2016
BENEFITS For
TRIMARK
EMPLOYEES
About this Material

This brochure provides an overview of options under the CITGO Petroleum Corporation Medical, Dental, Vision and Life Insurance Programs for Salaried Employees (Plan number 515) (the “Plan”). It also serves as your 2016 Summary of Material Modification. The benefits described are governed by legal plan documents, contracts and insurance policies. If a conflict should occur, the legal plan documents, contracts and insurance policies will prevail. To view Summary Plan Descriptions go to www.hr.CITGO.com.

A summary of benefits and coverage for the Plan is also available at www.myuhc.com or on the CITGO Benefit Connections website at www.hr.CITGO.com. You may also request a printed copy by contacting the CITGO Benefits HelpLine at 888-443-5707 or by email at benefits@CITGO.com.

Questions

Answers to frequently asked questions (FAQs) are available at www.hr.CITGO.com. The FAQs include questions on all areas of benefits, not just those pertaining to the 2016 Annual Election.

If you have any additional questions about your benefits including Annual Election, please contact the Benefits HelpLine at 1-888-443-5707, or email benefits@CITGO.com.
What’s New for 2016

All Plans

All health and welfare plans will be amended to allow spouses as eligible dependents from all legal marriages effective under the laws of the state in which the marriage was contracted, including both opposite sex and same sex marriages. As of January 1, 2016, an eligible “spouse” under the CITGO plan is defined as follows:

A person to whom you are legally married at the relevant time and which marriage is effective under the laws of the state in which the marriage was contracted, including a person legally separated but not under a decree of divorce.

Employees and retirees may add their eligible spouse and dependents during the Annual Enrollment period for 2016. Proof of eligibility will be required, and you may be asked to provide documentation in the form of a marriage certificate, birth certificate, adoption papers or court documents at any time in order for coverage to become effective or to continue. After the Annual Election Period, employees and retirees may add their eligible spouse and dependents within 31 days of an IRS Qualified Status Change as outlined under Status Changes Outside of Annual Enrollment.

Self-Directed Health Plan (SDHP) Only

Change of annual out-of-pocket maximums

- The employee/retiree only annual out-of-pocket maximum for the SDHP has changed from $4,000 to $3,425.

- The family annual out-of-pocket maximum for the SDHP has changed from $8,000 to $6,850.

2016 Healthy Rewards Program

The total incentives eligible to be earned for the 2016 Healthy Rewards Program have been modified and the requirements for earning the incentives have changed. See page 34 for the full 2016 Healthy Rewards Program Design.

Retiree Reimbursement Account Subsidy

As of January 1, 2016, the Retiree Reimbursement Account Program (RRA) will offer a $202 per month subsidy per eligible post-65 retiree and post-65 spouse.

Flexible Spending Accounts

Flexible Spending Accounts (FSAs) are not transferable; you must elect this option each year. The IRS limits the maximum contribution to a Healthcare FSA, which is per eligible employee, not household, and does not include employer contributions. FSA annual maximums for 2016 will be as follows:

- $2,550 - Regular Health Care FSA limit.
- $2,550 - Limited Health Care FSA limit.
- $5,000 - Dependent Care FSA limit, per household, subject to certain other limitations related to spousal income and tax filing status.
Health Savings Accounts

You must elect the amount to be deducted from payroll every year for your HSA. Changes to your payroll deductions can be made at any time by contacting the Benefits Helpline.

Health Savings Account (HSA) annual maximums for 2016 will be as follows:

- $6,750 – Family/Employee + One or more IRS limit.

Also, if you are 55 and older, “catch-up” contributions of $1,000 per year are available above these limits.

When calculating your contributions to your HSA, it is very important to include the amount of Healthy Rewards Incentives you plan to earn in your calculations.

For example, if you want to contribute the maximum 2016 annual HSA limit to your HSA for Single Coverage in 2016, and you want to earn Healthy Rewards of $900, your total annual contribution to your HSA will be $2,450 for the plan year ($2,450 individual annual payroll contribution PLUS $900 CITGO incentive contribution = $3,350 limit).

Your Benefits Program

CITGO is committed to providing you with a competitive benefits package that includes various choices to help you care for you and your family.

Your 2016 benefits program includes some enhanced choices in medical, dental, vision and tax-savings accounts to customize your benefits. Thus providing you with more:

- Control – make an election to reduce your annual cost.
- Options – choose the plan that works best for you.
- Opportunities – earn rewards for taking greater control of your health.

You have the opportunity to participate in a comprehensive range of insurance benefits, and as an added benefit, many of your plan contributions are paid on a tax-free basis, saving you money. As a regular, salaried employee, you are eligible for a comprehensive benefit program that includes:

- Medical coverage with a choice of plan options to meet your health care needs.
- Dental coverage which provides comprehensive preventive, general, prosthetic and orthodontic coverage.
- Vision coverage which provides coverage for eye exams, eyeglasses (frames and lenses), or contact lenses.
- Employee Assistance Program which helps employees resolve personal issues that may adversely impact their work performance, conduct, health and well-being.
- Flexible Spending Accounts and Health Savings Accounts to pay for eligible health care and/or dependent care expenses on a tax-free basis.
- Life Insurance to protect you and your family.
- Healthy Rewards Program to incentivize employees to make healthier choices in their health and overall lifestyle.
- Additional benefits such as paid holidays, voluntary benefits and the vacation days.
Eligibility

Verification of Dependent Eligibility

If you are enrolling a spouse or child for 2016 who is not covered now, you must also submit documentation of their eligibility. The Dependent Eligibility Verification Form can be found on the Benefit Connections web site at www.hr.CITGO.com under the Annual Election or Benefits Resources tab. The form outlines the types of documentation that are acceptable as proof of your dependent’s eligibility.

Voluntary Programs

Trimark active employees may enroll for the following voluntary benefits as of January 1, 2016 with premiums to be paid in full by the employee through payroll deductions:

• Critical Illness insurance offered by TransAmerica and managed by Mercer.
• Accident insurance offered by TransAmerica and managed by Mercer.
• Pre-paid Legal Services offered by Hyatt/MetLaw and managed by Mercer.

Neither CITGO nor Trimark maintain or endorse these programs. Additional information regarding enrollment in these voluntary benefits will be sent directly from the providers.

When Benefits Begin

Coverage for you and your covered dependents under the Medical, Dental, Vision, Spending Accounts, Optional Term Life Insurance, Dependent Child Life Insurance, Spousal Life Insurance and Personal Accident Insurance begins on your first day actively at work if you enroll within the first 31 days.

If you do not enroll within the first 31 days of employment, you and/or your dependents generally will not be eligible for benefits for that Plan Year.

The company-provided Basic Life Insurance and Occupational Accidental Death Insurance begin the first day you are actively at work.

Dual Company Coverage

If you are covered for benefits as an employee, you cannot be covered as a dependent. Eligible children can only be covered by one parent under the Medical, Dental, Vision and Life Insurance Programs if both parents are CITGO employees and/or retirees.

Eligible Dependent Family Members

For purposes of the Plan, eligible family members may also be covered under the Plan, and may include.

Your eligible spouse, including:

• The spouse of an eligible employee.
• The surviving spouse, who has not remarried, of a deceased eligible employee.

All references to spouse, to a married person or to a marriage shall refer to spouses as follows:

• A person to whom you are legally married at the relevant time and which marriage is effective under the laws of the state in which the marriage was contracted, including a person legally separated but not under a decree of divorce.
CITGO Benefits

- Your common law spouse, if common law marriage is recognized in the state of which you are a legal resident. You must submit the applicable paperwork required for your state of residence for review and approval by CITGO before coverage will begin.

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

Your child or children including:

- The child of an eligible employee.
- The child, whose surviving parent has not remarried, of a deceased eligible employee.

An eligible dependent child is defined as the following:

- Your biological child;
- Your adopted child or a child placed in your guardianship for adoption;
- Your stepchild; or
- A child for whom you or your current spouse has been awarded legal guardianship or legal custody by a court of law.

Your eligible dependent child must be under the age of 26 and can be enrolled, even if the child is:

- Not enrolled in school.
- Married.
- Not financially dependent on you for the majority of their support.
- Not residing with you in your home.

Proof of eligibility is required, and you will be asked to provide documentation, such as a marriage certificate, birth certificate, adoption papers or court documents in order for coverage to become effective or to continue.

Contributions

Both you and CITGO may contribute to the cost of medical, dental, vision and life insurance coverage. Most of your contributions are made through payroll deductions with "pre-tax" dollars. This means that your contributions are deducted from your paycheck before taxes are calculated. Thus, you pay no federal income or Social Security taxes, and in most states, no state income taxes on your monthly contributions. The monthly contribution rates are subject to change.

Special Enrollment Rights Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")

If you are declining enrollment for yourself or your dependents (including your spouse), because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage or if the employer stops contributing toward your or your dependents’ other coverage. However, you must request enrollment within 31 days after your or your dependents’ other coverage ends or after the employer stops contributing toward the other coverage. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. Special Enrollment Rights related to qualification for premium assistance under CHIP or Medicaid must be requested within 60 days. To request special enrollment or obtain more information, contact the Benefits HelpLine at 1-888-443-5707.
Eligibility

Status Changes Outside of Annual Enrollment

In order for you to make election and contribution changes for health and life benefits outside of the Annual Enrollment period and after payroll deductions have begun for the current plan year, you must experience an IRS Qualified Status Change. Qualified Status Changes include certain changes in family or work status. Any of the following conditions will constitute an eligible status change that may allow you to make a change to your elections and corresponding contributions during the Plan Year within 31 days of the qualifying event date:

- Marriage.
- Divorce, legal separation or annulment.
- Death of your spouse or eligible dependent child.
- Birth, adoption or placement for adoption of an eligible dependent child.
- You, your spouse or dependent child begin or end employment.
- You, your spouse or dependent child change residence or worksite.
- Your, your spouse’s or dependent child’s work schedule changes such as a reduction in work hours, increase in hours, strike or lockout, unpaid leave of absence – beginning or end, including beginning or ending a military leave.
- You, your spouse or dependent child change from part-time to full-time employment or vice versa.
- You acquire an eligible dependent that was not eligible for coverage during the previous Annual Election and later becomes eligible during the Plan Year.
- Your spouse or dependent children are no longer eligible as a dependent under the terms of the Plan (see “Dependent Eligibility” in the Summary Plan Description).
- You or your eligible dependent(s) lose health coverage from your spouse’s employer.
- A major change in a spouse’s benefits: an adverse change (such as major increases in out-of-pocket premium costs, deductible, copays or out-of-pocket maximums), including your spouse’s Annual Election changes when the Annual Election period of your spouse is on a different Plan Year.
- Court order resulting from a divorce, legal separation, annulment or change in legal custody that requires health coverage for your dependent child.
- Medicare, Medicaid or CHIP entitlement or loss of such entitlement.
- Any event as determined by the CITGO Benefit Plans Committee that is not inconsistent with laws and regulations applicable to the Plan.

