Vision Plan Provisions of the CITGO Petroleum Corporation Medical, Dental Vision & Life Program for Salaried Employees

Summary Plan Description
as in effect January 1, 2006

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

COMPANY VISION PLAN
HIGHLIGHTS

Eligibility

Regular Full-Time and Regular Part-Time Employees and eligible Retirees

Enrollment

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

Cost/Funding

Your pre-tax contributions depend on the total cost of coverage and the level of coverage you select. A schedule of contributions is published annually.

Benefits

In-Network Covered Services	Coverage You Pay	Deductible
Comprehensive Vision Exam Once Every 12 months by a network optometrist or ophthalmologist	**You pay $10**	**No**
Materials Materials copay applies to the entire purchase of eyeglasses (lenses and frames), or contacts in lieu of eyeglasses **Pair of lenses (for eyeglasses)** Once every 12 months for: • Standard single vision • Standard lined bifocal • Standard lined trifocal • Standard lenticular **Frames** Once every 24 months **Elective Contact Lenses (in lieu of eyeglasses)** Once every 12 months	**You pay $25**	**No**
Refractive Eye Surgery Discounts available from Spectera providers		

Deductible

None

Maximum Benefit

The maximum benefit limits are:

- One eye exam per year and associated lenses, and
- Associated frames once every 24 months.

Spectera Vision Program

Spectera (a United HealthCare Company) has developed a network of optometrists and ophthalmologists who provide their services at reduced rates. This program is entirely voluntary and yet allows you to maximize your benefits through the use of preferred providers on a co-payment basis for most services and materials.

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PURPOSE

The Vision provisions of the CITGO Petroleum Medical, Dental, Vision and Life Insurance Program for Salaried Employees ("Plan" or "Vision Plan") is offered to you and your eligible dependents to provide financial assistance towards expenses for necessary vision services. One of the key benefits of the Plan is fixed co-payments for eligible exams and necessary materials. This benefit helps you reduce your out-of-pocket expenses.

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

ELIGIBILITY

Active Employees

Who is Eligible

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

(1) You are a Regular Full-Time Employee compensated on a salaried basis or a Regular Part-Time Employee not covered under a collective bargaining agreement; and

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

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

Who is not Eligible

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

(1) You are employed on any basis other than as a salaried Regular Full-Time or Regular Part-Time Employee of the Company (for example, a temporary or seasonal employee);

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

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

(4) You are in a class of employees covered by a Collective Bargaining Agreement;

(5) You are employed by a related company which has not adopted the Plan; or

(6) You are a nonresident alien.

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

Dependents

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

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

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

Disabled Child Eligibility Guidelines

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

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

Dual Company Coverage

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

Retired Employees

Coverage Under the Plan: You will be eligible to continue coverage for yourself and your eligible dependents under the Plan after you retire, if you have been covered by the Plan, another Company-sponsored health care plan, or a predecessor plan for at least **10 consecutive years** while in active employment **and** you meet at least **one** of the following conditions:

(1) Your age plus your years of employment total 70 or more at the time you cease employment;

(2) You are age 55 or older and eligible to retire directly from employment with the Company under the provisions of the

- Retirement Plan of CITGO Petroleum Corporation and Participating Subsidiary Companies, or
- Cities Service Company Retirement Income Plan; **or**

(3) If you cease employment at age 55 or older and are eligible to receive benefits under the CITGO Petroleum Corporation Salaried Employees' Pension Plan or the CITGO Petroleum Corporation Hourly Employees' Pension Plan (whether you elect to defer receiving benefits or begin receiving them immediately).

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

Your coverage after retirement will continue unless you choose to waive coverage on the Continuation of Benefits form. In addition to waiving coverage, the Continuation of Benefits form allows you to elect how you will pay any required contributions if you are continuing coverage – you will either be billed monthly or you can elect electronic fund transfer. If you do not complete a Continuation of Benefits form and you have vision coverage prior to your retirement; coverage for you and any eligible dependents who are covered as of the date you retire, will continue automatically and you will be billed monthly for your contributions.

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

If you are a retiree, your coverage can be cancelled due to non-payment and **you will not be eligible to re-enroll at a later date** (see *Termination of Coverage* on page 22)

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

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

You may elect to add new dependents to your coverage at any subsequent Annual Election Period. If your addition of a dependent means that you must change the level of your coverage (for example, from "Employee only" to "Employee and spouse" or from "Employee and spouse" to "Employee and family" coverage), then you must change your level of coverage within 31 days of the Status Change (page 19). If you do not contact the Benefits HelpLine within 31 days of the change event, the dependent will not be eligible for coverage under the Plan for the duration of the Plan Year.

