Valero®

RETIREE BENEFITS HANDBOOK

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INTRODUCTION

This Valero Retiree Benefits Handbook (handbook), together with each of the separate benefit summaries is considered a Summary Plan Description (SPD) and a guide for Valero retiree benefits offered and available to those eligible retirees to whom this handbook is distributed. Valero Energy Corporation (the "Plan Sponsor" or "Company"), as the Plan Sponsor, reserves the right to amend or modify, in whole or in part, any provisions of the applicable plan(s) or terminate benefits from time to time. This handbook, together with each of the separate benefit summaries provides a condensed, simplified explanation of the administration and benefits available to eligible retirees.

The health and welfare benefit summaries available with and considered a part of this handbook may constitute a large part of the governing document for the Valero Energy Corporation Retiree Benefits Plan (Retiree Benefits Plan or Plan), and in some cases may constitute the governing document. This document and the separate benefit summaries should be read and maintained together. Electronic copies of all relevant documents are available on the Valero Retiree Health Care Website at www.valero.amwins.com and paper copies may be requested from the Valero Health & Welfare Benefits Department. The Retiree Benefits Plan is a comprehensive welfare benefit program available to certain retirees of various Valero Energy Corporation subsidiaries, collectively "Valero" or "the Company."

With respect to fully insured health and welfare benefits, this handbook does not replace any official documents or insurance contracts/policies that may govern the provisions of each component of the Plan. In the event of a discrepancy, the terms of the official plan documents will prevail. With respect to self-insured health and welfare benefits, this handbook is an integral part of the master plan document.

The following outlines the health care and legal insurance coverage options for which you may be eligible, along with a list of contacts for additional assistance. For information regarding the individual benefits, refer to the Benefit Highlights and/or Summary located at www.valero.amwins.com, or you may request a paper copy by contacting the Valero Health & Welfare Benefits Department (800) 333-3377, extension 4000.

NON-MEDICARE ELIGIBLE BENEFITS

The following benefits are available to retirees and their eligible dependents who are non-Medicare eligible:

- UnitedHealthcare $1000 Deductible Retiree Choice Plus, UnitedHealthcare Copay/$500 Deductible Retiree Choice Plus or the UnitedHealthcare $500 Deductible Retiree Out-of-Area PPO coverage options

- Express Scripts Prescription Drug Program

- UnitedHealthcare $50 Deductible Dental coverage
- VSP Vision coverage
- ARAG Legal Insurance

MEDICARE ELIGIBLE BENEFITS

The following benefits are available to retirees and their eligible dependents who are Medicare eligible:

- United American Insurance Company Basic, Enhanced or Premium Medicare Supplement medical coverage options
- Express Scripts Medicare Part D Rx Drug Program for Medicare Supplement
- UnitedHealthcare Medicare Advantage with Prescription Drug (MAPD)
- UnitedHealthcare $50 Deductible Dental coverage
- VSP Vision coverage
- ARAG Legal Insurance

Benefit	Toll-Free Number	Website
Medical *Non-Medicare Eligible* UnitedHealthcare	(844) 634-1235	www.myuhc.com (Network: Choice Plus)
Medicare Eligible United American Insurance Company (Medicare Supplement Coverage)	(800) 730-4648	www2.unitedamerican.com
UnitedHealthcare Medicare Advantage with Prescription Drug (MAPD)	(844) 481-8836	www.uhcretiree.com/valero
Prescription Coverage *Non-Medicare Eligible* Express Scripts	(800) 294-5060	www.express-scripts.com
Medicare Eligible Express Scripts Medicare Part D Rx Drug Program through United American (Medicare Supplement)	(855) 788-1503	
Optum Rx through UnitedHealthcare Medicare Advantage with Prescription Drug (MAPD)	(844) 481-8836	www.uhcretiree.com/valero
Dental UnitedHealthcare	(844) 634-1235	www.myuhc.com (Network: National Options PPO 30)

Benefit	Toll-Free Number	Website
Vision VSP	(800) 877-7195	www.vsp.com
Legal ARAG Legal Insurance	(800) 247-4184	www.araglegalcenter.com (Access Code: 11330ret)
Retiree Life Insurance Health & Welfare Benefits Department	(800) 333-3377 extension 4000	
Retiree Health Care Administration Amwins	(877) 422-4170	www.valero.amwins.com
COBRA Administration UnitedHealthcare	(866) 747-0048	https://uhcservices.com

PLAN ADMINISTRATION

Upon retirement, the Company may offer medical (which includes prescription drug coverage), dental, vision and legal insurance coverage to certain retirees and their eligible dependents. Retirees may also be provided with a Company-paid retiree life insurance benefit.

Amwins serves as a third-party administrator acting on behalf of Valero with respect to health care and legal insurance benefits. Amwins handles the daily administration of the retiree medical, dental, vision and legal insurance benefits. However, Valero, the Plan Administrator, sponsors the retiree health care benefits, and the Valero Health & Welfare Benefits Department administers the retiree life insurance benefit.

Contributions toward the cost of the health care coverage is dependent on the retiree's group or classification at retirement and the Medicare eligibility of the retiree and any eligible dependents.

ELIGIBILITY

In order to be eligible for health and welfare benefits under the Retiree Benefits Plan, you must:

- Be at least 55 years old, and
- Have at least five years of service at the time of retirement.

