You Pay:	You Pay:	You Pay:	You Pay:	You Pay:
Medical Deductible Applies?					
Outpatient	No	No	No	No	Yes
Inpatient	No	Yes	Yes	Yes	Yes
Annual Deductible	\$0	\$250	\$1,000	\$600	\$1,500/\$3,000
Covered Percentage					
• You Pay	10%	20%	40% of eligible charges	20% of eligible charges	20% of eligible charges
• Plan Pays	90%	80%	60% of eligible charges	80% of eligible charges	80% of eligible charges
Outpatient:					
• Copayment Per Visit	\$35	\$35	N/A	N/A	N/A
• Limits					
- Annual Visits	25	25	25	25	25
- Lifetime Visits	N/A	N/A	150	150	150
Inpatient:					
• Copayment Per Admission	\$250	\$250	\$250	N/A	N/A
• Limits					
- Annual Days	30	30	30	30	30
- Lifetime Days	60	60	60	60	60
Notification Requirements					
<ol style="list-style-type: none"> 1. UBH pre-authorization required for inpatient care. 2. Failure to obtain pre-authorization will result in a \$1,000 penalty. 3. Emergency admissions, notification must be received within 48 hours of admission 					

Copayments and non-network covered percentage amounts for outpatient MH/SA will **not** be applied to meet annual deductibles and coinsurance maximums in the Plan.

NOT COVERED EXPENSES

In addition to the exceptions detailed in the *Covered Expenses* section, there are other expenses not covered under the Plan. **The following list of benefit exclusions is not all-inclusive.** Other specific expenses may be determined to be not covered under the Plan by the Claims Administrator. If you have a question on a specific expense, you should contact the Claims Administrator.

To help you find specific exclusions more easily, we use headings to group the expenses or services. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you. The Plan will not pay benefits for any of the services, treatments, items or supplies described in this section as determined by the Claims Administrator in its sole discretion, even if it is recommended or prescribed by a Physician or it is the only available treatment for your condition.

Alternative Treatments

1. Acupressure.
2. Acupuncture not performed by an MD or licensed acupuncturist.
3. Aromatherapy.
4. Hypnotism.
5. Massage therapy.
6. Rolfing (soft tissue manipulation and movement education that alters a person's posture and structure.).
7. Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

Comfort or Convenience

1. Capital improvements to your home that do not have an exclusive health reason, such as swimming pool, spa or duct cleaning for allergies.
2. Television.
3. Telephone.
4. Beauty/Barber service, including tanning bed.
5. Guest services.
6. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
 - Air conditioners.
 - Air purifiers and filters.
 - Batteries and battery chargers.
 - Dehumidifiers and Humidifiers.
7. Devices and computers to assist in communication and speech.
8. Lifts and ramps.

NOT COVERED EXPENSES

Experimental, Investigational or Unproven Services

Experimental or Investigation Services and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven, in the treatment of that particular condition.

Experimental, Investigational or Unproven Services are defined as:

Medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Claims Administrator, in its sole discretion, makes a determination regarding coverage in a particular case, are determined to be:

1. not approved by the U.S. Food and Drug Administration (“FDA”) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service, or the United States Pharmacopoeia Dispensing Information, as appropriate for the proposed use; or
2. subject to review and approval by any institutional review board for the proposed use; or
3. the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

If you have a life-threatening sickness or condition (one which is likely to cause death within one year of the request for treatment) the Claims Administrator may, in its discretion, determine that an Experimental or Investigational or Unproven Service meets the definition of a Covered Health Service for that sickness or condition. For this to take place, the Claims Administrator must determine, at its discretion, that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Foot Care

1. Except when needed for severe systemic disease:
 - Routine foot care (including the cutting or removal of corns and calluses).
 - Nail trimming, cutting or debriding.
2. Hygienic and preventive maintenance foot care. Examples include the following:
 - Cleaning and soaking the feet.
 - Applying skin creams in order to maintain skin tone.
 - Other services that are performed when there is not a localized illness, injury or symptom involving the foot.
3. Treatment of flat feet.
4. Treatment of subluxation (misalignment of the bones that form a joint) of the foot.

Medical Supplies and Appliances

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
 - Ace bandages.
 - Over the counter elastic or support stockings.
 - Gauze and dressings.
 - Syringes (available through Prescription Drug Program).
 - Diabetic test strips (available through Prescription Drug Program).
3. Tubings, nasal cannulas, connectors and masks are not covered except when used with durable medical equipment.

Nutrition

1. Megavitamin and nutrition based therapy.
2. Nutritional counseling for either individuals or groups, including weight loss programs, health clubs and spa programs.
3. Enteral feedings and other nutritional and electrolyte supplements, including infant formula, donor breast milk, nutritional supplements, dietary supplements, electrolyte supplements, diets for weight control or treatment of obesity (including liquid diets or food), food of any kind (diabetic, low fat, cholesterol), oral vitamins and oral minerals. Plan will cover enteral feedings/nutritional formula for sole source of nutrition provided through a feeding tube rather than through oral ingestion, or to treat inborn errors of metabolism.

Physical Appearance

1. Cosmetic Procedures. Examples include:
 - Pharmacological regimens, nutritional procedures or treatments.
 - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
 - Skin abrasion procedures performed as a treatment for acne.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a cosmetic procedure.
Note: replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.
3. Physical conditioning programs such as athletic training, body-building, exercise, fitness flexibility, and diversion or general motivation. Includes health club dues.
4. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
5. Liposuction.
6. Wigs are not covered **except** one per lifetime **is** covered if needed due to a loss of hair resulting from treatment of a malignancy, medical condition causing hair loss, or permanent loss of hair from an accidental injury. (Also see *Durable Medical Equipment*, page 37).

NOT COVERED EXPENSES

Providers

1. Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal residence.
3. Services provided at a free-standing or hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
 - has not been actively involved in your medical care prior to ordering the service, or
 - is not actively involved in your medical care after the service is received.This exclusion does not apply to mammography testing.
4. Christian Science practitioners.
5. Any charges by a provider sanctioned under a federal program for reason of fraud, abuse or medical competency.
6. Any charges by a resident in a teaching Hospital where a faculty Physician did not supervise services.
7. Services rendered through a medical department, clinic or similar facility provided or maintained by the patient's employer.

Reproduction

1. Surrogate parenting.
2. Fees or direct payment to a donor for sperm or ovum donations.
3. Embryo transport.
4. Monthly fees for maintenance and/or storage of frozen embryos.
5. Over the counter contraceptive supplies.
6. Health services and associated expenses for elective abortion.
7. Fetal reduction surgery.
8. Health services associated with the use of non-surgical or drug-induced pregnancy termination.
9. In vitro fertilization, gamete intrafallopian transfer (GIFT) procedures, and zygote intrafallopian transfer (ZIFT) procedures, and any related prescription medication treatment.
10. Donor ovum and semen and related costs, including collection and preparation.
11. Artificial insemination.
12. Health services and associated expenses for infertility treatments.

Services Provided Under Another Plan

1. Health 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, such as any workers' compensation laws or employer liability laws. This limitation applies even if the participant is not enrolled for all coverage for which he or she has become eligible. Benefits under the Plan will be

NOT COVERED EXPENSES

reduced by the amount to which the participant would have been entitled under the governmental plan. The term “any government” includes the federal, state, provincial, or local government or any political subdivision of the United States or any other country. This provision is subject to any provision or regulation of the governmental plan or program that requires that benefits under the Plan be utilized before benefits are available under the governmental plan.

2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health services while on active military duty.

Transplants

1. Health services for organ and tissue transplants except for those described under *Transplantation Services* on page 47.
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient’s benefits under their Plan).
3. Health services for transplants involving mechanical or animal organs.
4. Any solid organ transplant that is performed as a treatment for cancer and any multiple organ transplants not listed previously.
5. Health services for transplants that are an Unproven, Experimental or Investigational Service unless, in the Claims Administrator’s judgment which will be rendered in its sole discretion, covered transplant services may be covered.