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

ENROLLMENT

Level of Coverage

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

- Employee Only;
- Employee and Spouse;
- Employee and Child(ren); or
- Employee and Family. (see Definitions, page 49)

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

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

You cannot obtain coverage only for your dependents.

When to Enroll

Regular Enrollment

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

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

Late Enrollment

If you enroll for coverage into the Company Vision Plan:

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

then you may enroll:

- Within 31 days after an eligible Status Change *(For details about eligible Status Change, see page 19)*; or
- During the next Annual Election Period.

You are not permitted to enroll at any other time.

Enrolling Your Dependent(s)

Current Dependents

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

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

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

Coverage for your eligible dependent is effective on the date of eligibility or the date of the Status Change.

If you don't meet this 31-day deadline, you will not be able to enroll your eligible dependents until the next Annual Election Period, unless you have a subsequent eligible Status Change. *(For details about eligible Status Change, see page 19).*

New Dependent(s)

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

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

Adoption: an adopted child who is eligible for coverage as defined in the section entitled *Eligibility – Dependents* (page 3) may be covered under the Plan under the same conditions applicable to children of eligible participants regardless of whether the adoption has become final. An adopted child will be eligible for coverage when the child is placed for adoption, but in no event earlier that the date of your coverage, provided you enroll them within 31 days.

Marriage: You may enroll a spouse who is eligible for coverage as defined under the section entitled *Eligibility – Dependents* (page 3) on the effective date of the marriage. You are required to notify the Benefits HelpLine at 1-888-443-5707 within 31 days from the date of marriage; otherwise you must wait until the next Annual Election Period or another eligible Status Change.

Adding Coverage for Dependents

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

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

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

Example: Adding a Dependent With Change in Coverage Level
Sally elects "Employee Only" coverage during the Annual Election Period. Several months later, she marries. Sally needs to change her level of coverage to "Employee and Spouse" coverage. She has 31 days from her date of marriage to elect coverage for her spouse. If Sally does not change her coverage within 31 days, her spouse will not be covered for the duration of that Plan Year.

Dropping Coverage for Dependents

You must have an eligible Status Change if you wish to drop coverage for a dependent(s) during the Plan Year. You must contact the Benefits HelpLine at 1-888-443-5707 within 31 days of the Status Change. If you do not contact the Benefits HelpLine in a timely manner, you cannot drop coverage for your dependent until the next Annual Election Period unless it is determined that a dependent ceased to meet eligibility requirements (for example, a dependent over age 19 who ceases to be a full time student). Coverage will be canceled retroactive to the end of the month in which the dependent lost eligibility. There will be no refunding of employee contributions paid if this results in a change in your level of coverage. Further, the Insurer will require reimbursement for any expenses paid after the retroactive loss of coverage date.

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

Annual Election Period

Changes if You Are Currently Covered

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

The changes you can make during the Annual Election Period include the following:

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

(2) Terminating or waiving coverage.

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

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

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

> ***Example: Dropping a Dependent During Annual Election Period***
> Tom has "Employee and Family" coverage under the Vision Plan. Tom's wife, Sarah, accepts employment July 1 and elects to be covered under her employer's group vision plan. Tom may drop Sarah's coverage under the Plan prior to July 31. However, if Tom does not notify the Benefits HelpLine within 31 days of her other coverage becoming effective, he must wait until the next Annual Election Period to drop Sarah's coverage.

Changes if You Are Not Currently Covered

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

Pre-Existing Condition Limitations

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

Transfers from Hourly to Salaried

If you are an hourly employee and are transferred to salaried status and were enrolled in the Hourly vision plan, you will automatically be enrolled in this Plan based upon your enrollment choice in the Hourly vision plan. For example, if you had elected "Employee and Family" coverage in the Hourly vision plan, you will automatically be enrolled for "Employee and Family" coverage in this Plan upon transferring to salaried status. You will, however, have the option to change coverage (see *Status Change* page 19).