MEDICARE ELIGIBILITY AND THE VALERO RETIREE BENEFITS PLAN

The Retiree Benefits Plan requires retirees and/or eligible dependents who are Medicare eligible due to age or disability be enrolled in Medicare Part A and Part B. Participants enrolling in any Valero-sponsored Medicare medical coverage option will be automatically enrolled in a corresponding Medicare Part D Prescription Drug Program. When making benefit elections, retirees must choose one coverage option for all covered members, except in the case of a split Medicare eligible and non-Medicare eligible household. For more information, please refer to the section below in this handbook titled "Split Households."

Participants with a Medicare medical coverage option must have an address within the domestic United States. Medicare eligible participants enrolling in the Medicare Advantage (MAPD) benefit cannot utilize a P.O. Box or foreign address.

For additional information, please contact Amwins at (877) 422-4170 or visit www.valero.amwins.com.

Medicare Eligible at Retirement

Retirees and their covered dependents who will be Medicare eligible **at retirement**must enroll in Medicare Part A and Part B by the retiree health care coverage effective date. To enroll in Medicare, eligible participants should contact the Social Security Administration Office at (800) 772-1213. Amwins will send an enrollment kit containing information about the Valero-sponsored Medicare supplement and Medicare Advantage coverage options. Retirees enrolling in a Medicare supplement or Medicare Advantage coverage option will automatically be enrolled in a corresponding Medicare Part D Prescription Drug Program.

Becoming Medicare Eligible during Retirement

Retirees who are no longer eligible for the non-Medicare Valero-sponsored benefits will be disenrolled the last day of the month prior to their Medicare eligibility. If other members of the household are currently enrolled in a non-Medicare benefit, they will remain enrolled as long as they meet eligibility requirements, are not Medicare eligible and pay applicable premiums.

If a retiree or a covered dependent becomes Medicare eligible due to a disability, they must notify Amwins immediately and enroll in Medicare Part A and Part B. Amwins will then send an enrollment kit containing information about the Valero-sponsored Medicare supplement and Medicare Advantage coverage options. Retirees enrolling in a Medicare supplement or Medicare Advantage coverage option will be automatically enrolled in the corresponding Medicare Part D Prescription Drug Program.

Retirees and their covered dependents who become Medicare eligible due to age will be notified by Amwins up to three months prior to turning age 65. Eligible participants will receive an enrollment kit containing information about the Valero-sponsored Medicare supplement and Medicare Advantage coverage options. Participants enrolling in a Medicare supplement or Medicare Advantage coverage option will be automatically enrolled in a corresponding Medicare Part D Prescription Drug Program.

Split Households

A split household contains both non-Medicare and Medicare eligible participants. A split household will be sent one enrollment kit for all non-Medicare eligible participants and one enrollment kit for all Medicare eligible participants.

Failure to Enroll when Becoming Medicare Eligible

Failure to enroll in Medicare Part A and Part B when eligible will impact enrollment in any Valero-sponsored Medicare supplement or Medicare Advantage benefit offered and will result in the denial of medical and prescription claims and/or termination of medical and prescription coverage.

Medicare eligible participants that do not enroll in Medicare Part A and Part B when first entitled may have to wait for a Medicare General Enrollment period which may result in premium penalties associated with the Medicare coverage.

ELIGIBLE DEPENDENTS

Retirees may elect coverage for eligible dependents under the Retiree Benefits Plan. Eligible dependents include the following:

Spouse − A certificate of marriage is required.

Common Law Spouse − A notarized Affidavit of Common Law Marriage and supporting documentation are required. If residing in a state that recognizes Common Law Marriage, a copy of the state issued certificate is required. For states that do not recognize the unity of common law marriage, the common law spouse can only be added during the Annual Open Enrollment period.

Domestic Partner/Same-Sex Partner − A notarized Affidavit of Domestic Partner relationship and supporting documentation are required. Opposite sex domestic partners must be common law spouses to be considered eligible for coverage. If residing in a state that recognizes Domestic Partner Relationship, a copy of the state issued certificate is required.

For more information about the Company's Policy for Common Law Marriage, the Policy for Domestic Partner/Same-Sex Partner or the Declaration of Tax Status, please contact the Valero Health & Welfare Benefits Department.

Dependent Children – Retirees may enroll dependent child(ren) in the Retiree Benefits Plan if the dependent child is younger than age 26. Dependent children are eligible for coverage up to the end of the month in which they turn 26.

Coverage for dependent children will be retroactive to the effective date of the qualified change event provided that supporting documentation is received within 30 days from the date of the qualified change event.

Eligible Child(ren) include:

- Children who are the retiree's natural children, stepchildren or legally adopted by the retiree. A birth certificate, Qualified Medical Child Support Order (QMCSO), or proof of adoption is required.

- Foster children or other children residing with the retiree in a legal guardian or conservator relationship (court-appointed) and relying on the retiree for support or other children where support and coverage are required by a court order. Proof of foster care, court-appointed legal guardianship or a copy of the court order is required.

- Children up to any age who were permanently, physically or mentally disabled before age 26 and who have been continuously eligible for coverage under the Retiree Benefits Plan. The dependent must be unable to support themselves, reside with the retiree and depend on the retiree for more than half their support. Proof of permanent disability is required and will be reviewed by the carrier.

- Children who are the natural children or legally adopted by the retiree's Common Law Spouse or Domestic Partner.

ELECTIONS AND ENROLLMENT PERIODS

Initial Enrollment Period

Upon notification of retirement, the Valero Health & Welfare Benefits Department will provide a personalized binder containing information about an employee's eligibility under the pension benefit, Valero Energy Corporation Thrift 401(k) Plan and/or Premcor Retirement Savings Plan, COBRA continuation of health care coverage, retiree health care administration, life insurance benefit and legal insurance.