NOT COVERED EXPENSES

Travel

Travel or transportation expenses, even though prescribed by a Physician. Some travel expense related to covered transplantation services may be reimbursed according to the section *Transplantation Services*, page 47.

Vision and Hearing

1. Purchase cost of eye glasses, contact lenses, or hearing aids. See vision plan for coverage information.
2. Fitting and exam charge for hearing aids, eye glasses or contact lenses.
3. Eye exercise therapy unless due to congenital anomaly or rehabilitation due to accident.
4. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

All Other Exclusions

1. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
2. Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends unless hospitalized.
3. Health services rendered to a person prior to the effective date of that person's coverage under the Plan.
4. Services or supplies which are not Covered Health Services (page 32).
5. Charges for items not necessary for treatment, such as a hospital admissions kits or a TV set in a hospital.
6. Charges and expenses in excess of reasonable and customary (R&C Excess, page 33) fees.
7. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.
8. Health services which an employer is required by law to furnish in whole or in part, including services which are covered by any workers' compensation laws or employer liability laws.
9. Smoking cessation.
10. Maternity benefits for covered dependent children.
11. For the out-of-network portion of the Choice Plus - preventative care including well baby, routine physicals, checkup and immunization; however, the Plan will pay \$300 of such charges for the Non-Network Option.
12. Sex transformation operations.
13. Domiciliary care.
14. Respite care.
15. Rest cures.
16. Psychosurgery.
17. Medical and surgical treatment of excessive sweating (hyperhidrosis).
18. Medical and surgical treatment of snoring, except when provided as part of treatment for documented obstructive sleep apnea.

NOT COVERED EXPENSES

19. Appliances specifically for snoring.
20. Non-surgical treatment of obesity and surgical treatment of obesity, excluding severe or morbid obesity as defined by the Body Mass Index (BMI) exceeding 40% or greater than 35% in conjunction with severe obesity..
21. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from injury, stroke or a congenital anomaly or as a result of a medical condition.
22. Speech therapy to treat stuttering, stammering, or other articulation disorders.
23. Replacement of lost or stolen prosthetic devices.
24. Personal trainer.
25. Naturalist.
26. Physical, psychiatric or psychological exams, testing, vaccination, immunization or treatments that are otherwise covered under the Plan when:
 - Required solely for purposes of career, sports or camp, employment, insurance, marriage or adoption.
 - Related to judicial or administrative proceedings or orders.
 - Conducted for purposes of medical research.
 - Required to obtain or maintain a license of any type.
27. Any charges for missed appointment, room or facility reservations, completing of claim forms or record processing.
28. Any charges for services, supplies, or equipment advertised by the provider as free.
29. Any charges prohibited by federal anti-kickback or self-referral statutes.
30. Outpatient rehabilitation services, spinal treatment or supplies including, but not limited to spinal manipulation by a chiropractor or other doctor, for the treatment of a condition which ceases to be therapeutic treatments and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.
31. Spinal treatment, including chiropractic and osteopathic, manipulation treatment, to treat an illness, such as asthma or allergies.
32. Utilities to run machinery.
33. Air cleaners and filters.
34. Legal fees.
35. Instructions concerning hygiene and diet (including diabetic care and educational programs).
36. Surgical treatment of TMJ.
37. Safety Glasses.

PRESCRIPTION DRUG PROGRAM

PRESCRIPTION DRUG PROGRAM

Whether you take medication on an ongoing basis or you simply need a prescription filled from time to time, the Prescription Drug Program offers savings, convenience and service for you and your eligible dependents. The Prescription Drug Program is administered by a partnership between UnitedHealthcare and Medco Health. Prescription drug coverage is provided both at participating pharmacies when you use your Medical/Prescription ID card and at non-participating pharmacies. The Prescription Drug Program also offers mail-order prescription drug coverage for maintenance prescriptions.

Participants in the Plan are eligible for the benefits described in this section. Dependents are also eligible for the benefits, provided that the Plan is the dependent's Primary Plan (see page 95) for prescription drugs. **If your dependents have their primary medical coverage under any other group health plan (other than Medicare) they are not eligible for the Prescription Drug Program** (see *Coordination of Benefits* on page 94).

The following is an overview of your prescription drug benefits.

Type of Prescription	Retail		Mail Order (up to a 90 day supply)*
	At Participating Pharmacies, Using Medical/Prescription ID Card (up to a 31 day supply)*	At Non-Participating Pharmacies (up to a 31 day supply)*	
For Short-Term and Immediate Prescriptions <i>Mandatory generic provision applies</i>			
<ul style="list-style-type: none"> • Tier 1 and Tier 2 (mainly generic and on Prescription Drug List) 	You pay 30% of the discounted price with a \$10 minimum	You pay the full price of the prescription, then file a claim to be reimbursed at 70% of the network contracted cost with a \$10 minimum	Not applicable
<ul style="list-style-type: none"> • Tier 3 (mainly not on Prescription Drug List) 	You pay 40% of the discounted price with a \$10 minimum	You pay the full price of the prescription, then file a claim to be reimbursed at 60% of the network contracted cost with a \$10 minimum	

PRESCRIPTION DRUG PROGRAM

Type of Prescription	Retail		Mail Order (up to a 90 day supply)*
	At Participating Pharmacies, Using Medical/Prescription ID Card (up to a 31 day supply)*	At Non-Participating Pharmacies (up to a 31 day supply)*	
For Long-Term and Maintenance Medications <i>Mandatory generic provision applies</i> Tier 1 and Tier 2 (mainly generic and on Prescription Drug List) • Tier 3 (mainly not on Prescription Drug List)	You pay 30% of the discounted price with a \$10 minimum You pay 40% of the discounted price with a \$10 minimum	You pay the full price of the prescription, then file a claim to be reimbursed at 70% of the network contracted cost with a \$10 minimum You pay the full price of the prescription, then file a claim to be reimbursed at 60% of the network contracted cost with a \$10 minimum	You pay • \$25 for Tier 1 & • \$50 for Tier 2 \$75 for Tier 3

* These benefits would apply after the \$1,500 or \$3,000 deductible has been met under the HDHP option.

Prescription drug expenses under the Choice EPO, the Choice Plus or the Non-Network option do not count toward the annual deductible, out-of-pocket maximum or lifetime maximum under the Medical Plan. Prescription drug expenses under the HDHP option are subject to a deductible and out-of-pocket maximum.

Prescription Drug List

Prescription Drug Program participants can utilize UnitedHealthcare's Prescription Drug List (PDL). The Prescription Drug List is a tool that guides you and your Physician, when selecting medications, toward drugs that maximize your benefit. The Prescription Drug List is a list of generic and brand-name prescription medicines that have been approved by the U.S. Food and Drug Administration (FDA). UnitedHealthcare's National Pharmacy Committee, a team of Physicians and pharmacists, meets regularly to review and update the list. The PDL can be updated during the year, usually at mid-year and year-end. They take into account the following factors: therapeutic advantages or limitations of a drug; side effects different from other drugs in the same therapeutic class; impact on health care costs; and patient outcomes.

PRESCRIPTION DRUG PROGRAM

The list does not restrict what your Physician can prescribe or what a pharmacist can dispense. Physicians are encouraged to follow the PDL when prescribing medicines for Plan participants; however, you and your Physician will have the choice in what is prescribed.

You can access the complete Prescription Drug List at www.myuhc.com or by calling UnitedHealthcare's Customer Service Center. An abbreviated version of the PDL will be mailed to your home annually at the first of the year. Physicians participating in the UnitedHealthcare networks receive a copy of the PDL every year from UnitedHealthcare. In addition, the PDL is available to physicians online at www.unitedhealthcare.com.

**Participant access to the Prescription Drug List
log on to www.myuhc.com or
call UnitedHealthcare's Customer Service at
1-866-317-6359**

Retail Pharmacy Program

The retail pharmacy program is designed to provide you prescriptions to treat short-term illnesses or ailments. There are over 50,000 participating pharmacies you can use to fill your prescriptions. You can get up to a 31-day supply at a participating pharmacy and pay 30% of the discounted price with a \$10 minimum for Tier 1 (mainly generic medication) and for Tier 2 (mainly brand medication on the PDL). For Tier 3 (mainly brand medication not on the PDL), you will pay 40% of the discounted price subject to a \$10 minimum. If the cost of the drug is less than \$10 then you will only be required to pay the lesser cost of the drug. Also if the drug falls within the rules of the Mandatory Generic Provision (see page 69), then you will pay more for the brand name drug.