OVERVIEW OF BENEFITS

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

Summary

COVERED SERVICES	COVERED BENEFIT	
	IN-NETWORK *	OUT-OF-NETWORK
Comprehensive Vision Exam (once every 12 months)	100% after $10 co-pay	Up to $50 reimbursement
Materials The materials co-pay is a single payment that applies to the entire purchase of eyeglasses (lenses and frames) or contacts in lieu of eyeglasses.	100% after $25 co-pay at Spectra Selection providers	scheduled reimbursement
Pair of Lenses (for eyeglasses) (once every 12 months) Standard single vision Standard lined bifocal Standard lined trifocal Standard lenticular	Standard scratch-resistant coating, tints and UV coating are covered in full.	Up to: Single vision $40 Bifocal vision $60 Trifocal vision $80 Lenticular vision $80
Frames (once every 24 months)	$50 wholesale frame allowance (retail value $120-$150) at private practice providers; or $130 at retail chains	Up to $45
Elective Contact Lenses (in lieu of eyeglasses) (once every 12 months)	100% after $25 co-pay	Up to $150
Medically Necessary Contact Lenses (see page 14) (once every 12 months)	100% after $25 co-pay	Up to $210

*** The network provider co-pay will apply once if frames and lenses are purchased at the same time.**

COVERED SERVICES	COVERED BENEFIT	
	IN-NETWORK	OUT-OF-NETWORK
Refractive Eye Surgery Participants receive access to discounted refractive eye surgery from numerous provider locations throughout the United States.	Access to discounted refractive eye surgery procedures from a Spectera Laser Network Provider. To find a participating laser eye surgeon in your area, visit www.spectera.com	Not Applicable

The chart is intended to summarize the benefits of the Vision Plan.

Key Terms

Co-payments or Co-pays

The per visit co-pay is the amount of covered vision expense you must pay for each covered person for Plan benefits within the network of participating providers.

Elective Contact Lenses

The fitting/evaluation fees, contacts (including disposables), and up to two follow-up visits are covered in full (after applicable $25 co-pay) for many popular brands, such as Acuvue by Johnson & Johnson and Optima by Bausch & Lomb. If covered disposable contact lenses are chosen, up to six (6) boxes (depending on prescription) are included when obtained from a network provider.

A $150 allowance is applied toward the fitting/evaluation fees and purchase of contact lenses outside of Spectera's covered-in-full contacts (materials co-pay of $25 does not apply). Toric, gas permeable and bifocal contacts are all examples of contact lenses that are outside of the covered-in full selection. In order to receive the full allowance, you must receive your exam, fitting and evaluation at the same network provider.

Once every 12 Months or Once every 24 Months

Benefits available every 12 or 24 months (depending on the benefit frequency), is based on the last date of service.

Maximum Benefit

Each individual enrolled for Plan coverage is eligible to receive up to a maximum of the stated wholesale value in benefits as stated. There is no dollar limit on the amount of benefits any one individual can be paid over his lifetime.

Medically Necessary Contact Lenses

Contact lenses are medically necessary if you or your dependent have:

- Keratoconus or irregular astigmatism;
- Anisometropia of 3.5 diopters or more;
- Post cataract surgery without intraocular lens; or
- Visual acuity in the better eye of less than 20/70 with visual correction by eyeglasses but better than 20/70 with visual correction by contact lenses.

In all cases, your provider must obtain prior approval.

Wholesale Allowance

The Plan will reimburse a portion of covered expenses up to an amount determined by the Insurer at a wholesale level. The wholesale level is approximately 30-40% of retail. As an example, a $50 wholesale allowance would equate to a $120-$150 retail charge.

If you incur a covered expense that is above the wholesale allowance, you are responsible for paying the excess amount. You have the right to have the Insurer review your claim if you or your provider believes that there are special circumstances that justify the charge over the wholesale allowance.

Spectera Vision Program

You have a choice of accessing network optometrists, ophthalmologists and other providers under Spectera's Vision Program. The Company Vision Plan provides for access to the Spectera's network of vision providers to help you save money for yourself and the Plan. This program is entirely voluntary. The Spectera Vision Program network provides several cost and quality advantages to you:

- Savings when using network vision providers;
- Optometrists and Ophthalmologists whose credentials are verified and whose practice patterns are monitored; and
- No claims to process.

You can maximize your Plan benefits through the use of preferred optometrists and Ophthalmologists. You are not required to use a preferred provider. The Plan will pay a fixed wholesale allowance for out-of network services. If you choose not to use a preferred provider, you will be responsible for initial payment and filing a claim with Spectera for reimbursement of eligible expenses. **You do not need an ID card for the vision care program.**

Following is more information about the Spectera Vision Program:

IN-NETWORK VS. OUT-OF-NETWORK PROVIDERS	
If You Use a Spectera In-Network Provider	**If You Use an Out-Of-Network Provider**
The provider will submit your claim forms.	You will need to file your own claim forms.
The providers have discounted rates so you don't have to worry about being charged more than your co-pay (unless you select materials over the maximum allowable expense covered by the Plan).	You must pay any charges in excess of the maximum allowable expense covered by the applicable wholesale allowance limits.
Spectera will pay benefits to participating providers directly, so you only pay your portion of the cost.	You must pay the provider and then file your receipts with Spectera for reimbursement.