Amwins will be notified of an employee's retirement so that they can prepare and mail the retiree an enrollment kit. The enrollment kit should be returned directly to Amwins in the envelope they provide. Retirees wishing to enroll in benefits under the Plan must complete and return the Enrollment and Direct Payment Authorization Forms within the later of 30 days from the date on the enrollment kit from Amwins or 30 days from the anticipated effective date of retiree health care coverage. If a retiree does not enroll within this period, they waive all rights to benefits under the Plan and are not eligible to enroll at any later date. Participation in the active employee health care coverage will end on the last day of the month in which the employee separates from Valero. Retiree health care and legal insurance coverage is effective the first of the month following the separation effective date.

When making elections, retirees must choose one coverage option for all covered members, except in the case of a split household with retirees who are both Medicare eligible and non-Medicare eligible. For more information, refer to the section in this handbook titled "Split Households."

Annual Open Enrollment

The Company's retiree health care benefits are maintained on a calendar year basis from January 1 through December 31. Each year, during the Annual Open Enrollment period, participants will receive notification of any benefit changes or premium changes for the upcoming plan year. The Annual Open Enrollment period is generally consistent with the Medicare enrollment window and will be communicated to participants by Amwins. Participants will have an opportunity to make changes during the designated Annual

Open Enrollment period. If no changes are made, the same benefit options will remain in effect for the coming plan year.

Information about retiree health care premiums will be provided during every Annual Open Enrollment period. Current premium information is available by calling Amwins at (877) 422-4170.

HEALTH CARE PREMIUMS

Retiree health care premiums will be electronically debited from a designated personal bank account on a monthly basis through Automated Clearing House (ACH). Retirees will need to complete the Direct Payment Authorization Form. This form will be distributed in the initial enrollment kit. Retirees should only submit a new form if there has been a change to their banking information. For questions about ACH, or to request a form, contact Amwins at (877) 422-4170 or visit www.valero.amwins.com.

ID CARDS

Retirees should give their ID card to their health care providers when seeking medical, dental or prescription drug services. Temporary ID cards may be viewed and printed from each carrier's website. In addition, most carriers have smartphone applications which allow participants to view their ID card on the phone.

UnitedHealthcare Medical Coverage for Non-Medicare Eligible Participants

Participants enrolled in a UnitedHealthcare coverage option will receive a medical ID card.

United American Insurance Company for Medicare Eligible Participants

Participants enrolled in the United American Medicare Supplement coverage option will receive a medical ID card upon their initial enrollment.

UnitedHealthcare Group Medicare Advantage (MAPD) for Medicare Eligible Participants

Participants enrolled in the UnitedHealthcare Medicare Advantage coverage option will receive a *combined* medical and prescription ID card upon their initial enrollment.

Prescription Drug Coverage

Non-Medicare Eligible Participants

All participants in a non-Medicare UnitedHealthcare medical coverage option will receive a separate Express Scripts Prescription Drug ID card at initial enrollment.

Medicare Eligible Participants

All participants in the United American Medicare Supplemental medical coverage option will receive an Express Scripts Medicare Part D Prescription Drug ID card upon their initial enrollment.

All participants in the UnitedHealthcare Medicare Advantage coverage option will use their *combined* medical and prescription ID card for their prescription benefits.

UnitedHealthcare $50 Deductible Dental Coverage

Participants enrolled in the UnitedHealthcare dental coverage option will have access to a digital ID card. Should participants want a printed copy, they may go online at www.myuhc.com or contact member services.

VSP Vision Coverage

VSP participants are not required to have an ID card to access services. Should participants want a card, they may go online at www.vsp.com to register and print an ID card.

Legal Insurance Coverage

Participants enrolled in the ARAG Legal Insurance coverage option will be issued an ID card.

QUALIFIED CHANGE EVENTS

A retiree may be eligible to add or drop coverage upon experiencing a Qualified Status Change (QSC) or upon receiving a judgment, decree or order (other than a divorce decree), these types of events are considered qualified change events. **It is the retiree's responsibility to notify Amwins of a qualified change event within 30 days of the qualified change event, including the ineligibility of a dependent.**

Qualified change events include, but are not limited to the following:

- Marriage (refer to the section of this handbook titled Eligible Dependents for more information on when spouses, common law spouses or domestic partners/same-sex partners can be added),

- Birth, adoption or placement for adoption of a dependent child, placement in foster care or legal guardianship,

- Divorce, legal separation or annulment, dissolution of a Common Law Marriage or Domestic Partner Relationship,

- Death of a dependent,
- Change in a dependent's employment status resulting in a loss or gain of coverage, or
- A QMCSO (or similar judgment or decree that affects the health care coverage of the retiree, the retiree's spouse or the retiree's dependent).

To qualify for a change in coverage, the change must directly affect benefits. Most changes are effective the first day of the month following the date of change in family status.

While a qualified change event may allow a coverage level change, the retiree may not change the medical coverage option originally selected.

The addition or deletion of a dependent must be reported to Amwins or Valero with supporting documentation within 30 days of the qualified change event.

A retiree may also wish to consider a change of beneficiary at the time of a qualified change event.

To Add a Dependent

To add a dependent(s), the following documentation is required depending on the qualified change event: a birth certificate (courtesy hospital copy is acceptable), marriage certificate, proof of adoption, legal guardianship or other appropriate court order, a QMCSO or similar judgment, or proof of loss of other coverage by the retiree's eligible dependent. An individual must be listed as an eligible dependent with Amwins in order to be covered by a Valero-sponsored benefit(s) when a qualified change event occurs. To add a dependent, retirees should contact Amwins at (877) 422-4170.