Always remember to show your Medical/Prescription Drug identification card to the pharmacist when you fill your prescription. Two ID cards are issued to all covered participants with dependent coverage. Additional cards are available by logging onto www.myuhc.com or calling UnitedHealthcare. When you show your ID card to the pharmacist at a participating pharmacy, the computerized system will confirm your eligibility for benefits.

**To find out if a specific pharmacy participates in the
UnitedHealthcare network:
log on to www.myuhc.com
or call
1-866-317-6359**

PRESCRIPTION DRUG PROGRAM

Non-Participating Pharmacies: You also can choose to have your prescription filled at a pharmacy that is not part of the network. If you do, you will need to:

- Pay the full pharmacy's price; and
- Submit a claim form for processing.

You will be reimbursed for 70% of the discounted cost of the drug for Tier 1 and Tier 2 medications. For Tier 3 medications you will be reimbursed for 60% of the discounted cost of the drug.

You have up to one year to file your claim. (see *Claims Procedures*, page 87).

Mail-Order Prescription Drug Program

The Company also offers you a money saving alternative to having your long-term or maintenance prescription filled at a local pharmacy. You may fill long-term or maintenance prescriptions through the Mail Order Prescription Drug Program. With the mail order program, you can order up to a 90-day supply of maintenance medication prescribed by your doctor for chronic or long-term conditions. When you do, you will pay:

- A \$25 co-payment for each Tier 1 drug (mainly generic); and
- A \$50 co-payment for each Tier 2 drug (mainly brand-name drugs on the Prescription Drug List); and
- A \$75 co-payment for each Tier 3 drug (mainly brand-name drugs not on the Prescription Drug List).

Prescriptions filled through the mail order service will be filled with the generic equivalent when available and permissible by law, unless your doctor specifically requests a brand name drug. This substitution means added savings to you, since your co-payment for a supply of generic drugs is substantially less than the co-payment for a supply of brand name drugs. See *Generic vs. Brand-name* on page 67 for important information about generic drugs. Also, if the drug falls within the rules of the Mandatory Generic Provision (see page 69), then you will pay more for the brand name drug.

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

- High blood pressure
- Ulcers
- Arthritis
- Heart or thyroid conditions
- Diabetes
- Glaucoma

You can fill a new mail-order prescription by completing the order form and mailing it in with your prescription and copayment. Order forms are available from the CITGO Benefits Department, the Benefits HelpLine at 1-888-443-5707, or online through the CITGO intranet or at <http://www.hr.CITGO.com>.

The first time the doctor prescribes a medication, ask for two copies of the prescription:

- The first for up to a 31 day supply to be filled at a participating network retail pharmacy.
- The second for the maximum supply you need, up to a 90 day supply, with three refills if appropriate. You will use this prescription to obtain your medication from the Mail-Order Prescription Drug Program.

This will help you start your new medication right away and also take advantage of the savings available through home delivery.

Please note, if your physician writes a prescription for less than a 90 day supply, you will be charged a copay for each refill. By law, Medco Health can only distribute the designated amount or less, never more.

Example: Your physician writes a prescription for a long-term or maintenance medication. He writes the prescription for a 31 day supply of a brand-name drug on the Prescription Drug List, with eleven refills. The mail-order pharmacy will fill with a 31 day supply and charge you \$50.00 every month. It is better for your physician to write the prescription for a 90 day supply of a brand-name drug on the Prescription Drug List, with three refills. The mail-order pharmacy will then only charge you \$50.00 every three months.

The refill options for mail-order prescriptions are:

1. On the Internet – www.myuhc.com/pharmacy. Have your ID card, the prescription number and your credit card ready.
2. By phone - 1-866-317-6359. Have your ID card, the prescription number and your credit card ready.
3. By mail - use the refill and order forms provided with your medication. You can also use the forms you used to fill a new mail-order prescription. Mail the forms with your copayment.

PRESCRIPTION DRUG PROGRAM

To help ensure that you do not run out of your prescription remember to reorder on or after the refill date indicated on your refill slip or medication container, or reorder when you have less than 14 days of medication left. Also, if you refill your prescriptions on the internet at www.myuhc.com/pharmacy, you can register to have your refills automatically filled. You will receive an email notifying you when your refill has been completed.

Your medication will be promptly delivered by U.S. Mail or UPS. Your package usually arrives within two weeks. It will include:

- Medication container(s),
- Instructions for refills, and
- Information about your medication.

**For more information about
the Prescription Drug
Program call 1-866-317-6359**

Generic vs. Brand-Name

There is very little difference between a generic and brand-name medication, except cost. A generic drug contains the same active ingredients in the same dosage form as the brand-name drug. The generic drug is therapeutically equivalent to the brand-name drug, but sold under its chemical or “generic” name. The FDA regulates the quality, strength and purity of generic medications, requiring that generic drugs contain the same active ingredients and be equivalent in strength and dosage to the original brand-name drugs.

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

Mandatory Generic Provision

Under the Mandatory Generic Provision, you will pay more for a brand name drug if:

- The prescription is not written as DAW (Dispense As Written); and
- Generic is available, and you request the brand name.

For retail prescription drugs, your cost will be the covered percentage on your total cost for the brand (30% or 40% depending on the tier) plus the difference between the cost of the brand and the generic drug. For mail order prescriptions, your cost will be the co-payment based on Tier 2 (\$50) plus the difference between the cost of the brand and the generic drug.

PRESCRIPTION DRUG PROGRAM

Examples of Mandatory Generic

John's physician issues a prescription and does not include "dispense as written". When John fills the prescription, he requests a brand name drug (a Tier 2 drug) rather than the available generic.

	If the total cost of the brand is...	If the total cost of the generic is...	John's cost is...	If John had requested the generic, his cost would be...
Retail	\$100	\$80	\$50 (30% of \$100) + (\$100 - \$80)	\$24 (30% of \$80)
Retail	\$100	\$50	\$80 (30% of \$100) + (\$100 - \$50)	\$15 (30% of \$50)
Mail Order	\$100	\$80	\$70 \$50 (Tier 2 copay) + (\$100 - \$80)	\$25 (Tier 1 copay)
Mail Order	\$100	\$50	\$100 \$50 (Tier 2 copay) + (\$100 - \$50)	\$25 (Tier 1 copay)

HDHP and the Prescription Drug Program

The HDHP option has a combined medical/pharmacy deductible. If you participate in the HDHP option, prescription drug costs are included in the deductible. **You must pay the full price of any prescription drug until your deductible is met.** The full price is the discounted network cost. In addition, the cost of the prescription drugs will be applied to your out-of-pocket maximum. However the costs of prescription drugs are not applied against your lifetime maximum plan benefit.

Retail: You will continue to use your ID card at a network pharmacy, to obtain the network discount. Once your deductible is met, then you will pay 30% or 40% of the discounted cost, depending on the Tier of the drug, with a \$10 minimum.

Mail Order: Once your deductible is met, then you will pay the co-payment of \$25, \$50, or \$75, depending on the Tier of the drug.