Participating Providers

Neither sole private practice provider networks nor sole retail chain provider networks satisfy everyone. Some people prefer to use the services of a private practice provider, especially if they have a longstanding relationship with a family eye doctor. Others prefer to use the services of a retail chain provider. Retail chain providers allow access to evening and weekend appointments. In addition, many retail chain providers have the ability to provide eyewear within 24 hours.

Spectera's national network offers the greatest choice and convenience with a diverse network of over 17,000 providers. The Spectera network includes private practice as well as leading retail chain providers.

To find a
Spectera Provider
In the Network, call
1-800-839-3242
or visit the website at
www.spectera.com

Cost Savings

Participating providers have contracted with Spectera for discounted fees. A lower cost results in lower out-of-pocket expense for you. Participating providers also extend lower, negotiated fees on services not covered by the Plan (including cosmetic expenses).

How to Get the Most Value from the Vision Plan

You may choose to receive vision care and materials from any vision service provider you wish. However you receive higher benefits when you use a Spectera provider. When you need eye care services, you choose whether or not to use a member of Spectera's national network of plan providers. You receive the highest benefit, or most value, from the Plan when you use in-network providers. To use in-network services, each time you need care you should:

1. Find a participating provider on Spectera's web site at: http://www.spectera.com. You can also call Spectera's Provider Locator at 1-800-839-3242. If you do not have access to a phone or computer, a list of providers is available from the Benefits HelpLine at 1-888-443-5707.
2. Make an appointment with your Spectera provider and identify yourself as a Spectera participant.
3. Pay your co-pay when you meet with the provider. No identification card is required. Let your provider know if you would like to be fitted for eyeglasses or contact lenses. **Be sure to ask what frames or lenses are covered in full before making your final decision.**
4. That's it! You do not need to file a claim when you receive care from an in-network provider. Spectera will pay the participating provider directly for covered services and materials. However, you will be responsible for paying any costs for non-covered services and materials.

Out-of-Network Benefits

If you use an out-of-network provider, you will pay in full at the time of your appointment, submit your receipts to Spectera, and receive reimbursement according to the benefit schedule of wholesale allowance limits. Be sure to submit your claim for services and materials purchased on different dates at the same time to receive reimbursement (only one reimbursement per participant every twelve months).

COVERED EXPENSES

For purposes of this summary, all services described in this SPD will be eligible for reimbursement. In addition, whenever a patient receives a more expensive treatment than is customarily provided, the Plan will pay only the applicable wholesale allowance for the *less* expensive procedure.

Some limitations and exclusions of coverage may apply to particular services and supplies, as outlined in this summary. Please refer to the section entitled *Not Covered Expenses (page 18)* for listings of certain expenses that are not covered under this Plan.

NOT COVERED EXPENSES

The following list of **Not Covered Expenses** is not all-inclusive. Other specific expenses may be determined to be not covered under the Plan by the Insurer or the Plan Administrator. If you have a question on a specific expense, you should contact the Insurer.

This plan is designed to cover your visual needs rather than cosmetic materials. If you select any of the following, you will be responsible for the additional charge:

1. Blended lenses;
2. Oversize lenses;
3. Progressive multifocal lenses;
4. Frames that exceeds the Plan allowance;
5. Certain limitations on low vision care;
6. Cosmetic lenses;
7. Optional cosmetic processes.

The following professional services or materials are not covered:

1. Orthoptics or vision training and any associated supplemental testing;
2. Plano lenses (non-prescription);
3. Two pair of glasses in lieu of bifocals;
4. Lenses and frames furnished under this program that are lost or broken will not be replaced or repaired except at the normal intervals when services are otherwise available;
5. Medical or surgical treatment of the eyes which requires the services of a physician;
6. Any eye examination, or any corrective eyewear, required by an employer as a condition of employment;
7. Services or materials for which the insured person may be paid under Workers' Compensation Law or other similar employer's liability law, or services which the insured person obtains at no cost from any federal, state, county, city or other governmental organization, except Medicaid;
8. Sunglasses, plain or prescription;
9. Corrective vision services, treatments and materials of an experimental nature;
10. Post cataract lenses (only excluded if vision problems can be corrected with glasses; otherwise, post cataract lenses are not covered);
11. Non-prescription items; or
12. Services and materials which are not specifically listed as covered.