Retirees who do not provide notification by the applicable deadline will not be allowed to add or make changes to their benefits until the next Annual Open Enrollment period, unless there is a subsequent qualified change event.

To Drop a Dependent

To drop a dependent(s) due to divorce, a copy of the final divorce decree, Affidavit of Dissolution of Common Law Marriage, Affidavit of Dissolution of Domestic Partner Relationship or a QMCSO is required. The judge's signature and date must be on the decree or order. To drop a dependent(s) due to eligibility of health benefits through the dependent's employer or because the dependent(s) will be covered through a spouse/ex-spouse, proof of coverage eligibility is required.

When a qualified change event results in a dependent losing coverage under the

Retiree Benefits Plan, certain dependents may be eligible to continue health care coverage in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). For more information, refer to the section of this handbook titled Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). To remove a dependent(s), retirees should contact Amwins at (877) 422-4170.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for health care benefits. All medical, dental and vision coverages are required by law to administer benefits in accordance with a QMCSO.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. For more information regarding QMCSOs, refer to the section titled Qualified Change Events.

CHANGE IN ADDRESS

Address changes must be submitted in writing. The written communication should include the effective date of the address change to ensure that correspondence is mailed to the correct address. The address change form may be obtained by calling Amwins at (877) 422-4170.

WHEN PLAN COVERAGE ENDS

Benefit coverage for a retiree and their covered dependents ends the earlier of the following dates:

A Retiree's Coverage Ends When/On:	A Retiree's Covered Dependent(s) Coverage Ends When/On:
• The date the retiree voluntarily drops coverage under the Retiree Benefits Plan	• The date the retiree voluntarily drops coverage under the Retiree Benefits Plan
• The last day of the month for which premiums were paid, if payment is not received within 30 days from the due date	• The last day of the month for which premiums were paid, if payment is not received within 30 days from the due date
• The date a fraudulent claim is made by the retiree or on behalf of the retiree with their knowledge	• The date a fraudulent claim is made by or on behalf of the dependent with the retiree's knowledge

A Retiree's Coverage Ends When/On:	A Retiree's Covered Dependent(s) Coverage Ends When/On:
• The plan is terminated	• The plan is terminated
• The retiree's death (for exception, see the section titled Continuing Coverage After the Death of a Retiree below)	• The retiree's death or dependent's death (for exception, see the section titled Continuing Coverage After the Death of a Retiree below)
	• The date the retiree's dependent(s) no longer meets the eligibility requirements of the plan

CONTINUING COVERAGE AFTER THE DEATH OF A RETIREE

In the event of the retiree's death, eligible dependents who wish to continue health care coverage must contact Amwins.

Spouses, Common Law Spouses and Domestic Partners may continue coverage as a surviving spouse under the benefits by which they were covered immediately prior to the retiree's death or as a primary insured participant in accordance with COBRA.

Eligible dependent children may continue coverage under the benefits by which they were covered immediately prior to the retiree's death under:

- A surviving spouse's coverage, if applicable, or
- As a primary insured participant in accordance with COBRA.

For information about health care coverage continuation under COBRA, refer to the section of this handbook titled Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

BENEFICIARY INFORMATION

A beneficiary is a person named to receive benefits in the event of a retiree's death. To name a beneficiary(ies), a Valero Energy Corporation Beneficiary Designation form (Beneficiary Designation form) must be completed. The Beneficiary Designation form must be on file with the Company before a retiree's death to ensure that benefits are paid to the beneficiary(ies) of the retiree's choice. Beneficiary Designation forms completed during active employment remain in force during the retiree's lifetime unless an updated

form is submitted in its place. A retiree may change beneficiary designations at any time. To obtain a Beneficiary Designation form, retirees should contact the Health & Welfare Benefits Department (800) 333-3377, extension 4000.

In the absence of a properly completed Beneficiary Designation form, survivor benefits will be paid as outlined in the plan documents.

AMENDMENT AND TERMINATION

The Company may determine, in its sole discretion, to amend or modify certain features of the various benefit programs under the Plan for any reason, including certain business reasons, or as required by changes in the various legal rules that apply to the plans. The Company reserves the right, in its sole discretion, to amend or modify, in whole or in part, any provisions of this plan, including the right to terminate the programs, or any part thereof, or otherwise modify or discontinue contributions toward the cost thereof, at any time and for any reason. Participants should remember that any such amendments or the termination of the programs could affect their future benefits and expectations from the programs. If the plan should end, benefits will be paid for eligible charges incurred before the termination.

RETIREE LIFE INSURANCE

The retiree life insurance provides certain retirees the opportunity to protect survivors' financial security in the event of the retiree's death. The Company-paid retiree life insurance benefit is administered by the Valero Health & Welfare Benefits Department. Should a retiree or their beneficiary have questions regarding the Company-paid retiree life insurance benefit, they may contact the Valero Health & Welfare Benefits Department at (800) 333-3377, extension 4000.

Cost of Coverage

Retiree life insurance is provided to certain retirees at no cost.

Coverage Amount

A retiree's company-paid life insurance coverage amount depends on the work location at the time of retirement and the date of retirement. For questions about retiree life insurance amounts, retirees should contact the Valero Health & Welfare Benefits Department.

IMPUTED INCOME

The amount of tax a retiree pays is based on the dollar value of the coverage assigned by the IRS. This is called imputed income. If the life insurance coverage amount from the company-paid life insurance is more than $50,000, a retiree will be required to pay income taxes based on the value of the coverage greater than $50,000. This amount will be reported to the IRS as taxable income. Retirees subject to imputed income will receive a Form 1099 from the Company.