Covered Prescription Drugs

If you have a question about whether a prescription drug is covered under the Prescription Drug Program, you can call UnitedHealthcare's Customer Service. Most prescription medication is covered under the Prescription Drug Program. The following are covered:

- Federal legend drugs
- State restricted drugs
- Compound and foreign prescriptions
- Insulin
- Needles and syringes
- Growth hormones
- Diabetic supplies
- Oral contraceptives
- Self-administered injectables

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

Prescription Drug Exclusions

The following exclusions apply to the Prescription Drug Program:

- Coverage for prescription drug products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
- Prescription drug products dispensed outside the United States, except as required for emergency treatment.
- Drugs which are prescribed or dispensed or intended for use while you are an inpatient in a Hospital, Skilled Nursing Facility or Alternative Facility.
- Experimental, Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by the Claims Administrator to be experimental, investigational or unproven.
- Prescription drug products furnished by the local, state and federal government. Any prescription drug product to the extent payment or benefits are provided or available from the local, state or federal government (for example Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
- Prescription drug products for any condition, injury, sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or similar laws, whether or no a claim for such benefits is made or benefits are received.
- Any product dispensed for the purpose of appetite suppression and other weight loss products.
- A specialty medication prescription drug product (including, but not limited to, immunizations and allergy serum) which, due to its characteristics as determined by the Claims Administrator, must typically be administered or supervised by a qualified provider

PRESCRIPTION DRUG PROGRAM

or licensed/certified health professional in an outpatient setting. This exclusion does not apply to Depo Provera and other injectibles used for contraception.

- Durable Medical Equipment, Prescribed and non-prescribed outpatient supplies, other than diabetic supplies and inhaler spacers specifically stated as covered.
- General Vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride and single entity vitamins.
- Unit dose packaging of prescription drug products.
- Medications for cosmetic purposes.
- Prescription drug products, including new prescription drug products or new dosage forms that are determined to not be a Covered Health Service.
- Prescription drug products as a replacement for a previously dispensed prescription drug product that was lost, stolen, broken or destroyed.
- Prescription drug products when prescribed to treat infertility.
- Prescription drug products for smoking cessation.
- Compounded drugs that do not contain at least one ingredient that requires a prescription order or refill. Compounded drugs that contain at least one ingredient that requires a prescription order or refill are assigned to Tier 3.
- Drugs available over-the-counter that do not require a prescription order or refill by federal or state law before being dispensed. Any prescription drug product that is therapeutically equivalent to an over-the-counter drug. Prescription drug products that are comprised of components that are available in over-the-counter form or equivalent.
- New prescription drug products and/or new dosage forms until the date they are reviewed and assigned to a tier by the Claims Administrator's Prescription Drug List Management Committee.

EVENTS AFFECTING COVERAGE

Status Change

Because your contributions for coverage are taken on a “pre-tax” basis, due to tax regulations you cannot increase or decrease your level of coverage (see page 8), terminate coverage, or change your contribution during the year unless you have an eligible **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 health 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 other health 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 health coverage for a dependent child;
- Beginning or losing eligibility for you, your spouse, or a dependent child for Medicare or Medicaid; or
- Any event as determined by the Plan Administrator, in its sole discretion, 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).

EVENTS AFFECTING COVERAGE

An eligible Status Change allows you to make a change in your level of coverage (see page 8). If your change does not meet the Status Change criteria above, you cannot change your level of coverage or terminate your coverage under the Plan during 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.

You cannot change your benefit option because of a Status Change unless the Status Change is due to a relocation that results in you moving from a network area to a non-network area or vice versa. Changes in your benefit coverage on any date other than January 1 will only be permitted if the change is consistent with 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 wishes to add his wife to his coverage. James can change his level of coverage to “Employee and Family” as long as he makes his change within 31 days after his marriage.

Example: Ineligible Status Change

During the Annual Election Period, Shelly elects “Employee and Family” coverage. During the following Plan 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 a 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.

EVENTS AFFECTING COVERAGE

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 medical 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 participant 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 the 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 Coverage* (page 77) for more details.

EVENTS AFFECTING COVERAGE

Waiver of Contributions While on Leave

You may be eligible for a waiver of contributions for your medical 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 medical 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*, page 77, 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 (see page 4);
- You become eligible for other health care coverage to which the Company makes contributions on behalf of employees (i.e., the salaried medical 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.

EVENTS AFFECTING COVERAGE

If you have dependent coverage under the Plan, the coverage of your dependent(s) will terminate at the same time your coverage under the Plan terminates. In addition, your dependent's coverage will 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 medical 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.

Certificate of Creditable Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires health plans to provide Certificates of Creditable Coverage to individuals who lose coverage under the employer's group health plan. The Company has retained Ceridian's COBRA Continuation Services ("CobraServ") for the administration of HIPAA Certificates of Creditable Coverage. You and/or your dependents will receive a Certificate of Creditable Coverage from CobraServ when medical coverage ends. Certificates will be sent to your home address each time you or your dependent(s) lose or drop medical coverage under the Plan. You or your dependents may also request a Certificate of Creditable coverage within 24 months after coverage under the Plan ceases by contacting CobraServ at 1-800-877-7994.

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

Transition Provisions

Certain temporary "transition" provisions have been made for participants undergoing treatment at the time that network options become effective in their area. These transition provisions apply only to participants who are covered under a Company-sponsored plan at the time the network options become effective in their area. The provisions, which are not automatic and whose length varies, are outlined below.

Transition for Pregnancy

If you or your spouse is in the second or third trimester of pregnancy as of the date the network options become effective and the attending physician is not participating in the UnitedHealthcare Choice Network, it may be possible to receive network benefits through pregnancy and delivery even while continuing to visit that physician. To do so, you must apply for transitional network benefits by contacting UnitedHealthcare Customer Service at 1-866-317-6359, prior to the date the network options become effective.

EVENTS AFFECTING COVERAGE

UnitedHealthcare will review the case and determine if the pregnancy qualifies for transitional network benefits. To qualify for transitional network benefits, you or your spouse must be covered under a Company-sponsored plan as of the day before the network options become effective. If approved, the transition will apply only to treatment for the pregnancy and delivery. It will expire at the end of the maternity treatment.

To receive network benefits for the baby, you must choose a network-participating provider for the baby's medical care.

Transition for Serious or Catastrophic Illness

If you or a family member is being treated for a serious, long-term illness by a physician who is not in the UnitedHealthcare Choice Network, it may be possible to receive network benefits for up to six months while you continue to visit that physician. You must apply to UnitedHealthcare for a network transition.

To qualify for transitional network benefits:

- the illness or injury must be considered severe or life-threatening;
- you or the family member must have had extended continuous treatment for the illness or injury under the direction of the out-of-network physician you wish to retain; and
- you or the family member must be covered under a Company-sponsored plan as of the day before the network options become effective.

To apply for a transition, contact UnitedHealthcare Customer Service at 1-866-317-6359. You must apply prior to the date the network options become effective. UnitedHealthcare will review the case and determine if the illness or injury qualifies for transitional network benefits.

Special Extension of Medical Benefits

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

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

CONTINUATION OF COVERAGE

CONTINUATION OF COVERAGE

Upon Retirement

Upon your retirement you may be eligible for continued medical coverage. Please refer to the section entitled *Eligibility-Retired Employees* page 4 for further information.

If you are not eligible for retiree medical, you and your dependents' medical 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 health care coverage if it is lost due to certain "qualifying events". The following chart describes the COBRA qualifying events for you and your covered dependents:

	Qualifying Event
You, the employee	<ul style="list-style-type: none">• Termination of employment, other than for gross misconduct• Reduction in hours resulting in loss of coverage
You, the retiree	<ul style="list-style-type: none">• A bankruptcy proceeding in a case under Title 11 of the United States Code with respect to the Company
Eligible dependents	<ul style="list-style-type: none">• Termination of your employment, other than for gross misconduct• Reduction in your hours worked that results in loss of coverage• Your death• Your entitlement to Medicare• Your divorce or legal separation• Your dependent child's eligibility for coverage ends• A bankruptcy proceeding in a Title 11 case is commenced with respect to the Company if you are retired.

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 of the qualifying event that is the bankruptcy of the Company, the term "lose coverage" includes any substantial elimination of coverage within one year before or after the date the bankruptcy proceeding commences.

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

CONTINUATION OF COVERAGE

1. You, your spouse or your dependent 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 your 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.

Continuation 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.