EVENTS AFFECTING COVERAGE

Status Change

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

- Your family status; or
- Your or your spouse's employment status.

An eligible Status Change in your family status includes:

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

An eligible Status Change in employment status includes:

- A Company authorized transfer requiring a change in your work location or relocation of your residence;
- The employment or unemployment of you, your spouse, or a dependent child;
- You, your spouse or a dependent child changes residence or worksite; or
- You, your spouse or a dependent child changes work schedule (i.e. a reduction or increase in hours, a switch between part time and full-time, strike or lockout, commencement or return from unpaid leave of absence).

If your change does not meet the Status Change criteria above, you cannot change your level of coverage or terminate your coverage under the Plan for the remainder of the Plan Year. You must wait until the next Annual Election Period.

If you have waived coverage under the Plan and have an eligible Status Change during the Plan Year, you may apply within 31 days of the change event for coverage under the Plan for yourself and/or your dependent(s), in accordance with the Status Change rules.

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

Example: Eligible Status Change
During the Annual Election Period, James elects "Employee and Child(ren)" coverage for himself and his two children. In the following Plan Year, he marries and wishes to add his wife to his coverage. James can change his level of coverage to "Employee and Family" during the Plan Year as long as he makes his change within 31 days of his marriage.

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

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

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

Change occurs:	**1st day of month**	**2nd - 15th**	**From 16th though last day of month**
Change in contributions begin	first pay period of the following month	first pay period of the following month	first pay period of following month

Absences

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

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

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

Payment of Contributions While on Leave

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

If you lose coverage under the Plan, you may be eligible to receive COBRA continuation of coverage in certain situations. See *COBRA Continuation* (page 23) for more details.

Waiver of Contributions While on Leave

You may be eligible for a waiver of contributions for your vision benefits for up to six months. To be eligible for a waiver, you must be:

- absent due to short-term disability
  - and receiving no pay; or
  - receiving pay that is not sufficient to cover all of your insurance deductions; or
- on an approved unpaid leave of absence.

While the waiver is in effect, your coverage will remain unchanged at no cost to you for up to six months. You will be notified if you are eligible for the waiver of contributions while on leave.

Reinstatement of Coverage

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

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

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

Termination of Coverage

Unless you are eligible to continue coverage as explained under the major heading *Continuation of Coverage* on page 23, coverage under the Plan will terminate at the end of the month in which the earliest of the following occurs:

- You cease to be an employee meeting the eligibility requirements;
- You terminate employment for any reason and are not eligible to continue coverage as a retiree (see page 4);
- You elect to waive coverage during Annual Election or with an eligible Status Change;
- The Plan terminates; or
- Contributions fail to be made in a timely manner.

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

Coverage can be terminated for failure to pay any required contribution once final written notice has been given. **If you are a covered retiree, and your coverage is cancelled due to non-payment, you will not be eligible to re-enroll in retiree vision at a later date.** If you are rehired, however, then you may re-enroll while you are an active employee at the next Annual Election. When you retire again, you will not be eligible for coverage as a retiree due to your previous cancellation due to non-payment.

CONTINUATION OF COVERAGE

Upon Retirement

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

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

COBRA Continuation Coverage

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (known as "COBRA"), you and your covered dependents may extend your present health care coverage if it is lost due to certain "qualifying events". The following chart describes the COBRA qualifying events for you and your covered dependents:

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

If you and/or your covered dependents lose coverage under the Plan as a result of one of these qualifying events, you and/or your covered dependents will be eligible to elect COBRA continuation coverage. In the case of the qualifying event that is the bankruptcy of the Company, the term "lose coverage" includes any substantial elimination of coverage within one year before or after the date the bankruptcy proceeding commences.

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

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

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

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

Continuation Coverage

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

COBRA Qualifying Event	How Long Coverage May Continue	
	You	**Dependents**
You terminate employment (except for gross misconduct)	18 months (may be extended an additional 11 months – if you or your dependents are determined under the Social Security Act to be disabled at any time within the first 60 days of continuation coverage and the applicable notice requirements are satisfied, see page 29).	18 months (may be extended an additional 11 months – if you or your dependents are determined under the Social Security Act to be disabled at any time within the first 60 days of continuation coverage and the applicable notice requirements are satisfied, see page 29).
Your hours are reduced, resulting in a loss of coverage	18 months (may be extended an additional 11 months – if you or your dependents are determined under the Social Security Act to be disabled at any time within the first 60 days of continuation coverage and the applicable notice requirements are satisfied, see page 29).	18 months (may be extended an additional 11 months – if you or your dependents are determined under the Social Security Act to be disabled at any time within the first 60 days of continuation coverage and the applicable notice requirements are satisfied, see page 29).
You die	N/A	36 months
You and your spouse divorce or are legally separated	N/A	36 months
Your child is no longer eligible	N/A	36 months