If you have an eligible status change, you may be eligible to make a corresponding change in your current coverage elections subject to IRS limitations and application of consistency provisions. Examples of eligible changes may include:

- You may begin participation.
- You may end participation.
- You may add or drop eligible dependents.
- You may increase your contributions to your flexible spending account(s).
- You may decrease your contributions to your flexible spending account(s).
- You can discontinue all future contributions to your flexible spending account(s) to the extent that contributions exceed reimbursements.
Consistency Rule Requirements

Under the IRS rules, employees can make mid-year election changes only if they are “on account of and corresponding with” a qualified change in status. In general, the IRS permits no exceptions to these consistency rules. There are two parts to determining if a change in election should be permitted. First, you must experience a change in status or other qualified event. Second, your requested change must be consistent with the event. The Summary Plan Description will include more information regarding other qualified changes, consistency requirements, required documentation and exceptions that may apply.

Proof of eligibility will be required, and you may be asked to provide documentation in the form of a birth certificate, adoption papers or court documents at any time in order for coverage to become effective or to continue.

When Plan Eligibility Ends

Eligibility for the Plan ends:

- When an employee ceases to be an eligible employee under the Plan.
- When a participant fails to make the required contributions for the medical, dental, vision and/or life insurance plan.
- For a spouse following a divorce.
- For a surviving spouse and children and/or stepchildren upon remarriage.
- For children when they reach the limiting age of 26.
- For children and/or stepchildren upon the remarriage of the surviving parent.

Annual Election

Once each year there is a specific time during which you may make new benefit elections for the next Plan Year (January 1 - December 31) for the Medical, Dental, Vision and Life Insurance plans. This period is the Annual Election Period. Annual Election is an important process that provides flexibility for CITGO to introduce benefit changes and for you to review and, if necessary, change your elections for the upcoming year.

For the 2016 Plan Year, Annual Election begins November 2, 2015 and ends on November 13, 2015.
CITGO Benefits
Medical Plan Highlights

Your Medical Plan Options

CITGO offers a variety of medical options administered by UnitedHealthcare. Options vary whether or not your home zip code falls within an area covered by the UnitedHealthcare network. In 2016, CITGO will continue to offer four medical plan options.

The four plan options are as follows:

1. SDHP
   Self-Directed Health Plan

2. PPO
   Preferred Provider Option

3. EPO
   Exclusive Provider Option

4. Non-Network

Information about participating providers in the UnitedHealthcare Choice network may be obtained through the CITGO intranet, via the web at www.myuhc.com or by calling UnitedHealthcare’s customer service center at 1-866-317-6359.

Contributions

Both you and the Company share in the cost of your medical benefits and you pay your contributions with “pre-tax dollars” through payroll deduction.

Each Plan Option Has Something to Offer

There are important features that are the same in all four of your medical plan options, and overall they are similar in how the benefits are paid.

Each option covers In-Network Preventive Care at 100% which means the deductible and coinsurance do not apply.

Each option offers you a choice on the amount of your annual deductible before paying benefits and how much you will have to meet. The exception is the prescription drug benefits in the Self-Directed Health Plan, which requires that you must meet the deductible.

After you meet the deductible, all of the options feature coinsurance or cost-sharing between you and the plan.

Once you meet the out-of-pocket maximum, the plan pays 100% for eligible covered expenses.

The differences among the options have to do with:

- The amount of your monthly contribution.
- The amount of the deductible.
- The amount of the annual out-of-pocket maximum.
- Whether you have access to a special account for qualified health care expenses and the features of that account. For example, this may include the amount of your maximum contributions and whether or not the funds roll over from year to year.
- How prescription drug coverage works.
- If out-of-network services are available and your coinsurance percentage.
2016 Changes to All Medical Options

The following changes take effect January 1, 2016.

All Plans

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Medical Plan Highlights

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The UnitedHealthcare Preferred Provider Network

The UnitedHealthcare Choice network will continue to be the preferred provider network offered for the EPO, PPO and SDHP medical options. The Choice network provides you access to a large, nationwide network of physicians, diagnostic providers, outpatient clinics, urgent care facilities and hospitals. You have two convenient ways to select providers or verify if the providers you currently use are in the Choice provider network. You can review the online provider directory by using the provider search tool located at www.myuhc.com/groups/CITGO, or by calling UnitedHealthcare’s Customer Service Center at 1-866-317-6359.

Please note, when you are enrolled in the EPO, the PPO, or the SDHP and want to access network benefits, it is your responsibility to confirm that a physician, facility or provider participates in the Choice provider network. You should regularly check the online provider directory available at www.myuhc.com to confirm that your provider is still a part of the network.

Hearing Aid Discount Program

CITGO now offers a hearing aid discount program through UnitedHealthcare (UHC), in conjunction with Hi-HealthInnovations, to provide employees and their dependents enrolled in our medical plans with discounts on premium hearing aids and easy access to hearing tests.

According to the National Institutes of Health, people generally pay between $3,000 and $5,000 for a single hearing aid. Through the UHC/Hi-HealthInnovations program, you get custom-programmed, high-quality hearing aids at a fraction of the retail price.

To get started, UHC members submit their health plan information at www.hihealthinnovations.com/united and are emailed their low member pricing, hearing test options and a physician certification form. Employees can even use an existing hearing test from CITGO Health Services if it is less than one year old. In just three simple steps, you could have a custom-programmed hearing aid delivered to you from $599 to $799 depending on the model chosen.

More information on the steps required to take advantage of this valuable new benefit is available on the Benefits Connection website. Additional information can also be obtained by contacting Hi-HealthInnovations at 1-866-926-6632, Monday - Friday, 9:00 a.m. - 5:00 p.m. CT.
CITGO Benefits
Health & Wellness

Get More From Your Healthcare

The UnitedHealthcare member website, www.myuhc.com is an online resource that will answer your benefit questions, provide physician locations quickly and easily, give you updates on claims payments, let you ask questions of health professionals online, and provide you with tools to help you get the most from your health benefits. You will find everything from hospital cost and quality rankings to information on staying healthy. Registration is easy. Just visit www.myuhc.com and select “Register” on the homepage. Follow the simple prompts. You’re just a few clicks away from enjoying immediate access to all types of health care information.

24-Hour Nurseline

UnitedHealthcare offers a dedicated NurseLine, with registered nurses available for medical treatment consultation 24 hours a day, 7 days a week. Access to nurses can be gained by telephone through a toll-free number at 1-866-735-5686 or via Internet at www.myuhc.com.

- Find doctors and hospitals that meet quality and efficiency of care criteria.
- Understand your symptoms and choose appropriate care for blood pressure concerns, insect bites and sprains.
- Explore treatment options and alternatives.
- Learn about managing pregnancy, diabetes and coronary artery disease.
- Know how to take medication effectively and safely.
Medical Plan Options

SDHP
Self-Directed Health Plan

Plan Highlights

• A Self-Directed Health Plan (SDHP) is also called a High Deductible Health Plan, an HSA-Qualified High Deductible Health Plan, and a Consumer Directed Health Plan.

• All your In-Network preventive care is covered at 100%, including preventive medications (as defined by the IRS list).

• When you have non-preventive medical and prescription costs, they apply to your Annual Deductible.

• After you reach your deductible, the plan pays the applicable percentage of your medical and prescription drug costs. The out-of-pocket maximum serves as a built-in cap on annual healthcare expenses and your deductible and prescription drug costs also apply to the maximum.

• You make decisions about what medical services you want and who you want to provide these services. You control how your health funds are spent.

• The key to the SDHP is that, under the IRS rules, if you are under the age of 65 and are not eligible for Medicare, enrollment in this plan option qualifies you to contribute to a Health Savings Account (HSA) as described on page 24.

• The SDHP offers an annual enrollment incentive just for enrolling in the SDHP option.

  – Employee-only coverage - $500 deposit to HSA.

  – Employee plus Dependent/Family coverage - $1,000 deposit to HSA.

  – For those employees enrolling during Annual Election, the enrollment incentive will be deposited during normal payroll processing in January. However, Fidelity cannot accept contributions to your HSA until you have opened your account. See Setting Up Your Fidelity HSA.
## Self-Directed Health Plan

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lifetime Max Benefit</strong></td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>$1,500/EE only&lt;br&gt;$3,000/EE + Dep</td>
<td>$1,500/EE only&lt;br&gt;$3,000/EE + Dep</td>
</tr>
<tr>
<td><strong>Annual Out-Of-Pocket Maximum</strong>&lt;br&gt;(Includes deductible and prescription drug costs)</td>
<td>$3,425/EE only&lt;br&gt;$6,850/EE + Dep</td>
<td>$3,425/EE only&lt;br&gt;$6,850/EE + Dep</td>
</tr>
<tr>
<td><strong>Office Visit</strong></td>
<td>You Pay: 20% After deductible</td>
<td>You Pay: 40% after deductible*</td>
</tr>
<tr>
<td><strong>Lab/X-Ray (Outpatient)</strong></td>
<td>20% After deductible</td>
<td>40% after deductible*</td>
</tr>
<tr>
<td><strong>Preventive Care</strong></td>
<td>0%, Not subject to deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Emergency Care</strong></td>
<td>20% After deductible</td>
<td>20% After deductible*</td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td>20% After deductible</td>
<td>40% After deductible*</td>
</tr>
<tr>
<td><strong>Hospital Service (Inpatient)</strong></td>
<td>20% After deductible</td>
<td>40% After deductible*</td>
</tr>
<tr>
<td><strong>Hospital Service (Outpatient)</strong></td>
<td>20% After deductible</td>
<td>40% After deductible*</td>
</tr>
<tr>
<td><strong>Maternity and Pregnancy Physician’s Office</strong></td>
<td>20% After deductible</td>
<td>40% After deductible*</td>
</tr>
<tr>
<td><strong>Mental Health and Substance Abuse</strong>&lt;br&gt;Inpatient</td>
<td>20% After deductible</td>
<td>40% After deductible*</td>
</tr>
<tr>
<td><strong>Mental Health and Substance Abuse</strong>&lt;br&gt;Outpatient</td>
<td>20% After deductible</td>
<td>40% After deductible*</td>
</tr>
</tbody>
</table>

**Rehabilitation Services Including: Physical, Occupational, Speech and Hearing**

| 60 Visit Maximum Per Therapy, Per Year | 20% After deductible | 40% After deductible* |

**Chiropractic Care and Spinal Treatment**

| 60 Visit Maximum Per Year | 20% After deductible | 40% After deductible* |

*For Out-of-Network benefits, you will pay your percentage of the cost based on reasonable and customary (R&C) charges; you will pay R&C percentage plus 100% of any excess amount above R&C. If Medicare is the primary payer, this provision does not apply.*
Plan Highlights

- You are free to visit any provider you want; however, the choice you make determines how much you pay in out-of-pocket expenses.

- When you choose a network doctor, laboratory or hospital, you will pay less because network providers offer services at pre-negotiated rates, and the Plan will cover more of the cost of eligible expenses. If you go to an Out-of-Network provider, your fees will be higher and the plan will cover less of the cost. The choice is yours.

- Includes the Prescription Drug Program (see page 30 for details).

- Preventive care will be covered at 100% with no office visit co-pay for In-Network physicians and labs only.

- You can choose to see a specialist without a referral.

- This option is not available if you are eligible for Medicare by reason of disability.

- The PPO option is best suited for individuals who want freedom of choice and the ability to have benefit coverage for both In- and Out-of-Network services.