LIFE INSURANCE CLAIMS

Valero's group life insurance benefits are provided under insurance policies issued by Metropolitan Life Insurance Company (MetLife).

A claim must be submitted to receive benefits. Upon notification of a loss, the Valero Health & Welfare Benefits Department will provide the beneficiary(ies) assistance in completing and filing the claim. The Valero Health & Welfare Benefits Department will attempt to contact the beneficiary(ies) and provide the proper claim forms. However, if the Health & Welfare Benefits Department is unable to contact the beneficiary(ies) it is the responsibility of the beneficiary(ies) to make certain a claim has been filed.

Claim Submission

In submitting claims for life insurance benefits ("Benefits"), the claimant must complete the appropriate claim form and submit the required proof as described in the packet

provided by the Valero Health & Welfare Benefits Department. Claim forms must be submitted in accordance with the instructions on the claim form.

Initial Determination

After MetLife receives a claim for Benefits, MetLife will review the claim and notify the claimant of its decision to approve or deny the claim.

Such notification is provided to the claimant within a reasonable period, not to exceed 90 days from the date MetLife receives the claim, unless MetLife notifies the claimant within that period that there are special circumstances requiring an extension of time of up to 90 additional days.

If MetLife denies a claim in whole or in part, the notification of the claims decision will state the reason why the claim was denied and reference the specific provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. The notification will also include a description of the review procedures and time limits, including a statement of the claimant's right to bring a civil action if the claim is denied after an appeal.

Appealing the Initial Determination

In the event a claim has been denied in whole or in part, the claimant can request a review of the claim by MetLife. This request for review should be sent in writing to Group Insurance Claims Review at the address of MetLife's office which processed the claim within 60 days after the claimant received notice of denial of the claim. When requesting a review, the claimant should state the reason they believe the claim was improperly denied and submit in writing any written comments, documents, records or other information the claimant deems appropriate. Upon the claimant's written request, MetLife will provide the claimant free of charge with copies of relevant documents, records and other information.

MetLife will re-evaluate all information timely submitted, will conduct a full and fair review of the claim, and the claimant will be notified of the decision. Such notification will be provided within a reasonable period not to exceed 60 days from the date MetLife received the request for review, unless MetLife notifies the claimant within that period that there are special circumstances requiring an extension of time of up to 60 additional days.

If MetLife denies the claim on appeal, MetLife will send the claimant a final written decision that states the reason(s) why the appealed claim is being denied, references any specific benefit provision(s) on which the denial is based, any voluntary appeal procedures offered by the benefit and a statement of the claimant's right to bring civil action if the claim is denied after an appeal. Upon written request, MetLife will provide the claimant free of charge with copies of documents, records and other information relevant to the claim.

AMENDMENT AND TERMINATION

The Company reserves the right, in its sole discretion, to amend or modify, in whole or in part, any provision of the plan or life insurance offered thereunder, including the right to terminate altogether, at any time and for any reason, without regard to whether expenses have already been incurred by a participant or whether injuries or expenses have already been incurred by a participant. Participants should remember that any such amendment or termination could affect their future benefits and expectations under the plan. If the plan or life insurance should end, benefits will be paid for losses that have already incurred.

PLAN INFORMATION

SOME BENEFITS REFERENCED IN THIS SECTION MAY NOT APPLY TO ALL RETIREES AS AVAILABILITY MAY VARY BY REGION.

INFORMATION APPLICABLE TO ALL PLANS

The items in this section provide information relating to all of the Company's retiree benefits, unless otherwise stated. This information should be read in conjunction with the individual descriptions of the Company's retiree benefits provided.

HOW TO FILE A CLAIM

Participants filing a claim should refer to the benefit summary of the coverage for which the claim will be made. Refer to the table of contents in this summary to identify benefits.

RIGHTS UNDER ERISA

The following paragraphs describe certain rights and protections that participants have under certain Valero retiree benefits plan. These rights and protections are provided for plans covered by ERISA. ERISA provides that all plan participants must be entitled to certain rights.

- Participants have the right to receive information about plans and benefits.
- Participants have the right to continue group health coverage.
- Participants have the right to prudent actions by plan fiduciaries.
- Participants have the right to enforce their rights.
- Participants have the right to receive assistance with their questions.

THE RIGHT TO RECEIVE INFORMATION ABOUT PLANS AND BENEFITS

The following are the participants' rights to receive information about plans and benefits.

- Participants have the right to examine, without charge, at the plan administrator's office and at other specified locations, such as work sites and union halls, all documents governing the plans, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the public disclosure room of the Employee Benefits Security Administration.

- Participants have the right to obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and an updated benefits summary. The administrator may charge a reasonable amount for the copies.

- Participants have the right to 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 the summary annual report.

- Participants have the right to obtain a Pension Plan statement stating whether they have a right to receive a pension at normal retirement age. If a participant is eligible, the statement states what benefits would be at normal retirement age if they stop working under that plan now. If a participant does not have a right to a pension, the statement will state how many more years they must work to be entitled to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The Pension Plan must provide the statement free of charge.

THE RIGHT TO CONTINUE GROUP HEALTH COVERAGE

If there is a loss of coverage as a result of a qualifying event, as defined by COBRA, a participant and/or their covered dependents may have the right to continue health care coverage under the health care benefits in which they were participating at the time. A participant and their covered dependents may have to pay for the continued coverage. Review the benefits summary and the documents governing the benefits on the rules governing COBRA continuation coverage rights. For more information, refer to the section in this handbook titled Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

THE RIGHT TO 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 retiree benefit plan. The people who operate the plans, called fiduciaries, have a duty to do so prudently and in the interest of plan participants and beneficiaries. No one, including an employer, union or any other person, may fire a participant or otherwise discriminate against a participant in any way to prevent the employee from obtaining a (pension or welfare) benefit for which they are eligible or exercising their rights under ERISA.