Second Qualifying Events

If you are receiving COBRA continuation coverage as a result of your termination of employment or reduction in hours, your total coverage under COBRA is limited to 36 months from the date of the first qualifying event. However, you may be eligible for an additional period of coverage if a second qualifying event (other than a bankruptcy proceeding with respect to the Company) occurs while you are receiving continued coverage under COBRA. You must notify the Benefits HelpLine at 1-888-443-5707 within 60 days after the second qualifying event.

Notification

If your spouse or dependent loses coverage under this Plan due to **divorce, legal separation, or loss of dependent eligibility,** it is your responsibility to notify the Benefits HelpLine within 60 days of the qualifying event or within 60 days of the date benefits would be lost as a result of the qualifying event. If the notice is sent to the Benefits HelpLine more than 60 days after the later of the date of one of the qualifying events described above or the date of loss of coverage because of the qualifying event, you may not be entitled to elect COBRA continuation coverage. The Plan Administrator is already notified if the event that causes loss of coverage is your death, termination, reduction in hours, or bankruptcy proceedings.

Enrollment

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

You will have 60 days from the date that benefits were lost as a result of a qualifying event (or the date you are notified of your right to extend these benefits, if later) to inform the Benefits HelpLine that you want COBRA continuation coverage. Each eligible dependent may independently elect COBRA coverage. You or your spouse, however, may elect COBRA coverage on behalf of all the eligible dependents. If you choose to waive coverage during the 60 -.day election period, you may revoke the waiver in writing at any time before the 60 - day period ends, and you will be entitled to COBRA continuation coverage as long as you and/or your dependent(s) meet all of the other conditions for continuation of coverage and the required contributions are paid on a timely basis.

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

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

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

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

Disability

You and your dependents may be eligible to extend your COBRA coverage an additional 11 months, after the original 18 – month COBRA period, if you or your dependent qualifies for disability determined under Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act at any time during the first 60 days of continuation coverage. To receive this extension, notice of the determination of disability under the Social Security Act must be provided in writing to CobraServ within 60 days of the date of the Social Security Administration's award, but before the end of the original 18-month period of COBRA coverage. The extension will continue so long as you or your dependent remains eligible for disability benefits under the Social Security Act, but not for more than 29 months of coverage after the qualifying event.

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

If you receive a determination from the Social Security Administration that you or your dependent is no longer considered disabled, you must notify CobraServ within 30 days of this determination. If the date of determination is after the original 18-month COBRA period, your COBRA benefits will cease the first day of the month beginning 30 days after the date of determination.

Cost of Coverage

In order to continue your coverage under COBRA, you must pay the **full** monthly cost plus a 2% administration fee.

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

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

Termination of COBRA Coverage

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

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

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

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

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

Eligibility for Reservists Called to Active Duty

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

Other Continuation of Coverage

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

Eligible Dependents of Deceased Active Employees not Eligible for Retiree Coverage

If you die as an active employee and you are not eligible for retiree coverage under the Plan, your dependents may continue coverage under the Plan **until the earlier of:**

- Six months following the end of the month in which your death occurred if your death is not the result of an on-the-job accident;
- The end of the month following the date that your spouse remarries;
- The end of the month following the date that your dependent loses eligibility under the Plan; or
- The end of the month following the date coverage under the Plan terminates due to failure to make required contributions in a timely manner.

The above continuation of coverage will be offset with COBRA Continuation Coverage (see page 23).

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

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

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

Qualified Medical Child Support Orders (QMCSO's)

If you are getting divorced or legally separated, coverage for your dependent children may be continued as long as they otherwise satisfy the eligibility requirements as eligible dependents. However, there may be a medical child support order that *requires* you to provide vision care coverage for your eligible children, regardless of whether:

(1) They are currently covered under the Plan;
(2) They are dependent on you for financial support; or
(3) You have legal custody of the children.

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

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

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

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

provisions will not apply. Enrollment of this type is considered an eligible Status Change.

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

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

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

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

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

ASSIGNMENT OF BENEFITS

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

CLAIMS PROCEDURES

When to Submit Claims

Whenever you have vision expenses, your Spectera provider will file a claim for your benefits on your behalf. However, you are responsible for meeting the copayments required for exams and materials and for your portion of the non-covered charges at the time of service, or when you receive a bill from the provider.