PPO
Preferred Provider Option
## CITGO Benefits
### Health & Wellness

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network</th>
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<tbody>
<tr>
<td><strong>PPO</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime Max Benefit</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Annual Deductible</td>
<td>$350/Person</td>
<td>$1,050/Person</td>
</tr>
<tr>
<td></td>
<td>$1,050/Family</td>
<td>$3,050/Family</td>
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<tr>
<td>Annual Out-of-Pocket Maximum</td>
<td>$4,350 (medical + deductible per person) + separate $1,000 Rx</td>
<td>$13,050 (medical + deductible per person) + separate $1,000 Rx</td>
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<tr>
<td></td>
<td>$9,050 (medical + deductible per family) + separate $2,000 Rx</td>
<td>$27,050 (medical + deductible per family) + separate $2,000 Rx</td>
</tr>
<tr>
<td><strong>You Pay:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td>$25 PCP</td>
<td>40% After deductible</td>
</tr>
<tr>
<td>Lab/X-Ray (Outpatient)</td>
<td>$40 Specialist</td>
<td>40% After deductible</td>
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<tr>
<td>Preventive Care</td>
<td>0%, No co-pay, Not subject to deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>$150 Co-pay per visit, plus 20%</td>
<td>$150 Co-pay per visit, plus 20%</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$50 Co-pay</td>
<td>40% After deductible*</td>
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<tr>
<td>Hospital Service (Inpatient)</td>
<td>$250 Co-pay per admission plus 20% after deductible</td>
<td>$250 Co-pay plus 40% after deductible*</td>
</tr>
<tr>
<td>Hospital Service (Outpatient)</td>
<td>$200 Co-pay plus 20% after deductible</td>
<td>$250 Co-pay plus 40% after deductible*</td>
</tr>
<tr>
<td>Maternity and Pregnancy Physician’s Office</td>
<td>$40 Co-pay (no co-pay for prenatal care after first visit)</td>
<td>40% After deductible*</td>
</tr>
<tr>
<td>Mental Health and Substance Abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>$250 Co-pay per admission; plus 20% After deductible</td>
<td>$250 Co-pay per admission; plus 40% After deductible*</td>
</tr>
<tr>
<td>Outpatient</td>
<td>$25 Co-pay</td>
<td>40% After deductible*</td>
</tr>
<tr>
<td><strong>Rehabilitation Services Including: Physical, Occupational, Speech and Hearing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60 Visit Maximum Per Therapy, Per Year</td>
<td>20% After deductible</td>
<td>40% After deductible*</td>
</tr>
<tr>
<td><strong>Chiropractic Care and Spinal Treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60 Visit Maximum Per Year</td>
<td>20% After deductible</td>
<td>40% After deductible*</td>
</tr>
</tbody>
</table>

*For Out-of-Network benefits, you will pay your percentage of the cost based on reasonable and customary (R&C) charges; you will pay R&C percentage plus 100% of any excess amount above R&C. If Medicare is the primary payer, this provision does not apply.
Medical Plan Options

EPO
Exclusive Provider Option

Plan Highlights

- Participants must choose an In-Network provider. Out-of-Network benefits are not covered, except in the case of a life-threatening emergency when notification requirements outlined in the plan are followed.

- Includes the Prescription Drug Program (see page 30 for details).

- Preventive care will be covered at 100% with no office visit co-pay for In-Network physicians and labs only.

- Your copays now apply to the annual out-of-pocket maximum.

- You do not designate a Primary Care Physician (PCP), however, you are still encouraged to use a network PCP for all non-specialty care. PCPs include Family Practitioners, General Practitioners, Internists and Pediatricians.

- Only In-Network doctors, hospitals and labs are covered.

- You can choose to see a specialist without a referral; however, this only applies to In-Network specialists.

- The EPO option is best suited for participants who do not mind paying more up front in contributions for a higher coinsurance and no annual deductible.

- This plan option is not available if you are eligible for Medicare by reason of disability.
## CITGO Benefits

### Health & Wellness

<table>
<thead>
<tr>
<th></th>
<th>EPO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lifetime Max Benefit</strong></td>
<td>Unlimited</td>
</tr>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>N/A</td>
</tr>
</tbody>
</table>
| **Annual Out-of-Pocket Max** | $5,350 medical + separate $1,250 Rx per person  
                           | $10,700 medical + separate $2,500 Rx per family maximum          |
| **Office Visit**          | $25 PCP  
                           | $40 Specialist                                                   |
| **Lab/X-Ray (Outpatient) - In-Network Only** | 0%                                                                |
| **Preventive Care**       | 0%, No Co-pay                                                     |
| **Emergency Care**        | $150 Co-pay per visit, plus 15%                                    |
| **Urgent Care**           | $50 Co-pay                                                        |
| **Hospital Service (Inpatient)** | $250 Co-pay admission, plus 15%                                  |
| **Hospital Service (Outpatient)** | $200 Co-pay plus 15%                                           |
| **Maternity and Pregnancy Physician’s Office** | $40 Co-pay (no co-pay for prenatal care after first visit)       |
| **Mental Health and Substance Abuse** |  
                           | **Inpatient**  
                           | $250 Co-pay per admission, plus 15%                             |
|                           | **Outpatient**  
                           | $25 Co-pay                                                      |
| **Rehabilitation Services Including: Physical, Occupational, Speech and Hearing** | 15%                                                               |
| **Chiropractic Care and Spinal Treatment** | 15%                                                              |

### Medical

- **Coordination of Benefits** 40
- **Monthly Contributions** 41
- **Flexible Spending Account** 42
- **Life & Accident Insurance** 46
Medical Plan Options

Non-Network
Available to participants living outside of the network or eligible for Medicare by virtue of disability.

Plan Highlights

• The Non-Network option is available only for those participants residing outside of the provider network area. However, if you are willing to travel to obtain your care within the network, you may choose a network option (EPO, PPO or SDHP).

• The Non-Network option becomes your only plan option available when you are eligible for Medicare by reason of disability.

• Your co-pays and deductibles now apply to the annual out-of-pocket maximum.

• It is a traditional medical option with most care subject to an Annual Deductible and coinsurance.

• Includes an unlimited preventive care benefit that is not subject to the Annual Deductible and co-insurance after Medicare pays their portion of the benefits.

• Preventive care includes routine check-ups or physicals, well-baby care and many types of immunizations.

• Includes the Prescription Drug Program (see page 30 for details).
## Non-Network

<table>
<thead>
<tr>
<th>Lifetime Max Benefit</th>
<th>Unlimited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible</td>
<td>$600/Person $1,800/Family</td>
</tr>
<tr>
<td>Annual Out-Of-Pocket Maximum</td>
<td>$5,600 (medical + deductible per person) + separate $1,000 Rx $11,200 (medical + deductible per family) + separate $2,000 Rx</td>
</tr>
</tbody>
</table>

### You Pay:

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage After Deductible*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visit</td>
<td>20% After deductible*</td>
</tr>
<tr>
<td>Lab/X-Ray (Outpatient)</td>
<td>20% After deductible*</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>0%, Not subject to deductible</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>20% After deductible*</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>20% After deductible*</td>
</tr>
<tr>
<td>Hospital Service (Inpatient)</td>
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</tr>
<tr>
<td>Hospital Service (Outpatient)</td>
<td>20% After deductible*</td>
</tr>
<tr>
<td>Maternity and Pregnancy</td>
<td>20% After deductible*</td>
</tr>
<tr>
<td>Physician's Office</td>
<td>20% After deductible*</td>
</tr>
<tr>
<td>Mental Health and Substance Abuse</td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>20% After deductible*</td>
</tr>
<tr>
<td>Outpatient</td>
<td>20% After deductible*</td>
</tr>
</tbody>
</table>

### Rehabilitation Services Including: Physical, Occupational, Speech and Hearing

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage After Deductible*</th>
</tr>
</thead>
<tbody>
<tr>
<td>60 Visit Maximum Per Therapy, Per Year</td>
<td>20% After deductible</td>
</tr>
</tbody>
</table>

### Chiropractic Care and Spinal Treatment

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage After Deductible*</th>
</tr>
</thead>
<tbody>
<tr>
<td>60 Visit Maximum Per Year</td>
<td>20% After deductible</td>
</tr>
</tbody>
</table>

*For Out-of-Network benefits, you will pay your percentage of the cost based on reasonable and customary (R&C) charges; you will pay R&C percentage plus 100% of any excess amount above R&C. If Medicare is the primary payer, this provision does not apply.
Health Savings Account

Health Savings Account (HSA) for Eligible SDHP Participants

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

• Be enrolled in an HSA-eligible SDHP.
• Not be enrolled in the Health Care Flexible Spending Account program (other than a limited FSA).
• Not be enrolled at the same time in a non-SDHP plan.
• Not be entitled to benefits under Medicare.

The Fidelity Health Savings Account (HSA) Features

• Your Fidelity Health Savings Account (HSA) is a tax-advantaged medical savings account available to you and your eligible covered dependents, who are enrolled in the Self-Directed Health Plan (SDHP).

• Unlike an FSA, your HSA funds roll over and accumulate year to year, if not spent.

• HSAs are owned by you and not Trimark.

• Each participant will receive a debit card to use for qualified medical expenses.

• Triple tax advantage:
  – Payroll deposits are made on a pre-tax basis.
  – Growth of HSA is tax-free.
  – Funds withdrawn are tax-free for qualified medical expenses.

• You will have sound Fidelity investment.

• Choices to grow your HSA funds if you choose to do so.

How Does an HSA Work?

You may use HSA funds to pay for:

– Expenses that must be met before your deductible.
– Services not covered by your health plan such as alternative therapies or your portion of Out-of-Network care.
– Insurance coverage during periods of unemployment.

• An HSA works much like a medical Flexible Spending Account (FSA), but if you do not use any or all of your HSA dollars they roll over to the next year and can accumulate over time for greater protection.

• Both you and Trimark can contribute to the HSA.

• Remember, the SDHP plan will not begin paying benefits other than your preventive care until your deductible is met.

Contributions to Your HSA

Contributions may be made via:

• The convenience of payroll deduction when you complete the enrollment section on the Benefits Enrollment Form provided in your new hire packet.

• Directly to your Fidelity HSA by check or bank debit on a post-tax basis.

• You may continue contributing to your HSA as long as you remain in a qualified HSA eligible health plan (the SDHP) and are not eligible for Medicare.

• Once you retire or leave CITGO for any reason, your Fidelity HSA account is yours to keep, and all the federal tax benefits continue.
For 2016, IRS HSA maximums are:

- $3,350 - Single / Employee Only IRS limit.
- $6,750 - Family / Employee + One or more IRS limit.

Also, if you are 55 and older, “catch-up” contributions of $1,000 per year are available above these limits.

When calculating your contributions to your HSA, it is very important to include the amount of Healthy Rewards Incentives you plan to earn in your calculations.

- For example, if you want to contribute the maximum 2016 annual HSA limits to your HSA for Single Coverage in 2016, and you want to earn Healthy Rewards incentives of $900, your total annual contribution to your HSA will be $2,450 for the plan year ($2,450 individual payroll contribution PLUS $900 Trimark incentive contribution = $3,350 maximum limit).

You may make changes to the amount you contribute via payroll deduction by contacting the Benefits Helpline at 1-888-443-5707 or benefits@citgo.com. Changes become effective within 1-2 pay periods.