THE RIGHT TO ENFORCE ERISA RIGHTS

If a participant's claim for a benefit is denied or ignored, in whole or in part, the participant has a right to know why it occurred, 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 a participant may take to enforce the above rights. For instance, if a participant requests a copy of governing documents or the latest annual report from the plan and does not receive them within 30 days, they pursue their rights under the Dialogue Dispute Resolution Program (Dialogue). In such a case, the arbitrator may require the plan administrator to provide the materials and pay the participant up to $110 a day for each violation until they receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator.

If a participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may pursue their rights under Dialogue. In addition, if a participant disagrees with the plan's decision, or lack thereof, concerning a QDRO or a QMCSO, the participant may pursue their rights under Dialogue.

If fiduciaries misuse the plan's money, or if a participant is discriminated against for asserting their rights, the participant may seek assistance from the U.S. Department of Labor or may file suit in a federal court. The court will decide who should pay costs and legal fees. If the participant is successful, the court may order the party the participant has sued to pay these costs and fees. If the participant is unsuccessful, the court may order the party to pay these costs and fees, for example, if it finds the participant's claim to be frivolous.

Dispute resolution in the case of an insured plan is covered by the insurance contract.

THE RIGHT TO ASSISTANCE WITH QUESTIONS

The participant should contact the plan administrator if they have any questions about their plans. If a participant has any questions about their rights under ERISA, or needs assistance obtaining documents from the plan administrator, the participant should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, or the Division of Technical Assistance and Inquiries.

Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue NW
Washington, D.C. 20210

A participant may also obtain certain publications about rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.

GENERAL INFORMATION

The following is plan administrator and employer information relating to all the Valero employee benefit plans:

Plan Administrator:
Valero
P.O. Box 696000
San Antonio, TX 78269-6000
(210) 345-2000

Plan Sponsor:
Valero Energy Corporation:
P.O. Box 696000
San Antonio, TX 78269-6000
(210) 345-2000

Human Resources:
Valero
P.O. Box 696000
San Antonio, TX 78269-6000
(210) 345-2000

Employer Identification Number of Valero Energy Corporation:
74-1828067

For insured benefits, the Plan administrator is provided under the terms of the insurance contract. Plan administrators for insured benefits are listed in the section of this handbook titled Plan Administration and Funding.

Legal Process

The following is the agent for service of legal process relating to the Company's employee benefit plans.

The Corporation Trust Company
1209 Orange Street
Wilmington, DE 19801

Legal process may also be served on the plan administrator and trustee.

Plan Year

Records for all of the Company's employee benefit plans are kept on a plan year basis from January 1 through December 31.

Administration

All of the Company's employee benefit plans, except insured plans, are administered by the BPAC, which is selected by the Board of Directors of the Company. The BPAC is responsible for the proper administration of the plans, other than insured plans, and has full power and authority to interpret the provisions of the plans.

In particular, the BPAC and any other designees (including the Claims Administrators) each have all such powers, authority and discretion as may be necessary to implement and carry out the provisions of the Plan, and to interpret and construe all of the terms, provisions and limitations of the Plan. Such power, authority and discretion include, but are not limited to, the power, authority and discretion to: (a) determine all questions regarding eligibility to participate in the Plan, as well as all questions regarding the status of particular employees, dependents and others in relation to the Plan; (b) determine all

questions regarding eligibility to receive benefits under the Plan, the date of commencement and termination of the payment of benefits and the amount of benefits; (c) interpret and construe all terms, provisions and limitations of the Plan, including without limitation, any and all doubtful, disputed or ambiguous provisions; (d) evaluate the compliance by participants and dependents of their respective obligations and responsibilities under the Plan; and (e) promulgate binding rules for the administration and implementation of the Plan. Its interpretations are final, conclusive and binding on the Company, the participants and all other parties of interest.

THE RIGHT TO RELEASE OR OBTAIN INFORMATION

Any participant in any of the plans offered in the Valero benefits program authorizes the Company to obtain or release any information required to determine benefits payable. Federal law prohibits the Company from using or disclosing Protected Health Information (PHI) for purposes other than health care treatment, payment or plan operations without an authorization from the participant. For further details, refer to the section of this handbook titled HIPAA Privacy Notice.

AMENDMENT AND TERMINATION

The Company reserves the right, in its sole discretion, to amend, in whole or in part, any provision of the plans described in this benefits summary, including the right to terminate the plans altogether, or any part thereof, at any time and for any reason, without regard to whether injuries or expenses have already been incurred by a participant. Participants should remember that any such amendment or termination of the plans could affect their future benefits and expectations under the plans. If there are important and material changes to the plans, participants will be notified. Additionally, in the event of termination of retirement plans funded with trust assets (i.e., the Thrift Plan and Pension Plan) there are special rules and protections relating to a participant's benefits.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

Valero has contracted with UnitedHealthcare to serve as COBRA administrator for retiree health care benefits. UnitedHealthcare will process all COBRA enrollments, premium payments, collections and maintain the plan's compliance with legal requirements beginning May 1, 2021.

For additional information regarding COBRA, please contact the UnitedHealthcare at (866) 747-0048.

If covered dependents of retirees lose health care coverage under the Plan, they may have the right to extend it under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Continuation coverage under COBRA is available only to benefits that are subject to the terms of COBRA, which applies to medical (includes prescription drug coverage), dental and vision benefits.