CONTINUATION OF COVERAGE

COBRA Qualifying Event	How Long Coverage May Continue	
	You	Dependents
You terminate employment (other than 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 during the first 60 days of continuation coverage and the applicable notice requirements are satisfied - see page 80).	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 during the first 60 days of continuation coverage and the applicable notice requirements are satisfied - see page 80).
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 during the first 60 days of continuation coverage and the applicable notice requirements are satisfied - see page 80).	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 during the first 60 days of continuation coverage and the applicable notice requirements are satisfied - see page 80).
You die	N/A	36 months
You become entitled to Medicare	N/A	36 months (special rules apply)
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

If you are receiving COBRA continuation coverage as a result of your termination of employment or reduction in hours, your total coverage under COBRA is limited to 36 months from the date of the first qualifying event. However, you may be eligible for an additional period of coverage if a second qualifying event (other than a bankruptcy proceeding with respect to the Company) 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.

CONTINUATION OF COVERAGE

Notification

If your 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 after the later of the qualifying event or 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 the qualifying event 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, Medicare eligibility 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.

CONTINUATION OF COVERAGE

Disability

You and your dependents may be eligible to extend your COBRA coverage an additional 11 months after the original 18-month COBRA 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, but before the end of the original 18-month period of COBRA coverage. The 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 after 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 the determination is after the original 18-month COBRA period, your COBRA benefits will cease the first day of the month beginning 30 days after the date of determination.

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 the 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 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.

CONTINUATION OF COVERAGE

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 entitled to Medicare;
- (3) You or your dependent becomes covered under a group health plan of another employer. However, if the other employer's medical plan contains an exclusion or limitation with respect to any pre-existing condition, you or your dependent may continue COBRA coverage under the Plan to cover the exclusion or pre-existing condition only;
- (4) The Company terminates medical coverage for all its active and/or retired employees; or
- (5) 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 of 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 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 (see page 77)

CONTINUATION OF 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 dependent(s) may continue coverage under the Plan **until the earlier of:**

- The end of the month following the date your spouse remarries;
- The end of the month following the date that your dependent loses eligibility under the 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.

Conversion Privileges

If your medical coverage is terminated, you may convert your coverage to an individual medical policy by contacting the Benefits HelpLine and submitting your application to the Claims Administrator.

If you wish to convert immediately following termination, you must waive your COBRA Continuation Coverage (page 77). If you are already receiving COBRA continuation coverage and wish to convert your coverage to an individual medical policy through the Claims Administrator, you must first complete the maximum required COBRA continuation coverage period (18 to 36 months, as applicable) before you will be eligible to convert your policy.

Application must be made within 31 days following termination or within 31 days following the end of the maximum required COBRA continuation period, whichever is applicable, and the medical policy will be of the type then issued by and at the premium rate established by the Claims Administrator. In order to convert your coverage, you must contact the Benefits HelpLine for details.

Dependents who have been covered under the Plan and no longer meet the eligibility requirements may apply for an individual policy under the same conversion provisions as employees.

CONTINUATION OF COVERAGE

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 health care 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 health benefit coverage with respect to a child, is issued pursuant to a state domestic relations law, and relates to benefits under a group health plan; or
2. Is issued pursuant to a law relating to medical child support with respect to a group health 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 health 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 QMCSOs. 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 certified 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.

CONTINUATION OF COVERAGE

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

ASSIGNMENT OF BENEFITS

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

CLAIMS PROCEDURES

When to Submit Claims

Medical

Network providers are paid directly for your health services. However, you are responsible for meeting the annual deductible, if applicable, for paying your covered percentage and for paying copayments to a Network provider at the time of service, or when you receive a bill from the provider. If you have met your annual deductible, paid your covered percentage and paid your copayments and still receive a bill from your provider, contact the Claims Administrator.

When you receive health services from a non-network provider, you are responsible for requesting payment through the Claims Administrator. If a non-network provider submits a claim on your behalf, you will be responsible for the timeliness of the submission.

If an employee provides written authorization to allow direct payment to a non-network provider, all or a portion of any eligible expenses due to a provider may be paid directly to the provider instead of being paid to the employee. The Plan will not reimburse third parties who have purchased or assigned benefits by Physicians or other providers.

For medical benefits, you must submit a request 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 health service will not be considered for payment under the Plan.

Prescription Drugs

Whether you fill your prescription through a participating retail pharmacy or through mail-order, you pay your portion of the cost up front. There is no claim form needed for reimbursement. A claim must be filed, however, if you fill your prescription at a non-participating pharmacy. You will pay for the pharmacy's price of the prescription at the time it is filled and then you must file a claim to be reimbursed for the portion of the cost that the Plan covers. You must submit a request for payment within **one year** after the date of purchase. See *Retail Pharmacy Program*, page 63, for more information.

Where to Submit Claims

Claims for health services should be sent to:

UnitedHealthcare
P.O. Box 740800
Atlanta, GA 30374-0800
Group No. 229556

Claims for prescriptions filled at a non-participating pharmacy should be sent to:

PAID Prescriptions, L.L.C.
P.O Box 2096
Lee's Summit, MO 64063-7096
Group No. UHEALTH

Filing Initial Claims for Benefits

When filing for medical 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. You must sign any release form required in order for benefits to be paid.

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

1. Name of the employee or retiree and address.
2. The patient's name, age (date of birth) and relationship to the employee/retiree.
3. The group and member number stated on your ID card.
4. The name and address of the provider of the service(s).
5. A diagnosis from the Physician.
6. An itemized bill from your provider that includes the Current Procedural Terminology (CPT) codes or a description of each charge and the date of service.
7. The date of service.
8. A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

When submitting a prescription drug claim form, attach all claim receipts or itemized bills to the claim form. Complete the form as directed.

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 at 1-888-443-5707. 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 if the provider notified the Claims Administrator your signature is on file, assigning benefits directly to that provider. If services are in-network, then the payment will be made to the provider of services.

You can review your claims by logging onto www.myuhc.com. If you have any questions about your claim for medical, hospital or prescription drug charges, please call UnitedHealthcare's Customer Service at the telephone number shown on your ID card, which is:

<p>Medical and Hospital Claims</p>	<p>Prescription Drug Claims</p>
<p>Log on to www.myuhc.com or</p>	<p>Log on to www.myuhc.com/pharmacy</p>
<p>call Customer Service, toll-free</p>	<p>or</p>
<p>1-866-317-6359</p>	<p>call Customer Service, toll-free</p>
	<p>1-866-317-6359</p>

Customer Service representatives are available to take your call during regular business hours, Monday through Friday from 7:00 a.m. – 10:00 p.m. CST.

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, the amount of payment, and the amount you are responsible for paying.

Benefit Determinations

Post-Service Claims

Post-service claims are those claims that are filed for payment of benefits after medical care has been received. Within 30 days following receipt of a post-service claim the Claims Administrator will either:

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

The Claims Administrator will notify you within this 30 day period if additional information is needed to process the claim, and may request a one time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, the Claims

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Administrator will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Pre-Service Claims

Pre-service claims are those claims that require notification or approval prior to receiving medical care. If your claim was a pre-service claim, and was submitted properly with all needed information, you will receive written notice of the claim decision from the Claims Administrator within 15 days of receipt of the claim. If you filed a pre-service claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 5 days after the pre-service claim was received. If additional information is needed to process the pre-service claim, the Claims Administrator will notify you of the information needed within 15 days after the claim was received, and may request a one time extension not longer than 15 days and pend your claim until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, the Claims Administrator will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Urgent Claims that Require Immediate Action (Pre-Certification)

Urgent care claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment:

1. Could seriously jeopardize your life or health or your ability to regain maximum function; or
2. In the opinion of a Physician, with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The claim does not need to be submitted in writing. You or your Physician should call the Claims Administrator as soon as possible. In these urgent situations:

- You will receive notice of the benefit determination in writing or electronically within 72 hours after the Claims Administrator receives all necessary information, taking into account the seriousness of your condition.
- Notice of denial may be oral with a written or electronic confirmation to follow within 3 days.

If you filed an urgent claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 24 hours after receipt of the urgent claim. If

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additional information is needed to process the claim, the Claims Administrator will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after the earlier of:

- The Claim Administrator's receipt of the requested information, or
- The end of the 48 hour period within which you were to provide the additional information, if the information is not received with that time.

A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care claim as defined previously, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The Claims Administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care claim and decided according to the time frames described in the previous section.