HSA deductions are taken from all pay periods (24 pay periods per year).

The SDHP offers an annual enrollment incentive just for enrolling in the SDHP option:

- Employee-only coverage - $500 deposit to HSA.
- Employee plus Dependent/Family coverage - $1,000 deposit to HSA.
- For those employees enrolling during Annual Election, the enrollment incentive will be deposited during normal payroll processing in January. However, Fidelity cannot accept contributions to your HSA until you have opened your account. See Setting Up Your Fidelity HSA on page 26.

Eligible HSA Expenses

- Your HSA funds can be withdrawn by debit card, check or a withdrawal request.
- Checks and debits do not have to be made payable to the provider.
- Funds can be withdrawn for any reason, but withdrawals that are not for documented qualified medical expenses are subject to income taxes and a 20% penalty.
- The 20% tax penalty is waived for persons who have reached the age of 65 or have become disabled at the time of the withdrawal.
- Funds can be used to pay for:
  - Future Medicare Premiums.
  - COBRA Premiums.
  - Long Term Care Premiums.

More information about qualified Health Savings Account expenditures can be found by accessing:

Setting Up Your Fidelity HSA

If you elect to enroll in the SDHP, you are eligible to establish a Fidelity HSA® (Health Savings Account). To open your Fidelity HSA, please:

- Go to NetBenefits or 401k.com.
- After you log on, click the “Open” link next to your Health Savings Account.
- Please complete and submit the Fidelity HSA online application so Fidelity can open your account and accept contributions. **Fidelity cannot accept contributions to your HSA until you have opened your account.**

You may also request a Fidelity HSA debit card with your application. After your Fidelity HSA is open, you may transfer assets from other Health Savings Accounts to your Fidelity HSA by submitting a Transfer of Assets request to Fidelity. If you don’t have Internet access, or if you have further questions, simply call 1-800-544-3716 for personal assistance in setting up your Fidelity HSA. It is important to remember that you may set up your HSA with your own HSA provider. However, **Fidelity is the only HSA provider where CITGO will sponsor the monthly administrative fee or deposit payroll deductions and Healthy Rewards Incentives.**
CITGO Benefits
Health & Wellness

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>12</td>
</tr>
<tr>
<td>Dental</td>
<td>36</td>
</tr>
<tr>
<td>Vision</td>
<td>39</td>
</tr>
<tr>
<td>Coordination of Benefits</td>
<td>40</td>
</tr>
<tr>
<td>Monthly Contributions</td>
<td>41</td>
</tr>
<tr>
<td>Flexible Spending Account</td>
<td>42</td>
</tr>
<tr>
<td>Life &amp; Accident Insurance</td>
<td>46</td>
</tr>
</tbody>
</table>

2016 Benefits for TRIMARK Employees

Health & Wellness

Medical | Dental | Vision | Coordination of Benefits | Monthly Contributions | Flexible Spending Account | Life & Accident Insurance |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>36</td>
<td>39</td>
<td>40</td>
<td>41</td>
<td>42</td>
<td>46</td>
</tr>
</tbody>
</table>
# Medical Plan Features

## Highlights of the 2016 Medical Plans

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>SDHP In-Network</th>
<th>SDHP Out-of-Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lifetime maximum benefit</strong></td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td><strong>Annual deductible</strong></td>
<td>$1,500/Employee only coverage</td>
<td>$3,000/Employee plus dependent coverage</td>
<td>$600/Person</td>
</tr>
<tr>
<td><strong>Annual out-of-pocket maximum</strong>**</td>
<td>$3,425/Employee only coverage</td>
<td>$6,850/Employee plus dependent coverage (Includes deductible and Rx costs)</td>
<td>$6,600 (medical + $600 deductible per person) + separate $1,000 Rx</td>
</tr>
<tr>
<td><strong>You pay:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office visit</td>
<td>20% after deductible</td>
<td>40% after deductible*</td>
<td>20% after deductible*</td>
</tr>
<tr>
<td>Lab/X-Ray (Outpatient)</td>
<td>20% after deductible</td>
<td>40% after deductible*</td>
<td>20% after deductible*</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>0%, Not subject to deductible</td>
<td>Not covered</td>
<td>0%, Not subject to deductible</td>
</tr>
<tr>
<td>Emergency care</td>
<td>20% after deductible</td>
<td>20% after deductible*</td>
<td>20% after deductible*</td>
</tr>
<tr>
<td>Urgent care</td>
<td>20% after deductible</td>
<td>40% after deductible*</td>
<td>20% after deductible*</td>
</tr>
<tr>
<td>Hospital service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>20% after deductible</td>
<td>40% after deductible*</td>
<td>20% after deductible*</td>
</tr>
<tr>
<td>Outpatient</td>
<td>20% after deductible</td>
<td>40% after deductible*</td>
<td>20% after deductible*</td>
</tr>
<tr>
<td>Maternity and Pregnancy Physician’s Office</td>
<td>20% after deductible</td>
<td>40% after deductible*</td>
<td>20% after deductible*</td>
</tr>
<tr>
<td>Mental Health &amp; Substance Abuse</td>
<td>20% after deductible*</td>
<td>40% after deductible*</td>
<td>20% after deductible*</td>
</tr>
<tr>
<td>Inpatient</td>
<td>20% after deductible*</td>
<td>40% after deductible*</td>
<td>20% after deductible*</td>
</tr>
<tr>
<td>Outpatient</td>
<td>20% after deductible*</td>
<td>40% after deductible*</td>
<td>20% after deductible*</td>
</tr>
<tr>
<td>Rehabilitation Services including: Physical, Occupational, Speech and Hearing</td>
<td>20% after deductible</td>
<td>40% after deductible*</td>
<td>20% after deductible*</td>
</tr>
<tr>
<td>Chiropractic Care and Spinal Treatment</td>
<td>20% after deductible</td>
<td>40% after deductible*</td>
<td>20% after deductible*</td>
</tr>
</tbody>
</table>

*For Out-of-Network benefits, you will pay your percentage of the cost based on reasonable and customary (R&C) charges; you will pay R&C percentage plus 100% of any excess amount above R&C. If Medicare is the primary payer, this provision does not apply.

**Your deductible now applies to the annual out-of-pocket maximum.
## Highlights of the 2016 Medical Plans

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>PPO In-Network</th>
<th>PPO Out-of-Network</th>
<th>EPO In-Network Only</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lifetime maximum benefit</strong></td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td><strong>Annual deductible</strong></td>
<td>$350/Person</td>
<td>$1,050/Person</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>$1,050/Family</td>
<td>$3,050/Family</td>
<td></td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket maximum</strong></td>
<td>$5,350 (medical + deductible per person) + separate $1,000 Rx</td>
<td>$14,050 (medical + deductible per person) + separate $1,000 Rx</td>
<td>$6,600 medical + separate $1,250 Rx per person</td>
</tr>
<tr>
<td></td>
<td>$11,050 (medical + deductible per family) + separate $2,000 Rx</td>
<td>$29,050 (medical + deductible per family) + separate $2,000 Rx</td>
<td>$13,200 medical + separate $2,500 Rx per family maximum</td>
</tr>
</tbody>
</table>

### You pay:

<table>
<thead>
<tr>
<th>Office visit</th>
<th>$25 PCP</th>
<th>40% after deductible*</th>
<th>$25 PCP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lab/X-Ray (Outpatient)</td>
<td>0%</td>
<td>40% after deductible *</td>
<td>0%</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>0%, No Co-pay, Not subject to deductible</td>
<td>Not covered</td>
<td>0%, No Co-pay</td>
</tr>
<tr>
<td>Emergency care</td>
<td>$150 co-pay per visit plus 20%</td>
<td>$150 co-pay per visit plus 20%</td>
<td>$150 co-pay per visit plus 15%</td>
</tr>
<tr>
<td>Urgent care</td>
<td>$50 co-pay</td>
<td>40% after deductible*</td>
<td>$50 co-pay</td>
</tr>
</tbody>
</table>

### Hospital service

| Inpatient                     | $250 co-pay plus 20% after deductible | $250 co-pay plus 40% after deductible* | $250 co-pay per admission plus 15% |
| Outpatient                    | $200 co-pay plus 20% after deductible | $250 co-pay plus 40% after deductible* | $200 co-pay plus 15% |

### Maternity and Pregnancy

| Physician’s Office            | $40 co-pay (no co-pay for prenatal care after first visit) | 40% after deductible* | $40 co-pay (no co-pay for prenatal care after first visit) |

### Mental Health & Substance Abuse

| Inpatient                     | $250 co-pay per admission; plus 20% after deductible and co-pay | $250 co-pay per admission; plus 40% after deductible and co-pay* | $250 co-pay per admission; plus 15% after co-pay |
| Outpatient                    | $25 co-pay | 40% after deductible* | $25 co-pay |

### Rehabilitation Services including: Physical, Occupational, Speech and Hearing

| 60 visit maximum per therapy, per year | 20% after deductible | 40% after deductible* | 15% |

### Chiropractic Care and Spinal Treatment

| 60 visit maximum per year | 20% after deductible | 40% after deductible* | 15% |

*For Out-of-Network benefits, you will pay your percentage of the cost based on reasonable and customary (R&C) charges; you will pay R&C percentage plus 100% of any excess amount above R&C. If Medicare is the primary payer, this provision does not apply.*

**Your deductible now applies to the annual out-of-pocket maximum.
Prescription Drug Benefits

Prescription Drug Plan Highlights

- Three tier levels of prescription drugs:
  - Generic
  - Mainly Preferred Brand
  - Non-Preferred Brand
- Automatic participation when enrolled in any CITGO medical plan option.
- Prescription expenses are not subject to a deductible, except for SDHP plan.
- Mandatory generic provision (see page 33).

Prescription Drug List

The Optum Rx 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). The Optum Rx Pharmacy and Therapeutics Committee and a team of physicians and pharmacists meet regularly to review and update the list. 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.
- Patient outcome.

The Prescription Drug List is available on Benefit Connections, www.myuhc.com, or by calling 1-866-317-6359. The list does not restrict what your physician can prescribe or what a pharmacist can dispense. Physicians are encouraged to follow the Prescription Drug List when prescribing medicines for CITGO plan participants. However, you and your physician will have the choice in what is prescribed.

Retail Prescription Drug Benefit for EPO, PPO and Non-Network

By presenting your combined medical and prescription drug identification card at one of more than 64,000 participating pharmacies, you will pay the discounted price of the medication for up to a 31-day supply per prescription. When the actual cost of the drug is less than the minimum coinsurance, you will only be required to pay the actual cost of the drug. There are no claim forms to file. To find a participating pharmacy near you, visit www.myuhc.com and access the pharmacy link, or call an UnitedHealthcare Health Advocate at 1-866-317-6359.
The following chart summarizes the Prescription Drug Program provisions.