The Company is required to provide the qualified beneficiary with coverage that is identical to the coverage provided under the Plan to similarly situated non-COBRA participants and/or covered dependents. Should coverage change or be modified for non-COBRA participants, the change, and/or modification will be made to the COBRA coverage as well.

COBRA continuation coverage for retirees is only offered in the time of retirement or if there is a commencement of proceeding in bankruptcy with respect to employer.

CONTINUATION COVERAGE UNDER FEDERAL LAW (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call Amwins if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary." A Qualified Beneficiary is any of the following persons who were covered under the health care benefit on the day before a qualifying event:

- A retiree's enrolled dependent, including with respect to the retiree's children, a child born to or placed for adoption with the retiree during a period of continuation coverage under federal law.
- A retiree's former spouse, common law spouse or domestic partner.

QUALIFYING EVENTS FOR CONTINUATION COVERAGE UNDER COBRA

The following table outlines situations in which your dependent may elect to continue coverage under COBRA for your dependents, and the maximum length of time they can receive continued coverage. These situations are considered qualifying events.

If Coverage Ends Because of the Following Qualifying Events:	Your Dependent May Elect COBRA:	
	For Your Spouse/ Common Law Spouse/ Domestic Partner	For Your Child(ren)
You or your surviving spouse dies	36 months	36 months
You divorce (or legally separate)	36 months	36 months
Your child is no longer an eligible family member (e.g., reaches the maximum age limit)	n/a	36 months

GETTING STARTED

After receiving a notice of a qualifying event, the Plan must provide the Qualified Beneficiary with an election notice, which describes their rights to continuation coverage and how to make an election. The election notice must be provided to the Qualified Beneficiary within 14 days after the plan administrator receives the notice of a qualifying event.

The Qualified Beneficiary will receive their notification by mail. The notification will give instructions for electing COBRA coverage and will advise the Qualified Beneficiary of the monthly cost. The monthly cost is the full cost of the coverage, plus a 2% administrative fee or other cost as permitted by law.

The Qualified Beneficiary will have up to 60 days from the date they receive notification or 60 days from the date their coverage ends to elect COBRA coverage, whichever is later. They will then have an additional 45 days to pay the cost of their COBRA coverage, retroactive to the date their health care under the plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a provider, inform that provider of the Qualified Beneficiary's right to elect COBRA coverage, retroactive to the date their COBRA eligibility began.

While a participant in the medical coverage under COBRA, a Qualified Beneficiary has the right to change their coverage election:

- During the Annual Open Enrollment period.

- Following a change in family status, as described under the section of this handbook titled Plan Administration.

NOTIFICATION REQUIREMENTS

Once you have notified Amwins of a qualifying event, the Qualified Beneficiary will then be notified by mail of their election rights under COBRA. Due to a 60-day COBRA notification period, if your covered dependents lose coverage due to divorce, legal separation, or loss of dependent status, you or your dependents must notify Amwins within 60 days the latest of:

- The date of divorce, legal separation or an enrolled dependent's loss of eligibility as an enrolled dependent.
- The date your enrolled dependent would lose coverage under the Plan.
- The date on which you or your enrolled dependent are informed of your obligation to provide notice and the procedures for providing such notice.

If you or your dependents fail to notify Amwins of these events within the 60-day period, then rights to continuation coverage will be forfeited. You or your dependents must also notify UnitedHealthcare when a qualifying event occurs that will extend continuation coverage. If your dependent is continuing coverage under federal law, they must notify UnitedHealthcare within 30 days of the birth or adoption of a child. Once they have notified UnitedHealthcare, they will then be notified by mail of their election rights under COBRA.

COBRA PREMIUM PAYMENTS

All initial premiums are due within 45 days of signing the COBRA enrollment form. Coverage will not be activated until the full initial payment is received. Once this payment is received COBRA coverage will be made retroactive to the initial loss of coverage. Your monthly cost is the full cost of the coverage plus a 2% administration fee or other cost as permitted by law.

COBRA premium payments are due on the first day of each month. Payments not received by the last day of the month are considered late. A 30-day grace period will be allowed, however if a COBRA participant fails to pay their premiums, coverage will be terminated retroactively back to the last paid date. If coverage is terminated due to nonpayment, the participant will not be allowed to reenroll for coverage at any later date. COBRA participants may pay for their premiums by electronic funds transfer (EFT), credit card, debit card, personal check, money order or cashier's check. COBRA premium payments should be mailed to:

UnitedHealthcare
P.O. Box 713082
Cincinnati, OH 45271-3082

https://uhcservices.com
(866) 747-0048

Claims may be "pended" each month with the insurance carrier until they receive notice that the monthly COBRA premium payment has been made. Please bear in mind that each insurance carrier's schedule for releasing pended claims may be different. For questions about the status of insurance claims, contact the insurance carrier directly.

WHEN COBRA ENDS

COBRA coverage will end before the maximum continuation period, on the earliest of the following dates:

- The date, after electing continuation coverage, that coverage is first obtained under any other group health benefit.
- The date coverage ends for failure to make the first required premium payment (premium is not paid within 45 days).
- The date coverage ends for failure to make any other monthly premium payment (premium is not paid within 30 days of its due date).
- The date the entire Plan ends.
- The date coverage would otherwise terminate under the Plan as described in the section of this handbook titled Plan Administration.
- The date, after electing continuation coverage, the Qualified Beneficiary notifies UnitedHealthcare of their decision to terminate COBRA continuation coverage.