If you use a non Spectera provider and they do not file your claim, you should file the claim yourself in a format that contains all of the information required, as described below.

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

Where to Submit Claims

Claims for vision services should be sent to:

Spectera Claims Department
P.O. Box 26618
Baltimore, MD 21207-6618

Or via facsimile: 410-265-5013

With the following information:
Group number A907

Filing Initial Claims for Vision Benefits

When filing for vision benefits under the Plan, failure to submit properly completed information will delay the processing of the claim while the necessary information is obtained. When submitting a non network vision claim you should include the following information:

1. Name of the employee or retiree and complete home address.
2. The patient's name and date of birth.
3. Primary insured's unique identification number or, social security number.
4. The group number.
5. The name and address of the provider of the service(s).
6. An original itemized paid receipt(s) from your provider that includes the description of each charge.

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

Please note: Receipts for services and materials purchased on different dates must be submitted together to receive reimbursement!

Benefit Determinations

Within 60 days following receipt of a claim, Spectera will either:

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

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

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

Payment of Claims

Regardless of whether your claim for benefits covers expenses incurred by you or one of your dependents, payment of the claim will be made directly to you, the active employee or retiree, unless you have assigned the payment to the provider of services. All payments to providers are automatically assigned to them unless the receipt indicates payment in full.

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

Vision Claims
To contact Spectera Customer Service, call toll-free:

1-800-638-3120

Customer Service representatives are available to take your call during regular business hours, Monday through Friday 8:30am to 8:00pm and Saturday 9:00am to 5:00pm, Eastern time.

How to Appeal a Claim Decision

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

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

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

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

Appeal Determinations

The Insurer will send you written or electronic notification of its decision on claims within 60 days of the receipt of the claimant's request for review of the denial.

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

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

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

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

Legal Actions

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

Coordination of Benefits (COB)

Many times, because both husband and wife are working or due to divorce or remarriage, members of a family may be covered under more than one group vision plan. **Coordination of Benefits is not applicable for the Vision Plan.** The benefits payable under the Plan are not coordinated with benefits payable under other group vision plans not sponsored by the Company. "Other plans" are those which provide benefits or services in connection with vision care or treatment for which an employer pays all or part of this cost or for which an employer makes payroll deductions.

Rights of Recovery

Overpayment of Benefits

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

ADMINISTRATION

The Plan Administrator, on behalf of the Plan, has contracted with Spectera to provide coverage as the Insurer under the Plan. You may obtain a certificate of coverage from the Insurer by making a request to the Benefits HelpLine at 1-888-443-5707.

The provisions of this Plan are subject to the terms and conditions of the Vision Contract between the Company and the Insurer. The Insurer makes all payments of benefits under the terms of the Plan.

The Plan Administrator is responsible for the administration of the Plan and has final discretionary authority to interpret the Plan's provisions, to resolve ambiguities in the Plan and to determine all questions relating to the Plan, including eligibility for benefits. The decisions of the Plan Administrator will be final, conclusive and binding on all persons with respect to all issues and questions relating to the Plan, except those specifically governed by the Vision Contract.

The Plan Administrator may delegate to other persons the responsibilities for performing ministerial duties in accordance with the terms of the Plan and may rely on information, data, statistics or analysis provided by these persons. The Company's determination will be conclusive regarding status of employment.

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

CITGO Employees' Benefit Trust

Assets of the Plan consist of negotiated contributions. Employee contributions to the Plan are held in the CITGO Employees' Benefit Trust to pay premiums. Premiums for benefits payable under the Plan are paid from the assets of the Trust to the Insurer. The current trustee is The Bank of Oklahoma, N.A., Trust Division, Bank of Oklahoma Tower, P.O. Box 880, Tulsa, Oklahoma 74101-0880. Trustees are subject to change.

In the event of the termination of the Program, assets of the Program will be used to pay Program benefits, premiums, and administrative expenses. Any remaining assets will be used for the payment of similar benefits or distribution in accordance with the CITGO Employees' Benefit Trust Agreement and applicable law.

COST/FUNDING

The Plan is a fully insured welfare benefit plan. This means that claims are paid by an insurance contract. Contributions made by Plan participants are used to pay participant premiums plus operating expenses charged to the Plan.

The Plan Administrator, on behalf of the Plan, has contracted with Spectera to provide coverage as the Insurer under the Plan. You may obtain a certificate of coverage from the Insurer by making a request to the Benefits HelpLine at 1-888-443-5707.