### 2016 Prescription Drug Program at a Glance

<table>
<thead>
<tr>
<th>Annual Rx Out-of-Pocket Maximum</th>
<th>SDHP Prescription Drug out-of-pocket costs apply to the SDHP Annual Deductible and out-of-pocket maximum</th>
<th>PPO $1,000 per individual $2,000 per family</th>
<th>EPO $1,250 per individual $2,500 per family</th>
<th>Non-Network $1,000 per individual $2,000 per family</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preventive drugs on the approved Preventive Drug List</strong> (See Annual Election Resources at <a href="http://www.hr.CITGO.com">www.hr.CITGO.com</a> for a list of preventive drugs) Prescription Drug Program pays 100% with no deductible. All other covered drugs you pay 100% of the discounted amount until the annual deductible is met when you use a network retail or mail order pharmacy.</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td></td>
</tr>
</tbody>
</table>

#### Retail: Up to a 30-Day Supply – Mandatory Generic Provision Applies

<table>
<thead>
<tr>
<th>Tier 1 Mainly Generic Per Prescription You Pay</th>
<th>25% coinsurance* $10 minimum up to $150 maximum after deductible</th>
<th>25% coinsurance $10 minimum up to $150 maximum</th>
<th>25% coinsurance $10 minimum up to $150 maximum</th>
<th>25% coinsurance $10 minimum up to $150 maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 2 Mainly Preferred Brand</td>
<td>30% coinsurance* $20 minimum up to $150 maximum after deductible</td>
<td>30% coinsurance $20 minimum up to $150 maximum</td>
<td>30% coinsurance $20 minimum up to $150 maximum</td>
<td>30% coinsurance $20 minimum up to $150 maximum</td>
</tr>
<tr>
<td>Tier 3 Mainly Non-Preferred Brand</td>
<td>30% coinsurance* $30 minimum up to $150 maximum after deductible</td>
<td>30% coinsurance $30 minimum up to $150 maximum</td>
<td>30% coinsurance $30 minimum up to $150 maximum</td>
<td>30% coinsurance $30 minimum up to $150 maximum</td>
</tr>
</tbody>
</table>

#### Mail Order: Up to a 90-Day Supply – Prescriptions filled at Mail Order with a supply of 46 days or less will be processed at the Retail benefit level; Mandatory Generic Provision Applies.

<table>
<thead>
<tr>
<th>Tier 1 Mainly Generic</th>
<th>25% coinsurance* $25 minimum up to $150 maximum after deductible</th>
<th>25% coinsurance $25 minimum up to $150 maximum</th>
<th>25% coinsurance $25 minimum up to $150 maximum</th>
<th>25% coinsurance $25 minimum up to $150 maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 2 Mainly Preferred Brand</td>
<td>30% coinsurance* $50 minimum up to $150 maximum after deductible</td>
<td>30% coinsurance $50 minimum up to $150 maximum</td>
<td>30% coinsurance $50 minimum up to $150 maximum</td>
<td>30% coinsurance $50 minimum up to $150 maximum</td>
</tr>
<tr>
<td>Tier 3 Mainly Non-Preferred Brand</td>
<td>30% coinsurance* $75 minimum up to $150 maximum after deductible</td>
<td>30% coinsurance $75 minimum up to $150 maximum</td>
<td>30% coinsurance $75 minimum up to $150 maximum</td>
<td>30% coinsurance $75 minimum up to $150 maximum</td>
</tr>
</tbody>
</table>

To find a participating pharmacy near you, visit www.myuhc.com and then access the pharmacy link, or call Optum Rx at 1-866-317-6359.

*SDHP participants pay 100% of the cost of the prescription until the annual deductible has been met. Then they pay the coinsurance amounts shown.*
Mail Order Prescription Drug Benefit for EPO, PPO and Non-Network

The mail order program offers convenience and cost savings on medications you may take on a regular basis (such as medication for high blood pressure or heart conditions). You can receive up to a 90-day supply, as prescribed by your doctor, plus refills. However, prescriptions filled by the Mail Order pharmacy that are less than a 46-day supply will be processed at the retail co-insurance level.

When the actual cost of the drug is less than the minimum mail order co-pay, you will pay the actual cost.

Prescription Drug Benefit for SDHP

Unlike the other medical plan options, the SDHP has a combined medical and prescription drug deductible. You must pay the full price of any prescription drug until your deductible is met, except for medications approved by the IRS as preventive prescription drugs covered under the SDHP. The full price is the discounted cost. You will use your combined medical and prescription ID card at the pharmacy to obtain the discount. In addition, the cost of your prescription drugs will be applied to your annual Out-of-Pocket Maximum.

100% SDHP Preventive Prescription Drug Coverage

The IRS guidelines for the SDHP with an HSA permit certain prescription drugs to be eligible for coverage as Preventive Prescription Drugs, which are not subject to the Annual Deductible.

Preventive Drugs are medications that Optum Rx, in conjunction with its Pharmacy & Therapeutics Committee, has determined may prevent the onset of a disease or condition when taken by a person who has developed risk factors for a disease or condition that has not yet manifested itself or has not become clinically apparent (asymptomatic), or may prevent the recurrence of a disease or condition from which a person has recovered. Some examples include cholesterol lowering drugs to prevent heart disease and ACE inhibitors to reduce the risk of a participant having a recurrence of a stroke. Preventive medications do not include drugs used to treat an existing illness, injury or symptomatic conditions.

The Preventive Prescription Drug coverage under the SDHP balances the importance of helping you take full advantage of the SDHP option, while being able to focus on healthy living.

Preventive Prescription Drugs eligible under the SDHP will be covered at 100% with no co-pay. This benefit is still subject to plan provisions and future changes in the IRS guidelines. The Preventive Prescription Drug List for the SDHP option is available on Benefit Connections at www.hr.CITGO.com.

You can also contact Optum Rx customer service at 1-866-317-6359.
Benefit After Meeting SDHP Deductible

Once your SDHP deductible has been met for the plan year, the prescription drug coinsurance schedule is the same as the one for the EPO, PPO and Non-Network plan options. Please refer to the Prescription Drug chart on page 31 for information about what you pay after the SDHP deductible is met.

Mandatory Generic

The prescription drug program includes a mandatory generic provision for prescription drugs. You may pay more for a brand-name drug if:

- Your physician writes a prescription that does not include “dispense as written” (DAW);
- A generic is available; and
- You request the brand name.

For retail prescription drugs, your cost will be the covered percentage on the brand (30 or 40 percent 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 copayment plus the difference between the cost of the brand and the generic drug. When a preferred brand drug is less expensive (in a lower tier) than its generic equivalent, the mandatory generic provision is waived and no penalty will apply.
Healthy Rewards Program

2016 Healthy Rewards Program

There is a strong correlation between high stress/emotional issues and poor lifestyle choices. To be effective, our health improvement programs must and will focus on your emotional and physical well-being. CITGO will continue to partner with a recognized wellness provider to bring our employees and their eligible covered spouse healthy living resources, on-line, and telephonic coaching. Having an independent healthy living provider assures confidentiality of your information.

Prevention is the key to better health and regular preventive care helps:

- Detect health problems early.
- Reduce risk of disease.
- Protect you from higher costs down the road.
- SAVE YOUR LIFE.

CITGO is excited to include Rally as part of our new Healthy Rewards Program. Rally is a personalized, interactive health experience designed to help you create positive habits that may improve your health and well-being. When you sign up with Rally, the first thing you discover is your Rally Health Age, which tells you how your body is feeling right now. Then you can start exploring all the great digital tools that may help you make healthier choices based on your life, schedule and needs.

All active CITGO employees enrolled in one of the CITGO medical plan options are eligible to participate in the Healthy Rewards Program and access Rally. An employee’s spouse who is enrolled in one of the medical plan options may also participate through Rally and earn rewards. Even enrolled dependents over age 13 can access Rally. Your spouse and dependents will need to create and use their own separate log-in to myuhc.com in order to reach the Rally site.

To start your participation in the 2016 Healthy Rewards Program, go to www.myuhc.com and click on the Rally icon or Health & Wellness tab. Please note, the first time you visit the site you will need to create a Rally username and password. If you participated in Rally last year, your information will carryover but after January 1, you will be prompted to complete the Rally Health Survey again to begin earning your rewards for 2016.

For 2016, all healthy reward activities must be completed by 11/30/2016.

Incentives are normally deposited on a monthly basis for activities earned in the prior month. Results are processed by UHC and incentives earned are reported to CITGO for funding every two weeks through the normal payroll process.
Start your Rally experience by visiting www.myuhc.com

All active CITGO employees enrolled in one of the CITGO medical plan options are eligible to participate in the Healthy Rewards Program and access Rally. An employee’s spouse who is also enrolled in one of the medical plan options may also participate through Rally and earn rewards.

Additionally, the SDHP offers an annual enrollment incentive just for enrolling in the SDHP option:

- Employee-only coverage - $500 deposit to HSA.
- Employee plus Dependent/Family coverage - $1,000 deposit to HSA.
- For those employees enrolling during Annual Election, the enrollment incentive will be deposited during normal payroll processing in January. However, Fidelity cannot accept contributions to your HSA until you have opened your account. See Setting Up Your Fidelity HSA on page 26.

### Earn 2016 CITGO Healthy Rewards Program Incentives through Rally

<table>
<thead>
<tr>
<th>ACTIVITY to be completed by enrolled Employee OR enrolled Spouse by 11/30/2016</th>
<th>SDHP</th>
<th>PPO</th>
<th>EPO</th>
</tr>
</thead>
<tbody>
<tr>
<td>COMPLETE online Rally Health Survey between 1/1/2016 and 11/30/2016</td>
<td>$75 – Employee</td>
<td>$25 – Employee</td>
<td>$25 – Employee</td>
</tr>
<tr>
<td></td>
<td>$75 - Spouse</td>
<td>$25 - Spouse</td>
<td>$25 - Spouse</td>
</tr>
<tr>
<td>COMPLETE three personalized online Rally Missions between 1/1/2016 and 11/30/2016</td>
<td>$75 – Employee</td>
<td>$25 – Employee</td>
<td>$25 – Employee</td>
</tr>
<tr>
<td></td>
<td>$75 - Spouse</td>
<td>$25 - Spouse</td>
<td>$25 - Spouse</td>
</tr>
<tr>
<td>COMPLETE Biometric Screening and submit to Rally between 1/1/2016 and 11/30/2016</td>
<td>$350 – Employee</td>
<td>$100 – Employee</td>
<td>$100 – Employee</td>
</tr>
<tr>
<td></td>
<td>$350 - Spouse</td>
<td>$100 - Spouse</td>
<td>$100 - Spouse</td>
</tr>
<tr>
<td></td>
<td>$500 - Spouse</td>
<td>$150 - Spouse</td>
<td>$150 - Spouse</td>
</tr>
<tr>
<td>Deposited* to Employee’s Account</td>
<td>HSA</td>
<td>FSA</td>
<td>FSA</td>
</tr>
</tbody>
</table>
Dental Benefits

Dental Plan Highlights

• The Dental Plan is a stand-alone plan and not part of the Medical Plan.

• Benefits include examinations, cleanings, basic and major restorative services.

• **MetLife does not issue ID cards** – simply advise your dentist that your coverage is through MetLife and provide your social security number.

• MetLife offers access to a nationwide network of private practice dental providers.

• You benefit from lower costs when you receive your care from a Network dentist and there are no claims to file. However, Out-of-Network benefits are available.

• There are two convenient ways to find a MetLife network dentist:
  – Online at www.metlife.com/dental
  – Call MetLife’s customer service at 1-800-942-0854

CITGO Dental Basic Option

features the following In-Network plan coverage:

• 100% of preventive care covering your preventive exam, cleaning and X-rays with no deductible.