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

How to Appeal a Claim Decision

If you have a question or concern about a benefit determination, you may call Customer Service before requesting a formal appeal. If you disagree with the claim determination after talking with a Customer Service representative, you may submit your question in writing. You can ask the Claim Administrator to formally reconsider your claim and the representative will provide you with the appropriate address of the Claims Administrator. If you are appealing an urgent care claim denial, please refer to the *Immediate Action - Urgent Claim Appeals* on page 93 and contact Customer Service immediately.

Appeal Process

There are two levels of appeal – the first level of appeal is submitted to the Claims Administrator. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal to the Plan Administrator.

If the appeal relates to a claim for payment, your written first level appeal to the Claims Administrator should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first level of appeal must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

The Claims Administrator will appoint a qualified individual to resolve or recommend the resolution of the appeal. This individual will not have been involved in the initial decision being appealed. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional who was not involved in the initial determination with appropriate expertise in the field. The Claims Administrator (first level appeals) and the Plan Administrator (second level appeals) may consult with, or seek the participation of, medical experts as part of the appeal resolution process. By requesting appeal, you consent to this referral and the sharing of pertinent medical claim information. Upon request, and free of charge, you have the right to reasonable access to any copies of all documents, records, and other information relevant to your claim for benefits.

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Appeals Determinations for Pre-Service and Post-Service Claims

The Claims Administrator will conduct the first level of appeal and provide you written or electronic notification of the decision within 15 days from receipt of a request for appeal of a denied pre-service claim and within 30 days from receipt of a request for appeal of a denied post-service claim. For procedures associated with urgent claims, see the next section titled *Immediate Action - Urgent Claim Appeals*.

If you are not satisfied with the first level appeal decision of the Claims Administrator, you have the right to request a second level appeal from the Plan Administrator. Your second level appeal request must be submitted to the Plan Administrator within 180 days from receipt of first level appeal decision. If you do not appeal the denial within 180 days to the Plan Administrator, the denial will be considered final, conclusive and binding.

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 has the exclusive right to interpret and administer the Plan, and these decisions are conclusive and binding. You will be provided written notification of the decision within 15 days from receipt of your second and final written appeal for a pre-service claim and within 30 days from receipt of your second and final appeal of a post-service claim.

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 health service is necessary or appropriate is between you and your Physician.

Immediate Action – Urgent Claim Appeals

Your initial claim for benefit determination may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing.
- You or your Physician should call the Claims Administrator as soon as possible.
- The Claims Administrator will provide you with a written or electronic determination within 72 hours after receipt of your request for review of the determination taking into account the seriousness of your condition.

The Claims Administrator has the exclusive right to interpret and administer provisions of the Plan for urgent claim appeals. The Claims Administrator's decision is conclusive and binding.

Voluntary External Review Program

If a final determination to deny benefits is made, you may request to participate in the voluntary external review program. The option of an external review becomes available to you once all appeals have been exhausted. In the event of continued disagreements between you and the Claims Administrator and Plan Administrator, you will be able to appeal the decision to an independent review organization that uses medical experts, with expertise in the area of question, who will review the decision and determine its appropriateness. The clinical decisions made by the independent review organization will be used by the Plan Administrator to make coverage determinations.

The Claims Administrator will provide you with the necessary procedures to obtain the review. This program only applies if the decision is based on either of the following:

- Clinical reasons
- The exclusion is for an Experimental or Investigational Services (page 56).

The external review program is not available if the coverage determinations are based on explicit benefit exclusions (see *Not Covered Expenses*, page 55) or benefit limits.

Contact Customer Service at 1-866-317-6359, for more information on the Voluntary External Review Program.

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 three (3) 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 health plan. In these situations, it is 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 health plans not sponsored by the Company. “Other plans” are those which provide benefits or services in connection with medical care or treatment for which an employer pays all or part of this cost or for which an employer takes payroll deductions. This includes any government-sponsored plan (i.e., Tricare for military dependents), including Medicare (see page 7) and Medicaid.

The COB provision applies only where group health plans are involved. It does not apply to benefits payable under any private accident or health insurance plans you or your dependents may have, nor does it apply to benefits payable under any other group insurance or health 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 provisions. Under no circumstance will the sum of the benefits paid from each plan exceed the actual expense incurred.

If your dependent’s Primary Plan is another group health plan (other than Medicare), they are not eligible for the Prescription Drug Program and therefore COB will not apply (see *Prescription Drug Program*, page 62).

What Happens When COB Is Applied

When an individual is covered under more than one group health plan, one plan is determined to be the Primary Plan and the others are considered Secondary Plans. The Primary Plan pays benefits first 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”),

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- 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 medical expenses,
- You are an active employee age 65 or over and your other group health plan is Medicare, or
- The spouse, age 65 or over, of an active employee and their other group health plan is Medicare.

In order to avoid delays in claims processing, your claims should be submitted to the Primary Plan as soon as possible. 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 benefits are paid for expenses incurred on account of a covered person, that covered person, or any other person or organization that was paid, must make a refund to the Plan if either of the following apply:

- All or some of the expenses were not paid by the covered person or did not legally have to be paid by the covered person; or
- All or some of the payment exceeded the benefits under the Plan.

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

If the covered person, or any other person or organization that was paid, does not promptly refund the full amount, the amount of any future benefit payments may be reduced. The reductions will equal the amount of the required refund.

Subrogation

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, the Plan shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and Benefits the Plan provided to Covered Persons, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this Summary Plan Description, the Plan shall also have an independent right to be reimbursed by Covered Persons for the reasonable value of any services and Benefits the Plan provides to Covered Persons, from any or all of the following listed below:

- Third parties, including any person alleged to have caused a Covered Person to suffer injuries or damages.

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- Any person or entity who is or may be obligated to provide Benefits or payments to a Covered Person, including Benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to a Covered Person on any equitable or legal liability theory.

These third parties, persons or entities are collectively referred to as "Third Parties". Covered Persons agree as follows:

That a Covered Person will cooperate with the Plan in a timely manner in protecting our legal and equitable rights to subrogation and reimbursement, including, but not limited to:

- provide any relevant information requested by the Plan,
- sign and/or deliver such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim,
- respond to requests for information about any accident or injuries,
- appear at depositions and in court, and
- obtain the consent of the Plan or its agents before releasing any party from liability or payment of medical expenses.

That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits and/or the institution of legal action against a Covered Person.

That the Plan has the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

That no court costs or attorneys' fees may be deducted from the Plan's recovery without the Plan's express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and the Plan is not required to participate in or pay court costs or attorneys' fees to the attorney hired by a Covered Person to pursue his or her damage/personal injury claim.

That regardless of whether a Covered Person has been fully compensated or made whole, the Plan may collect from Covered Persons the proceeds of any full or partial recovery that a Covered Person or his or her legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment. The proceeds available for collection shall include, but not be limited to, any and all amounts earmarked as non-economic damage settlement or judgment.

That benefits paid by the Plan may also be considered to be benefits advanced.

That Covered Persons agree that if they receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, the Covered Person will serve as a

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constructive trustee over the funds and failure to hold such funds in trust will be deemed as a breach of the Covered Person's duties hereunder.

That Covered Persons or an authorized agent, such as the Covered Person's attorney, must hold any funds received from any potentially responsible party that are due and owed to the Plan, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the institution of legal action against the Covered Person.

That the Plan shall be entitled to recover reasonable attorney fees from Covered Persons incurred in collecting from the Covered Person any funds held by the Covered Person that he or she recovered from any Third Party.

That the Plan may set off from any future benefits otherwise allowed by the Plan the value of benefits paid or advanced under this section to the extent not recovered by the Plan.

That Covered Persons will neither accept any settlement that does not fully compensate or reimburse the Plan without the Plan's written approval, nor will the Covered Person do anything to prejudice the Plan's rights under this section.

That Covered Persons will assign to the Plan all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits the Plan provided, plus reasonable costs of collection.

That the Plan's rights will be considered as the first priority claim against Third Parties, including tortfeasors for whom Covered Persons are seeking recovery, to be paid before any other of the Covered Person's claims are paid.