Cost of Your Coverage

The monthly cost of your insurance coverage is determined by the level of coverage you elect. Based on periodic analysis of Plan experience and projections of future vision costs, the Insurer will determine whether contribution rates should be adjusted. Contribution rate announcements are published annually during the Plan's Annual Election Period.

Your contribution will be equally divided and deducted on a pre-tax basis from your normal semi-monthly payroll checks. If you are on a leave of absence without pay or otherwise not receiving payroll compensation from the Company, please see the section titled *Absences* on page 21.

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

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

If you drop your dependent(s) coverage within 31 days of the loss of eligibility which results in a reduction in your level of coverage, you will be entitled to a refund. If you fail to drop coverage for your dependent within 31 days of the loss of eligibility, you will not be entitled to a refund of contributions. Further, the Insurer will require reimbursement for any expenses paid after the retroactive loss of coverage date.

Funding of the Plan

You pay the full cost for this Plan. All contributions are made on a pre-tax basis and held in the CITGO Petroleum Corporation Employees' Benefit Trust where they are used to pay premiums to the Insurer.

Future of The Plan

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

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

ADDITIONAL INFORMATION

As a participant or beneficiary under this Plan you have certain rights and protections as more fully described within the Statement of ERISA Rights on page 40. Other important information about the Plan is provided below:

Plan:	Vision provisions of the Medical, Dental, Vision, and Life Insurance Program for Salaried Employees of CITGO Petroleum Corporation; and
Type of Plan:	Fully-Insured Welfare Benefit Plan
Plan Sponsor:	CITGO Petroleum Corporation 1293 Eldridge Parkway Houston, TX 77077
Plan Sponsor's Employer Identification No.:	73-1173881
Plan Administrator:	Benefit Plans Committee – Secretary CITGO Petroleum Corporation P.O. Box 3758 Tulsa, OK 74102 OR Benefit Plans Committee CITGO Petroleum Corporation 1293 Eldridge Parkway Houston, Texas 77077
Plan Number:	515
Plan's Effective Date:	January 1, 2005
Plan Year:	January 1 – December 31
Funding Method:	Funded by Employee, Retiree, LTD, COBRA and Surviving Spouse participant contributions under contract with Spectera

Insurer:	Spectera 2811 Lord Baltimore Drive Baltimore, MD 21244 Spectera Customer Service 1-800-638-3120 Participating Provider Service 1-800-839-3242 www.spectera.com Group Number: A907
COBRA Administrator:	Ceridian's COBRA Services (CobraServ) 1-800-877-7994
Benefits HelpLine: **Email**	1-888-443-5707 Benefits @citgo.com
Benefits Department:	The Benefits Department can be contacted as follows: CITGO Petroleum Corporation Attn: Benefits Department 1293 Eldridge Parkway Houston, Texas 77077 Telephone: 1-888-443-5707

Statement of ERISA Rights

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

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

Receive Information About Your Plan and Benefits

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

(Form 5500 Series) and updated summary plan description. The Plan Administer may make a reasonable charge for the copies.

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

Continue Group Vision Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

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

HIPAA - Health Insurance Portability and Accountability Act of 1996

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

Definitions

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

The Use and Disclosure of Protected Health Information

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

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

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

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

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

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

(e) utilization review activities, including pre-certification and preauthorization of services, concurrent and retrospective review of services; and

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

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

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

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

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

(d) underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance) provided certain requirements are met if applicable;

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

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

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

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

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

(iii) resolution of internal grievances;

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

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

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

Disclosure to the Plan Sponsor

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

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

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

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

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

Additional Agreements of Plan Sponsor

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

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

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

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

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

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

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

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

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

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

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

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

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

Adequate Separation between the Plan and the Plan Sponsor

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

(1) Plan Administrator;

(2) Human Resources employees within the Benefits Group;

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

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

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

(6) Employees in the area of Benefits Accounting;

(7) Employees in the Internal Audit Department; and

(8) In-house legal counsel.

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

Consistency with HIPAA and HIPAA Regulation

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

Other Uses and Disclosures of Health Information

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

DEFINITIONS

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

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

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

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

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

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

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

"Network Provider" means any Optometrist, Ophthalmologist, Optician or other vision care provider who may lawfully provide covered services who has contracted, directly or indirectly with Spectera.

"Out-of-Network Provider" means any Optometrist, Ophthalmologist, Optician or other vision care provider who may lawfully provide covered services who has not contracted, directly or indirectly with Spectera.

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

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

"Service" means an examination, material selection, fitting of glasses and related adjustments.

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

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