• 80% for minor restorative services such as fillings and periodontal care.

• 50% for major services such as crowns and bridges.

• A $50 Annual Deductible per person (applicable to minor restorative and major services).

• An Annual Maximum benefit of $1,500.

CITGO Dental Plus option

features the following enhanced In-Network coverage:

• 100% of preventive care covering your preventive exam, cleaning and X-rays with no deductible.

• 80% for minor restorative services such as fillings and periodontal care.

• 50% for major services such as crowns and bridges.

• A $50 Annual Deductible per person (applicable to minor restorative and major services).

• An Annual Maximum benefit of $3,000 (In-Network) or $1,500 (Out-of-Network). The annual maximum limits cannot be combined.

• 50% coverage for In-Network orthodontia services after deductible, up to a $3,000 lifetime maximum In-Network or $1,500 lifetime maximum Out-of-Network.

• 50% coverage for implants after deductible, up to $3,000 annual maximum In-Network or $1,500 annual maximum Out-of-Network.

About the MetLife Dental Preferred Provider (PDP) Network

The dental plan offers the MetLife Preferred Dentist Program (PDP). Dentists participating in the PDP agree to accept negotiated fees as “payment in full” for services rendered to plan participants when they are covered under the plan, up to the benefit plan maximum for the option you choose. The MetLife PDP network offers more than 142,000 network dentist locations, including more than 29,000 specialist locations. When you see a MetLife dentist, you’re assured of getting care from a dentist who has met MetLife’s credentialing standards. MetLife reviews PDP dentists’ credentials on a regular basis.
Finding a MetLife network dentist is easy. You have two convenient ways to find a MetLife dentist:

• You can get a list of these participating PDP dentists online at www.metlife.com/dental; or

• Call the MetLife customer service center at 1-800-942-0854 to have a list faxed or mailed to you.

You benefit from lower costs when you receive your care from a Network dentist.

Your out-of-pocket expenses may be lower if you see a network dentist, since In-Network PDP dentists agree to accept MetLife’s negotiated fees as payment in full.

Typically, these fees are as much as 15-45% less than the average fees charged by dentists in the same community. Keep in mind: those negotiated fees even apply to non-covered services like cosmetic dentistry and extra cleanings, so you can save even more.

There are no claim forms to file when you use a network dentist. Any MetLife provider you choose will submit your claims for you. Your dentist can also get a pre-treatment estimate while you’re in the dental office.

What if Your Dentist Isn’t in the MetLife Network?

With both the Dental Basic and Dental Plus options, you can go to the dentist you’re most comfortable with and still receive benefits. You will pay a higher percentage of the costs for all services except preventive (which are covered 100%). You also may be responsible for fees above reasonable and customary amounts.

Your Contributions

You and the Company share in the cost of your dental benefits, and you pay your contributions with “pre-tax” dollars through payroll deductions.

The chart below provides a high level overview of the CITGO dual choice dental plan options and also compares the In-Network and Out-of-Network coverage levels available under the plan.

<table>
<thead>
<tr>
<th>Dental Benefit</th>
<th>Dental Basic Pays:</th>
<th>Dental Plus Pays:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Preventive &amp; Diagnostic</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Minor Restorative</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Major Services</td>
<td>50%</td>
<td>40%</td>
</tr>
<tr>
<td>Implants</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Orthodontia (Child &amp; Adult Coverage)</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Deductible</td>
<td>$50 Per Person Per Year</td>
<td>$50 Per Person Per Year</td>
</tr>
<tr>
<td>Waived for Preventive &amp; Diagnostic</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Annual Maximum</td>
<td>$1,500</td>
<td></td>
</tr>
<tr>
<td>Ortho Lifetime Maximum</td>
<td>Not Covered</td>
<td></td>
</tr>
</tbody>
</table>
Vision Benefits

Vision Plan Highlights

CITGO will continue to offer a dual choice vision plan that will be administered through UnitedHealthcare Vision. You will have the ability to choose the Vision Basic option or the Vision Plus option. Both options will offer In-Network and Out-of-Network benefit coverage.

Vision Plan Highlights

• The Vision Plan is a stand alone plan and not part of the Medical Plan.

• Benefits include examinations and glasses (frames and lenses) or contact lenses.

• Most services are covered under the applicable copay.

• When network providers are used, the frame benefit covers more than 60% of all frames in-full after the applicable copay.

• When network providers are used, the contact lens benefit covers fitting/evaluation fees, contact lenses and up to two follow-up visits for most contacts (after the copay).

• The Vision Plan offers access to a nationwide network of private-practice optometrists and ophthalmologists as well as retail chain providers.

• The Vision Plan offers access to discounted laser vision correction through the Laser Vision Network of America.

• Out-of-Network benefits are available.

• **ID cards are not issued for the Vision Plan.** Simply advise your provider your coverage is through UnitedHealthcare Vision and provide your social security number.

CITGO Vision Basic Option

features the following In-Network plan coverage:

• Lower contributions.

• $130 frame allowance once every two years.

• $10 exam copay.

• $25 materials copay.

• Progressive lenses, polycarbonate lenses and lens coatings are available at a discount.

• Contact lenses covered as an alternate to eyeglasses.

CITGO Vision Plus Option

features the following enhanced In-Network coverage:

• $250 frame allowance once per calendar year.

• $10 exam copay.

• $25 materials copay.

• Progressive lenses, polycarbonate lenses and lens coatings are covered in full.

• Contact lenses covered as an alternate to eyeglasses.
Using Your Vision Benefit

Through UHC Vision’s provider network, you will receive a complete examination as well as glasses (frames and lenses) or contact lenses. You will receive most services at no additional cost beyond applicable copays. Once you locate a network provider, simply call the provider directly to schedule your appointment. Identify yourself as having UHC Vision coverage. The network provider will perform a complete eye examination, examination for eye pathology and abnormalities, visual analysis (refraction), diagnosis and prescription, and visual skill testing.

If prescription eyewear is necessary, your UHC Vision provider will assist with your selection and order your prescription. Contact lenses are covered as well, including disposable lenses (up to 6 boxes depending on the prescription). If you elect vision coverage and use an Out-of-Network provider, you will still receive a benefit. You will be reimbursed up to the Non-Network maximums. A generous benefit amount is provided toward the fitting/evaluation fee and purchase of contact lenses at a Non-Network provider. However, you will need to file a claim with UHC Vision and include the itemized paid receipt(s) to be reimbursed for Non-Network provider services.

Your Contributions

You pay the full cost of your vision premium with “pre-tax” dollars through payroll deductions.

The chart below provides a high level overview of the CITGO dual choice vision options and also compares the In-Network and Out-of-Network coverage levels available under the plan.

<table>
<thead>
<tr>
<th>Vision Benefits</th>
<th>Vision Basic</th>
<th>Vision Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Eye Exam</td>
<td>Once Per Calendar Year</td>
<td>Once Per Calendar Year</td>
</tr>
<tr>
<td>Eyeglass Lenses or Contact Lenses</td>
<td>Once Per Calendar Year</td>
<td>Once Per Calendar Year</td>
</tr>
<tr>
<td>Frames</td>
<td>Once Every Two Years</td>
<td>Once Per Calendar Year</td>
</tr>
<tr>
<td>Vision Exam by a licensed Optometrist or Ophthalmologist</td>
<td>$10 Exam Co-pay</td>
<td>up to $50</td>
</tr>
<tr>
<td>Frames</td>
<td>$25 Materials Co-pay with up to $130 retail frame allowance at a UHC Vision network provider</td>
<td>up to $45</td>
</tr>
<tr>
<td>Single, Bifocal, Trifocal and Lenticular Lenses*</td>
<td>*Covered in full, (Progressive lens and lens’ coatings covered at a discount only)</td>
<td>Up to $80, varies by lens type</td>
</tr>
<tr>
<td>Elective Contact Lenses in lieu of Eyeglasses</td>
<td>Covered-in-full elective contact lenses, fitting/evaluation fees, up to 6 boxes</td>
<td>up to $150</td>
</tr>
</tbody>
</table>

Medically necessary contact lenses are determined by your vision provider for both In-Network and Out-of-Network coverage. If your provider considers your contacts medically necessary, your provider should contact UHC Vision concerning coverage.

*The network provider co-pay will apply once if frames and lenses are purchased at the same time.
Coordination of Benefits for Medical and Dental Benefits When You Have Other Health Care Coverage

Remember, the benefits you receive from a CITGO Plan option may affect the benefits you receive from another group health plan, and vice versa. It is very important to let your health care providers and claims administrator know if you or a family member is enrolled in more than one health plan (for example, if your spouse is enrolled in a CITGO Plan and his or her employer’s plan). When this happens, the CITGO Plan will apply a “carve-out” of benefits provision to coordinate payments with the other plan. This provision ensures that payments from the other plan, plus any payments from the CITGO medical plan, do not exceed the amount CITGO would have paid if there were no other coverage. To calculate benefits, it is necessary to determine which plan is the primary plan and which is the secondary plan. The primary plan pays benefits first. The secondary plan pays benefits after the primary plan has paid. The CITGO medical plan is always secondary to any automobile insurance coverage, including, but not limited to, no-fault coverage and uninsured motorist coverage, and to any medical payment provision under homeowner’s or renter’s insurance. The order in which benefits are paid generally depends on whether the coverage is in an active plan or a retiree plan, and whether you are Medicare eligible. If you are covered under another plan, you should contact the other plan’s administrator for the coordination of benefit rules for the other plan.
## Monthly Contributions

### 2016 Medical, Dental and Vision Monthly Contributions

<table>
<thead>
<tr>
<th>Level Of Coverage</th>
<th>Medical</th>
<th>Dental</th>
<th>Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SDHP</td>
<td>PPO</td>
<td>EPO</td>
</tr>
<tr>
<td>Employee Only</td>
<td>$11.00</td>
<td>$120.00</td>
<td>$153.00</td>
</tr>
<tr>
<td>Employee and Spouse</td>
<td>$22.00</td>
<td>$233.00</td>
<td>$296.00</td>
</tr>
<tr>
<td>Employee and Child(ren)</td>
<td>$16.00</td>
<td>$179.00</td>
<td>$227.00</td>
</tr>
<tr>
<td>Employee and Family</td>
<td>$28.00</td>
<td>$316.00</td>
<td>$403.00</td>
</tr>
</tbody>
</table>
Flexible Spending Account Program

The CITGO Flexible Spending Account (FSA) program offers employees a way to save money on certain health care and dependent care expenses by setting aside part of your pay on a pre-tax basis through your payroll deductions. Employee tax savings include federal income tax, and in most jurisdictions, state and local income taxes.

For 2016, the period for incurring eligible expenses under all FSA Accounts will be January 1, 2016 through December 31, 2016. The deadline for filing eligible claims under the 2016 FSA Program will be March 31, 2017.

Advantages of Participating in a Flexible Spending Account

A flexible spending account is a valuable employee benefit that allows you and other CITGO employees to have pre-tax dollars withheld from their salaries to pay for medical expenses such as copays and deductibles and dependent care expenses, such as babysitting or elder care. Pre-tax means you pay no Federal Income, Social Security (FICA) or Medicare tax and, in most states, no state income taxes on your spending account contributions. Your reimbursements for eligible expenses are also not subject to any taxes. You can reduce your taxable income and use the income reduction to pay for expenses that would otherwise be paid for with after tax dollars. By using flexible spending accounts, you pay less tax; therefore, you have more take-home pay.