That the Plan's rights will not be reduced due to the Covered Person's own negligence.

That the Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including filing suit in the Covered Person's name, which does not obligate the Plan in any way to pay the Covered Person part of any recovery the Plan might obtain.

That the Plan shall not be obligated in any way to pursue this right independently or on behalf of the Covered Person.

That if the injury or condition giving rise to subrogation or reimbursement involves a minor child, this section applies to the parents or guardian of the minor child.

That if the injury or condition giving rise to subrogation or reimbursement involves the wrongful death of a Plan beneficiary, this section applies to the personal representative of the deceased Plan beneficiary.

CLAIMS PROCEDURES

Plan participants may be contacted by a subrogation service provider, Ingenix, to gather information about medical treatment received. Ingenix will use several factors to decide whether to contact you, including the kind of injury or illness and the type of treatment received.

If you receive a letter or call from Ingenix asking whether medical treatment was the result of an accident or injury, please respond promptly. Ingenix will offer several options for you to respond including via mail, phone or Internet.

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 UnitedHealthcare Insurance company to act as the Claims Administrator - to process claims under the Plan and provide certain other administrative services. **UnitedHealthcare Insurance Company, 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 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 of the Plan.

Based on an actuarial analysis of Plan experience and projections of future medical 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, actuarial 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. 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's contributions are voluntary payments for participants. The Company reserves the right to withhold or discontinue these contributions at any time.

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 73.

“Pre-tax basis” means an amount equal to your monthly contribution that 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 (Medicare) 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 contribute towards the cost of their coverage only 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

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

Plan: **The CITGO Petroleum Corporation Medical, Dental, Vision and Life Insurance Program for Hourly Employees**

Type of Plan: Self-Insured Group Health Plan

Plan Sponsor: CITGO Petroleum Corporation
1293 Eldridge Parkway
Houston, TX 77077

Plan Sponsor's Employer Identification No.: 73-1173881

Plan Administrator: Benefit Plans Committee - Secretary
CITGO Petroleum Corporation
1293 Eldridge Parkway
Houston, TX 77077

OR

Benefit Plans Committee
1293 Eldridge Parkway
Houston, TX 77077

Plan Number: 518

Plan's Effective Date: April 1, 1984

Plan Year: January 1 – December 31

Funding: Funded by employer and employee, retiree, surviving spouse, LTD and COBRA participant contributions. Plan assets are held in the CITGO Employees' Benefit Trust by the Trustee

Trustee: The Bank of Oklahoma, N.A.
Trust Division
Bank of Oklahoma Tower
P.O. Box 880
Tulsa, OK 74101-0880

ADDITIONAL INFORMATION

Type of Administration: Contract – under an Administrative Service Only (ASO) contract with the Claims Administrator

Claims Administrator: UnitedHealthcare
P.O. Box 740800
Atlanta, GA 30374-0800

UnitedHealthcare Customer Service Center
1-866-317-6359
www.myuhc.com

Provider directory at www.provider.uhc.com/citgo/

Group Number: 229556

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

Agent for Service of Legal Process: Plan Sponsor;
In addition, service of legal process may be made upon the Plan Trustee or the Plan Administrator

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 and union halls, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500) 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, collective bargaining agreements, copies of the latest annual report (Form 5500), and updated summary plan description. The Plan Administrator may charge a reasonable amount for the copies.

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

Continue Group Health Plan Coverage

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

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, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

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

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-444-3272.

Medicaid

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

Compliance by the Plan with Assignment of Rights

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

Enrollment and Provision of Benefits Without Regard to Medicaid Eligibility

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

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

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

ADDITIONAL INFORMATION

Required Written Notice of Current Benefits

Legislation enacted two amendments for self-insured group health plans that are governed under ERISA.

- Women's Health and Cancer Rights Act of 1998
- Newborns' and Mothers' Health Protection Act of 1996

These amendments represent benefits that were already provided under the Plan.

Women's Health and Cancer Rights Act of 1998

The Plan will cover certain breast reconstructive benefits in connection with a mastectomy. If you elect breast reconstruction in connection with a mastectomy, coverage is available in a manner determined in consultation with you and your physician for:

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

Such coverage is subject to all terms of the Plan, including relevant deductibles and coinsurance provisions.

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable).

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

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Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This section incorporates the requirements of the Health Insurance Portability and Accountability Act of 1996, as amended (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 elsewhere in the Plan, the meaning given in this section 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.

ADDITIONAL INFORMATION

(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 of practitioner and provider performance, health plan performance, conducting training programs with 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;

ADDITIONAL INFORMATION

- (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 the requirements listed under the headings “Additional Agreements of Plan Sponsor” and “Adequate Separation Between the Plan and the Plan Sponsor” below. The Plan has received this certification from the Plan Sponsor. 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.

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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 and disenrollment information, summary health information and protected health information disclosed pursuant to an authorization under 45 C.F.R. § 164.508 and shall ensure that any agents

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(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) The Plan Administrator;
- (2) Human Resources employees within the Benefits Planning and Administration Department;
- (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 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.

ADDITIONAL 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 section inconsistent therewith, this section 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.

Notice of Privacy Practices

The HIPAA Regulations require the Plan to provide you with a notice describing the Plan's privacy practices and other information regarding your privacy rights with respect to protected health information. This notice is provided at the time of enrollment to new Plan enrollees. In addition, an updated notice will be provided to all Plan participants within 60 days of any material revision of the notice. Copies of the notice are available at all times on the CITGO intranet, at <http://www.hr.CITGO.com> or by calling the Benefits HelpLine at 1-888-443-5707.

Uniformed Services Employment and Reemployment Rights Act

An Employee who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Employee and the Employee's Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1984, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Employees may elect to continue coverage under the Plan by notifying the Plan Administrator or Benefits HelpLine in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on an Employee's behalf. If an Employee's Military Service is for a period of time less than 31 days, the Employee may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

An Employee may continue Plan coverage under USERRA for up to the lesser of:

- The 24 month period beginning on the date of the Employee's absence from work; or
- The day after the date on which the Employee fails to apply for, or return to, a position of employment.

Regardless of whether an Employee continues health coverage, if the Employee returns to a position of employment, the Employee's health coverage and that of the Employee's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on an Employee or the Employee's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator or the Benefits HelpLine if you have questions about your rights to continue health coverage under USERRA.

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 specifically apply to the Medical Plan:

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

- Pre-scheduled surgical services.
- Emergency Health Services.
- Pre-scheduled rehabilitative, laboratory or diagnostic services.

An Alternate Facility may also provide Mental Health Services or Substance Abuse services on an outpatient or inpatient basis.

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

“Authorization for Out-of-Network Services” if you are in a network option (Choice EPO or Choice Plus) and you live in a network area that does not include an “in-network” specialist in a certain field, you may call United HealthCare to request an exception to see a “non-network” provider and receive “in-network” benefits.

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

“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.

“BMI” means a measure used in obesity risk assessment to determine the degree of obesity by approximating the measure of total body fat as compared with the assessment of body weight alone. Also referred to as Body Mass Index.

“Care Coordination” means a program provided by the Claims Administrator designed to encourage an efficient system of care for covered Persons by identifying and addressing possible unmet covered health care needs.

“Claims Administrator” means the company, or its affiliate, that provides certain claim administration services for the Plan.

DEFINITIONS

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

“Congenital Anomaly” means a physical developmental defect that is present at birth, and is identified within the first twelve (12) months of birth.

“Cosmetic Procedures” means procedures or services that change or improve appearance without significantly improving physiological function, as determined by Care Coordination on the Plan’s behalf.

“Covered Health Service(s)” means those health services provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, Substance Abuse, or their symptoms.

Covered Health Services must be provided:

- When the Plan is in effect;
- Prior to the effective date of any of the individual termination conditions set forth in this Summary Plan Description; and
- Only when the person who receives services is a Covered Person and meets all eligibility requirements specified in the Plan.