Important Elements of the CITGO Flexible Spending Account

UnitedHealthcare is the administrator of both the FSA and the company medical plan. You are eligible to participate in the CITGO Flexible Spending Account program if you are a regular full-time or regular part-time employee. Features of the FSA program include:

- The health care spending account and the dependent care spending account are completely separate.
- You make a separate election for each account each year.
- You may not transfer money from one spending account to the other.
- Online account access.
- Quarterly participant account statements mailed to your home or available online.
- Claims filing by fax or by mail.
- Automatic Claim Rollover for eligible medical, prescription drug, vision and dental expenses is available.
- Direct deposit of your FSA reimbursements is available.

The Use-It-or-Lose-It Rule

The “use-it-or-lose-it” rule is a provision in the IRS regulations that requires that all money contributed to your FSA must be used to reimburse qualified expenses incurred during that Plan Year. Money not used to reimburse eligible expenses is forfeited. The unused portion of your health care or dependent care FSA may not be paid to you in cash or other benefits, including transferring money between FSAs. To reduce the risk of forfeiture, it is critical that you carefully estimate your expenses when choosing your Annual Election amount each year.
Health Care Flexible Spending Account

The Health Care Spending Account allows you to be reimbursed for certain out-of-pocket medical, prescription drug, dental and vision care expenses not paid by any other plan. The maximum amount you can contribute to your Health Care Spending Account is $2,550 annually. When you enroll in the SDHP option you are not eligible to enroll in the regular Health Care FSA.

Your Contributions

Contributions that begin after January 1 are subject to monthly maximums and minimums, not the annual maximum. There is a $10 minimum up to $212.50 maximum per month not to exceed $2,550 per Plan Year.

Eligible Health Care FSA Expenses

Expenses may be for you, your spouse or your eligible dependents. Generally, allowable items are the same as those allowable for the medical tax deduction, as outlined in IRS publication 502. These include products or services purchased for the diagnosis, cure, mitigation, treatment, or prevention of disease. Examples include:

- Coinsurance, copayments and annual deductibles.
- Dental expenses including cleanings, fillings, caps, bridges, root canals.
- Eyeglasses including exam, frames and lenses, contact lens fitting fees, laser eye surgery.
- Hearing exams, hearing aids and batteries.
- Physical therapy.
- Prescription drugs not covered by any health plan.
- Smoking cessation expenses when prescribed by a physician.
- Weight loss program fees when your physician writes a prescription for the care in conjunction with another specific medical condition such as obesity or hypertension.

Health Care FSA Exclusions

The following is a partial listing of expenses that are NOT eligible for reimbursement under the Health Care Flexible Spending Account program. Examples include:

- Amounts covered under another health plan, health insurance premiums or long-term care expenses.
- Cough suppressant or decongestant syrup, nasal spray.
- Cosmetics such as face creams, hand or body lotion, lip balm, soap and sunscreen.
- Cosmetic surgery, hair removal, hair growth procedures or treatments, non-medical dermatology procedures, deodorants, feminine hygiene products.
- Diaper rash ointments, mouthwash, toothpaste.
- Dietary supplements, exercise equipment or programs.
- Massage therapy for general health or to relieve stress.
- Non-prescription hormone therapy, non-prescription birth control or vitamins including prenatal vitamins, sleep aids and fiber supplements.
- Any over-the-counter medications unless accompanied by a written prescription from your attending physician.
Flexible Spending Account

Limited Health Care Flexible Spending Account

CITGO will continue to offer a Limited Health Care Flexible Spending Account (FSA) which is specifically designed to coordinate with your Health Savings Account (HSA) when you enroll in the Self-Directed Health Plan option. The maximum amount you can contribute to your Limited Health Care FSA is $2,550 annually.

The Limited FSA is restricted to covering dental and vision out-of-pocket expenses not covered under any other health plan. The benefit to you is that this will help you grow your HSA dollars for the future and still have the tax savings benefits of an FSA just for non-medical expenses. However, this Limited FSA Account does not roll over like your HSA and operates under the “use-it-or-lose-it” rule.

Eligible Dependent Care FSA Expenses

Generally, allowable expenses are the same as those allowable for the dependent care and elder care tax deduction, as outlined in IRS publication 503.

- Nursery, as well as before and after school care expenses, and babysitting services.
- Adult elder care for a qualifying parent or relative.
- Licensed day care center or nursery school that meets federal and state requirements.
- Summer day camp (not overnight camp) so long as no significant educational services are provided.

Note: The dependent care income tax credit and the dependent care FSA interact with various other tax laws concerning income, losses, deductions and credits. For more information log on to www.irs.gov and refer to IRS Publication 503 or consult a tax adviser regarding your individual tax situation.

Filing Your FSA Claims

Once an expense has been incurred, you can submit a claim for reimbursement directly to the Claims Administrator, UnitedHealthcare, by mail or by fax. You must submit a completed Flexible Spending Account Claim Form with proper documentation to UnitedHealthcare. You can access a copy of the form on Benefit Connections.

Your Contributions

The maximum amount you can contribute to this account is the smallest of the following amounts:

- Your pay.
- Your spouse’s pay.
- $10 minimum up to $417 maximum per month not to exceed the plan maximum of $5,000 per year.
- Up to $200 per month for one child or $400 per month for two or more children for each month that your spouse is a full-time student or disabled.
- $2,500 annually if you are married and file separate income tax returns.
- $5,000 per household annually if you are filing as a single taxpayer or married with you and your spouse filing jointly.
Health Care FSA Claim Submission and Reimbursement

All health care expenses submitted for reimbursement must be for services provided during the period in which you were an active participant in the spending account. Each Plan Year, the full amount of your annual contribution amount is available on January 1. This means if you incur an unexpected health care expense you may not have planned for, the funds are available to assist you in covering any eligible costs even though all the deductions will not be completed until December 31.

Automatic Claim Rollover of Eligible Health Care FSA Expenses

UnitedHealthcare is the administrator of both the FSA and the company medical Plan. The Flexible Spending Account program offers convenient Automatic Claim Rollover. This means you will automatically be reimbursed for your out-of-pocket medical, prescription drug, vision and dental expenses, as these charges are automatically filed electronically to the FSA claims unit. Automatic Claim Rollover is set up at the beginning of each Plan Year for each employee enrolled in a Health Care FSA. To opt out of Automatic Claim Rollover you can submit your request online at www.myuhc.com, or by calling UnitedHealthcare at 1-866-317-6359.

Dependent Care FSA Claim Submission and Reimbursement

The dependent care provider will need to complete the Dependent Care Provider Certification section of the Flexible Spending Account Claim Form. The receipt must include the care provider’s name, dates of service, amount paid, the care provider’s address and tax identification number or Social Security number.

You will be reimbursed for dependent care expenses incurred during the Plan Year. The date an expense is incurred is the date you (or your family member) received the dependent care service. The date you are billed for a dependent care service or the date you paid for a dependent care service is not the date an expense is incurred. You will be reimbursed for incurred dependent care expenses up to the total amount of money credited to your account.

Where to File Your Claims

You can submit a claim for reimbursement directly to the claims administrator, UnitedHealthcare, by mail, or by fax.

UnitedHealthcare
Health Care Account Service Center
Attn: Flexible Spending UnitedHealthcare
P.O. Box 981506
El Paso, TX 79998-1506
Customer Service: 1-800-331-0480
Fax: 1-915-231-1709
Toll-Free Fax: 1-866-262-6354

FSA Minimum Claim Reimbursement Amount

The minimum claim reimbursement amount is $25, except for any final payment to clear your account.

Direct Deposit for FSA Reimbursements

You may elect to have your FSA reimbursements deposited directly into your bank account by enrolling in direct deposit online at www.myuhc.com. This will give you easier access to your money. Once enrolled for direct deposits, you will not need to enroll again each year. You may deactivate direct deposit by visiting www.myuhc.com or by calling 1-877-311-7849.
Life & Accident Insurance

The Life Insurance plan is designed to provide valuable protection for you and your family 24 hours a day, while on the job, commuting, traveling and at home. The company’s life insurance options are administered by MetLife.

Basic Life Insurance

The company provides you with life insurance in an amount equal to two times your annual base salary.

Occupational Accidental Death Benefit

As an active employee you are automatically covered by a $500,000 death benefit payable to your beneficiary in the event death occurs as a result of an occupational related accident.

Personal Accident Insurance

Personal Accident Insurance provides coverage for you and your family. Full benefits are paid if there is a death solely as a result of an accident. Full or partial benefits are paid in certain cases if seriously injured in an accident. You may enroll in up to ten times your annual base pay, in multiples of $5,000. The minimum coverage you can elect is $10,000 and the maximum is $750,000.

Optional Life Insurance

Optional Life Insurance coverage provides group term life insurance protection during your active employment. You may elect from one to five times your annual base pay in Optional Life Insurance, which is payable in the event of your death from any cause. Your cost will change on January 1 in the year you enter a new age bracket in accordance with the following schedule.

<table>
<thead>
<tr>
<th>Age</th>
<th>Optional Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 30</td>
<td>.05</td>
</tr>
<tr>
<td>30-34</td>
<td>.06</td>
</tr>
<tr>
<td>35-39</td>
<td>.08</td>
</tr>
<tr>
<td>40-44</td>
<td>.10</td>
</tr>
<tr>
<td>45-49</td>
<td>.15</td>
</tr>
<tr>
<td>50-54</td>
<td>.21</td>
</tr>
<tr>
<td>55-59</td>
<td>.43</td>
</tr>
<tr>
<td>60-64</td>
<td>.63</td>
</tr>
<tr>
<td>65-69</td>
<td>1.11</td>
</tr>
<tr>
<td>70 and over</td>
<td>1.80</td>
</tr>
</tbody>
</table>

Personal Accident Schedule

(Monthly Premium is for each $1,000 of coverage)

<table>
<thead>
<tr>
<th>Age</th>
<th>Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$.012/$1,000</td>
</tr>
<tr>
<td>Family</td>
<td>$.026/$1,000</td>
</tr>
</tbody>
</table>
Spousal Life Insurance

You may elect to cover your spouse for a minimum of $10,000 up to a maximum of $250,000, in $10,000 increments; however, your spousal life insurance cannot equal more than 50 percent of the amount of life insurance you have for yourself (Basic plus Optional Life). The spousal life insurance rate schedule is the same as the optional term life insurance schedule. Your cost for spousal life insurance will be based on your spouse’s age as of January 1 of each year.

Statement of Health

If you do not enroll in Optional Life or Spousal Life Insurance within 31 days of first becoming eligible, a Statement of Health will be required if your coverage exceeds:

- Three times your annual base pay for optional life insurance.
- Employee basic plus optional is greater than $1,500,000.
- $30,000 for spousal life insurance.

If you do not enroll in Optional, Spousal, or Dependent Child Life Insurance within 31 days of first becoming eligible and later decide to participate, a Statement of Health may be required. Any new or additional coverage requiring a Statement of Health will not begin until approved by the insurance company.

Dependent Life Insurance

You may elect to cover your eligible children at either a $5,000 or $10,000 level. Your monthly cost for dependent child life insurance regardless of the number of eligible children is:

<table>
<thead>
<tr>
<th>For:</th>
<th>Your monthly cost is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>$5,000 of coverage</td>
<td>$0.68</td>
</tr>
<tr>
<td>$10,000 of coverage</td>
<td>$1.36</td>
</tr>
</tbody>
</table>
Additional Benefits

Sick Leave Benefit

The purpose of sick leave is to provide continuation of pay to eligible employees who are absent from work because of disability, illness or accident. You accrue 1½ hours of sick leave each pay period, up to a maximum of 40 hours.

Holidays

There are four paid holidays each year. These are New Year’s Day, Independence Day, Thanksgiving Day and Christmas Day.

Vacation

You become entitled to one week of vacation after 12 months of service.
CITGO continues to take pride in providing extra tools to help our employees manage their benefits. In addition to the 24-Hour NurseLine and Cancer Resource Services, to name a few, other services are included. These services are available to you and in most cases, your covered family members.

### Benefit Connections

**www.hr.citgo.com**

The CITGO Benefit Connections website (www.hr.citgo.com) for CITGO Employees and Retirees is your resource for benefits information and is available 24-hours-a-day, 7-days-a-week. Benefit Connections brings a wealth of benefits information right to your fingertips with the convenience of having access to the site while you are traveling on business or from your home computer. On the site you will find:

- A snapshot of your benefit programs.
- Contacts and direct links to claims administrators and providers.
- A forms and documents library with the most frequently used forms as well as the Summary Plan Descriptions (SPDs).
- Frequently asked questions.

### Medical – UnitedHealthcare

**www.myuhc.com**

You can manage your healthcare and set your healthy lifestyle goals.

- Find out about alternative medicine providers, extra no-cost programs and member discounts.
- Find a healthcare provider or facility, locate a pharmacy, look up your benefits and estimate your health care costs.
- View your claims history, benefits statements and FSA account balances, set up direct deposit, access claim forms and print an ID card.

### Hearing Aid Discount Program

**www.hihealthinnovations.com/united**

CITGO now offers a hearing aid discount program through UnitedHealthCare (UHC), in conjunction with Hi-HealthInnovations, to provide participants enrolled in our medical plans with discounts on premium hearing aids and easy access to hearing tests.

To get started, UHC members must submit their health plan information at www.hihealthinnovations.com/united and are emailed their low member pricing, hearing test options and a physician certification form.

Additional information can also be obtained by contacting Hi-HealthInnovations at 1-866-926-6632, Monday - Friday, 9:00 a.m. - 5:00 p.m. CT.
CITGO Benefits

Prescription Drugs
– Optum Rx
www.myuhc.com

• Manage and order prescriptions.
• Obtain additional information regarding the plan and the benefits available.
• Find easy ways to help save money on your prescriptions.
• Learn more information about medicines and health conditions.

Dental and Life Insurance
– MetLife
www.metlife.com/mybenefits

Perform key tasks related to your dental and life insurance plans, such as:

• View your plan benefits, deductibles and maximums.
• View your dental claim statements and estimate your dental care cost.
• See a list of frequently asked dental questions.
• Download forms and printing ID cards.

Healthy Rewards Program
You can access additional information regarding the Health Rewards program online by visiting Benefits Connections and selecting the “Healthy Rewards Program” tab.

Additional Contacts & Helpful Information
Contact the CITGO Benefits HelpLine at Benefits@CITGO.com or (888) 443-5707 for:

• General inquiries.
• Address changes.

Additional helpful information can be found on CITGO’s Benefits Connection Website at www.hr.CITGO.com.
Annual Disclosures

Required Notices

Each year, CITGO is required to provide certain annual notifications to all eligible participants of the Plan to ensure awareness of the availability of benefits that are provided under certain legislative acts. The CITGO Petroleum Corporation Medical Plan provisions include the benefits described below in the Medical, Dental, Vision and Life Insurance Program Summary Plan descriptions for Hourly Employees (Plan Number 518) and Salaried Employees (Plan Number 515). To review your additional rights under ERISA, please refer to your Summary Plan Description (SPD) available online at www.hr.CITGO.com.

HIPAA Privacy and Security Notice

On April 14, 2003, privacy regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) went into effect. The privacy notice, including information about your privacy rights, is available online via the CITGO intranet and www.hr.CITGO.com, or by requesting the notice from the HIPAA Services Contact, using one of the following means:

- email HIPAARequest@CITGO.com
- by phone at 1-888-443-5707 or
- regular mail addressed to:
  HIPAA Services Contact CITGO Petroleum Corporation Benefits Department N5063
  P.O. Box 4689 Houston, TX 77210-4689

Important Notice About Your CITGO Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with CITGO Petroleum Corporation and prescription drug coverage under Medicare Part D for people eligible for Medicare. This information can help you decide whether or not to enroll in a Medicare prescription drug plan.

1. Medicare prescription drug coverage became available in 2006 to everyone eligible for Medicare under Medicare Part D. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. CITGO Petroleum Corporation has determined that the prescription drug coverage offered by the CITGO Petroleum Corporation Medical, Dental, Vision and Life Insurance Program for Salaried and Hourly Employees is, on average for all participants, expected to pay out at least as much as the standard Medicare prescription drug coverage pays and is considered Creditable Coverage.

3. Read this notice carefully. This information tells you about where to find more information to help you make decisions about your prescription drug coverage.
If You Drop Your Current Coverage With the CITGO Program

If you decide to enroll in a Medicare prescription drug plan and drop your CITGO Petroleum Corporation medical and prescription drug coverage, be aware that you may not be able to get this coverage back. If you drop your coverage with CITGO and enroll in Medicare prescription drug coverage, you and your covered eligible dependents may not be able to get this coverage back until the next CITGO Annual Election period, or, in the case of nonpayment of your contributions, you can never re-enroll.

If You Drop Current Coverage With the Trimark Program

If you decide to enroll in a Medicare prescription drug plan and drop your medical and prescription drug coverage, be aware that you may not be able to get this coverage back. If you drop your coverage and enroll in Medicare prescription drug coverage, you and your covered eligible dependents may not be able to get this coverage back until the next Annual Election period, or, in the case of nonpayment of your contributions, you can never re-enroll.

If You Enroll in Medicare Part D Immediately After Current Coverage Ends

Because your existing CITGO coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty), if you later decide to enroll in Medicare prescription drug coverage. If you lose, through no fault of your own, or decide to leave CITGO coverage, you will be eligible to enroll in Medicare Part D coverage at that time using a two month Employer Group Special Enrollment Period. You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

If You Delay Enrolling in Medicare Part D After Current Coverage Ends

You can enroll in a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7. It is important for you to know that if you drop or lose coverage with CITGO and do not enroll in a Medicare prescription drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (penalty) to enroll in Medicare prescription drug coverage at a later time. Medicare rules as of May 15, 2006, state that if you go 63 continuous days or longer without prescription drug coverage that’s at least as good as Medicare’s prescription drug coverage, your monthly premium may go up at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without coverage, your premium may consistently be at least 19% higher than the base beneficiary premium. You may pay more than what most other people pay. You’ll have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll.
Annual Disclosures

For More Information About This Notice or Your Current Prescription Drug Coverage

Contact the CITGO Benefits HelpLine at 1-888-443-5707 or by email at benefits@CITGO.com.

Note: You may receive this notice at other times in the future from CITGO Petroleum Corporation, including before the next period you can enroll in Medicare prescription drug coverage and if this coverage changes. You also may request another copy of this notice from us.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is available in the “Medicare & You 2016” handbook. You will receive a copy of the handbook in the mail from Medicare every year. You may also be contacted directly by Medicare prescription drug plans. You can also get more information about Medicare prescription drug plans from these sources:

• Visit Medicare online at www.medicare.gov, or the Centers for Medicare and Medicaid Services (CMS) at www.cms.hhs.gov.

• Call your State Health Insurance Assistance Program for personalized help, (see the inside back cover of your copy of the “Medicare & You 2016”) handbook for their telephone number).

• Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

• For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA).

For more information about this extra help, visit SSA online at www.socialsecurity.gov or call them at 1-800-772-1213 (TTY 1-800-325-0778).

On page 31 is a simplified chart explaining the current CITGO Prescription Drug Program provisions.

Remember: Keep this Creditable Coverage notice. If you enroll in one of the plans approved by Medicare that offers Medicare Part D Prescription Drug coverage after you initially become eligible for Medicare, you may need to send a copy of this notice with your Medicare enrollment to confirm you have maintained creditable coverage.

Date: January 1, 2016

Plan Name: CITGO Petroleum Corporation Medical, Dental, Vision and Life Insurance Program for Salaried Employees

Name of Entity: CITGO Petroleum Corporation

Contact: Benefits Plans Committee

Address: 1293 Eldridge Parkway
Houston, Texas 77077

Phone Number: 1-888-443-5707

Email: benefits@citgo.com
CITGO Benefits

Women’s Health and Cancer Rights Act

As required by the Women’s Health and Cancer Rights Act of 1998, medically necessary mastectomy-related benefits received under our health coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of 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 treatment of physical complications of all stages of the mastectomy, including lymph edemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan.

Newborns’ and Mothers’ Health Protection Act

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 the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).
Contact Information

UnitedHealthcare

- Customer Service Center
  1-866-317-6359

- NurseLine Services
  1-866-735-5686, PIN: 980

- Pre-determinations and Pre-certifications
  www.myuhc.com

- Medicare Solutions
  www.myuhcplans.com/CITGO
  1-877-753-5150

- Find A Doctor
  www.myuhc.com

Hearing Aid Discount Program

- Hi-Health Innovations
  www.hihealthinnovations.com/united
  1-866-926-6632

Cancer & Transplant Resource Services

- www.myoptumhealthcomplexmedical.com
  1-866-317-6359

Bariatric Resource Services

- 1-888-936-7246

Mental Health Hospitalization

- 1-888-231-4886

Prescription Drug

- Optum Rx
  1-866-317-6359
  www.myuhc.com

Dental

- MetLife
  1-800-942-0854
  www.metlife.com/mybenefits

- MetLife Retiree Voluntary Dental
  1-800-438-6388 (1-800-GET-MET-8)

Vision

- UnitedHealthcare Vision
  1-800-638-3120
  www.myuhcvision.com

Healthy Rewards

- Customer Service - 1-877-818-5826
  www.werally.com
  www.myuhc.com

Employee Assistance Program

- United Behavioral Health
  1-888-231-4886
  www.liveandworkwell.com
  Access code: 42920

Flexible Spending Accounts (FSA)

- UHC Health Care Accounts
  1-800-331-0480
  915-231-1709 (fax)
  866-262-6354 (toll-free fax)
  www.myuhc.com

COBRA & HIPAA

- United Healthcare
  1-866-747-0048

- HIPAA Certificate of Coverage
  1-866-747-0048

Life & Disability Inquiries

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

Health Savings Accounts (HSA)

- Fidelity
  1-800-544-3716
  www.netbenefits.com or www.401k.com

CITGO Benefits HelpLine

- Phone: 1-800-443-5707 (toll-free)
- Email: benefits@CITGO.com
- Web: www.hr.CITGO.com
CITGO Benefits