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

“Custodial Care” means services that:

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

“Designated United Resource Network Facility or URN” is a Hospital that the Claims Administrator names as a Designated United Resource Network Facility. A Designated United Resources Network Facility has entered into an agreement with the Claims Administrator to render Covered Health Services for the treatment of specified diseases or conditions. A designated United Resource Network Facility may or may not be located within your geographic area. The fact that a hospital is a Network Hospital does not mean that it is a Designated United Resource Network Facility.

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

- Can withstand repeated use,
- Is not disposable,

DEFINITIONS

- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms,
- Is generally not useful to a person in absence of a Sickness, Injury or their symptoms, and
- Is appropriate for use in the home.

“Eligible Expenses” are the amounts the Plan will pay for Covered Health Services determined based on either of the following:

- When Covered Health Services are received from Network providers, Eligible Expenses are the contracted fee(s) with that provider; or
- When Covered Health Services are received from Non-Network providers, the Claims Administrator calculates Eligible Expenses based on available data resources of competitive fees in that geographic area, unless you received services as a result of an Emergency or as otherwise arranged through the Claims Administrator. In this case Eligible Expenses are the fee(s), on billed charges, that are negotiated with the Non-Network provider.

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

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

“Emergency” is a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness which is both of the following:

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

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

- The patient’s health would be placed in serious jeopardy,
- Bodily function would be seriously impaired, or
- There would be serious dysfunction of a bodily organ or part.

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

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“Emergency Health Services” are health care services and supplies necessary for the treatment of an Emergency.

“Experimental, Investigational or Unproven Services” are medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be:

1. not approved by the U.S. Food and Drug Administration (“FDA”) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service, or the United States Pharmacopoeia Dispensing Information, as appropriate for the proposed use; or
2. subject to review and approval by any institutional review board for the proposed use; or
3. the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or

If you have a life-threatening sickness or condition, (one which is likely to cause death within one year of the request for treatment) the Claims Administrator may, in its discretion, determine that an Experimental, Investigational or Unproven Service meets the definition of a Covered Health Service for that sickness or condition. For this to take place, the Claims Administrator must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

“Extended Care Facility” is a facility accredited by the Joint Commission on Accreditation for Hospitals as an Extended Care Facility.

“Family” as when used in the medical plan to describe coverage options means the employee, an eligible spouse and at least one eligible dependent child.

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

- (1) It is primarily a place for delivery of children following a normal, uncomplicated pregnancy, that is operated and equipped in accordance with any applicable state law;
- (2) It is equipped to perform routine diagnostic and laboratory examinations, such as hematocrit and urinalysis for glucose, protein, bacteria and specific gravity;
- (3) It has available to handle foreseeable emergencies trained personnel and necessary equipment, including but not limited to oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders;
- (4) It is operated under the full-time supervision of a licensed doctor of medicine (MD) or registered graduate nurse (RN);

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- (5) It maintains a written agreement with at least one hospital in the area for immediate acceptance of patients who develop complications; and
- (6) It maintains an adequate medical record for each patient, which contains prenatal history, prenatal examination, any laboratory or diagnostic tests and postpartum summary.

“Full-Time Student” means a person who is enrolled in and attending, full time, a recognized course of study or training at one of the following:

- An accredited high school.
- An accredited college or university.
- A licensed vocational school, technical school, beautician school, automotive school or similar training school.

Full-time student status is determined in accordance with the standards set forth by the educational institution. You are no longer a Full-time student on the date you graduate or otherwise cease to be enrolled and in attendance at the institution on a full-time basis and eligibility for coverage ceases at the end of the month.

You continue to be a Full-time student during periods of regular vacation established by the institution. If you do not continue as a Full-time student immediately following the period of vacation, the Full-time student designation will end as described above.

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

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

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

The following services will not be covered:

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

“Hospice” means a centrally administered program of palliative and supportive services which provides physical, psychological, social and spiritual care for dying persons (who have six

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months or less to live as diagnosed and certified by the attending Physician) and their families. Services are provided by a Physician-supervised interdisciplinary team of professionals and volunteers. Hospice services are available in the home. Home care is available on a part-time, intermittent, regularly scheduled, and around-the-clock on-call basis. Bereavement services are available to the family.

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

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

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

“Injury” means bodily damage other than Sickness, including all related conditions and recurrent symptoms.

“In-Network” or “Network” (Area/Benefits) encompasses a group of participating Physicians and hospitals that have contracted with UnitedHealthcare. If your zip code is listed in the Network Benefits Zip Code List then you live in a Network Area. The Network Area is determined by the Plan Administrator.

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

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

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

“Mental Health Service” means Covered Health Services for the diagnosis and treatment of Mental Illness. The fact that a condition is listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.

“Mental Illness” means those mental health or psychiatric diagnostic categories that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded under the Plan.

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

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

A provider may enter into an agreement to provide only certain Covered Health Services, but not all covered Health Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Health Services and products included in the participation agreement, and a non-Network provider for other Health Services and products. The participation status of providers will change from time to time.

“Network Benefits” means Benefits for a Covered Health Service that are provided by (or directed by) a Network Physician or other Network provider in the provider’s office or at a Network or non-Network facility.

“Network Benefits Zip Code List” is a list of the zip codes that are mandatory Network Areas. The list is available online through the CITGO intranet or at <http://www.hr.CITGO.com> or by calling the Benefits HelpLine at 1-888-443-5707.

“Non-Network” or “Out-Of-Network” encompasses a group of Physicians and hospitals that have not contracted with UnitedHealthcare. If your zip code is not listed in the Network Benefits Zip Code List then you live in a Non-Network area. Network benefits will not apply.

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

“Out-of-Network Benefits” means if you are enrolled in the “Choice EPO” or “Choice Plus” option, you receive out-of-network benefits any time you receive care without using the network. Out-of-network benefits are more limited than network benefits and are subject to usual, necessary and customary guidelines.

“Physician” means any Doctor of Medicine, “MD”, or Doctor of Osteopathy, “DO”, who is properly licensed and qualified by law.

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

“Preadmission Test” means a test performed in anticipation of hospital confinement if:

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

“Pregnancy” includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

“Preventive Care” means medical services aimed at early detection and intervention. Focuses on wellness, health promotion, and other activities that reduce the likelihood of illness or Injury.

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

“Psychologist” means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification is required, “psychologist” means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner if the person is:

- Operating within the scope of a license; and
- Performing a service for which benefits are provided under this Plan when performed by a psychologist.

“R&C” means the reasonable and customary (R&C) charges for non-network providers, surgeon fees and related surgical fees. 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 UnitedHealthcare.

“R&C Excess” means any excess amount over R&C charges. You must pay 100% of this amount.

“Regular Full-Time Employee” means an employee of the Company who is regularly scheduled to work at least 20 hours per week and six months per year.

“Regular Part-Time Employee” means an employee of the Company who completes 1,000 hours of service during either a calendar year or a twelve-month period starting on the date which he or she began employment.

“Room and Board” means room, board, general duty nursing, intensive nursing care in an intensive care unit by whatever name called, and any other services regularly rendered by the hospital as a condition of occupancy of the class of accommodations occupied, but not including professional services of Physicians, nor special nursing services rendered outside of an intensive care unit by whatever name called.

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

“Semi-private Room” is a room with two or more beds. When an inpatient stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room

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and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private room is not available.

“Sickness” is a physical illness, disease or Pregnancy. The term Sickness as used in this SPD does not include Mental Illness or substance abuse, regardless of the cause or origin of the Mental Illness or substance abuse.

“Skilled Nursing Facility” means a facility approved by Medicare as a skilled nursing facility.

If not approved by Medicare, the facility may be covered if it meets the following tests:

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

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

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

“Substance Abuse Services” means Covered Health Services for the diagnosis and treatment of alcoholism and substance abuse disorders that are listed in the current diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded. The fact that a disorder is listed in the diagnostic and Statistical Manual of the American Psychiatric Association does not mean that the treatment of the disorder is a covered Health Service.

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

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

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

If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) the Plan and the Claims Administrator may, at their discretion, determine that an Unproven Service meets the definition of a Covered Health Service for that sickness or condition. For this to take place, the Plan and the Claims Administrator must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes for Health.

"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 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.