Note: If the Qualified Beneficiary selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed in this section, whichever is earlier.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) contains certain other requirements for certain of the Company's health benefits. HIPAA applies only to the following Valero benefits: medical, dental and vision coverages under the company's active employee benefit plans. As a stand-alone retiree health care plan, the Retiree Benefits Plan is not formally subject to all aspects of HIPAA. Nonetheless, the Company has determined to offer the following special enrollment rights to participants under the plan. The effective dates for coverage are determined by the terms of the plan. For more information, refer to the section in this handbook titled Qualified Change Event. HIPAA does not apply to any other Valero-sponsored benefits described in this handbook.

HIPAA SPECIAL ENROLLMENT RIGHTS

HIPAA provides special mid-year enrollment opportunities to certain retirees, their dependents and COBRA qualified beneficiaries who are actually receiving COBRA coverage.

Loss of Coverage

If a retiree's dependent is eligible for coverage but not currently enrolled because they had alternative health coverage, they may enroll if the other coverage is lost because:

- Coverage was under COBRA, and the COBRA period was exhausted,
- Coverage was terminated as a result of loss of eligibility for coverage (including as a result of legal separation, divorce, death, termination of employment), or
- Employer contributions for the coverage were terminated.

To enroll under the special enrollment right, the retiree must request enrollment within 30 days after the loss of coverage. There is no HIPAA special enrollment right if the other coverage ceases as a result of an individual's failure to pay premiums, or for cause.

Acquisition of New Dependent

A special enrollment opportunity is also available if a retiree marries or acquires a dependent by marriage, birth, adoption or placement for adoption. The special enrollment right applies to the retiree, the retiree's spouse and the newly acquired dependent. To obtain coverage under this special enrollment right, a retiree must request enrollment within 30 days of the marriage, birth, adoption or placement for adoption.

THE RIGHT OF SUBROGATION AND REIMBURSEMENT

Unless otherwise provided under a fully insured benefit document or elsewhere in this handbook, if an individual is entitled to or receives benefits under any coverage described in this handbook with respect to any medical condition, and is also entitled to or otherwise collects compensation or any other funds from another party (except another benefit maintained by the Company) in connection with that same medical condition, whether by insurance, litigation, settlement or otherwise:

- The plan shall be entitled to such funds to the extent of plan benefits paid to the individual, whether or not the individual has been "made whole," and without regard to any common fund doctrine, and

- May recover such funds by constructive trust, equitable lien, right of subrogation, reimbursement or any other equitable or legal remedy.

The plan shall have the right to terminate or suspend benefit payments and/or recover the reimbursement due to the plan by withholding, offsetting and recovering such amount out of any future plan benefits or amounts otherwise due from the plan to or with respect to such individual if:

- An individual fails, refuses or neglects to reimburse the plan or otherwise comply with the provisions of this provision, or

- Payments are made under the plan based on fraudulent information or otherwise in excess of the amount necessary to satisfy the provisions of the plan, then, in addition to all other remedies and rights of recovery that the plan may have.

The plan shall also have the right in any proceeding at law or equity to assert a constructive trust, equitable lien, or any other equitable or legal remedy or recovery against any and all individuals that have assets that the plan may claim rights to. The plan has the right of first dollar recovery from any judgment, settlement or other payment, regardless of whether the individual has been "made whole," and all funds resulting from and without regard to any common fund doctrine.

Upon notification that a claim may be related to an accident or injury caused by a third party and potentially reimbursed or settled by a third party or insurance company, the Company's medical benefit administrator (or their representative) will issue a subrogation claim to the participant. Before payment may be considered on any claim for medical benefits received in connection with the accident or third-party incident, the participant must complete, sign and return the subrogation claim, or provide any requested information to the party initiating the subrogation claim. Any claims for medical benefits received prior to receipt of this information may be denied.

Refer to the medical summaries found on the Valero Retiree Health Care Website for more information on subrogation and reimbursement under the UnitedHealthcare medical coverages.

LEGAL NOTICES

This group health care plan complies with the following federal laws. Should you have any questions about these laws, please contact the Health & Welfare Benefits Department.

HIPAA PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT AN INDIVIDUAL MAY BE USED AND DISCLOSED AND HOW AN INDIVIDUAL MAY GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Some of the benefits described in this handbook may involve the use and/or disclosure of health information that is protected by HIPAA. These benefits include the UnitedHealthcare $1000 Deductible Retiree Choice Plus, UnitedHealthcare Copay/$500 Deductible Retiree Choice Plus, or the UnitedHealthcare $500 Deductible Retiree Out-of-Area PPO coverage, and to the extent PHI is present, the UnitedHealthcare $50 Deductible Dental and VSP Vision coverage.

The Plan is required by law to maintain the privacy of PHI. PHI includes any identifiable information that we obtain from participants or others that relates to a participants physical or mental health, the health care a participant has received, or payment for health care.

As required by law, this notice provides information about participants' rights and our legal duties and privacy practices with respect to PHI. The Company must comply with the provisions of this notice, although the Company reserves the right to change the terms of this notice from time to time and to make the revised notice effective for all PHI we maintain. Participants may always request a copy of our current privacy notice by contacting the Privacy Officer identified later in this section.

Permitted Uses and Disclosures

The Company is permitted to use or disclose participants' PHI for purposes of treatment, payment and health care operations.

Health Care Operations – The support functions of the administrative practice relating to treatment and payment, such as quality assurance activities, case management, audits, and administrative activities.

Treatment – The provision, coordination, or management of health care. For example, a doctor treating a participant for a broken leg may need to know if that participant has diabetes because diabetes may slow the healing process. The Company is therefore permitted to disclose the participant's PHI to help doctors determine whether the participant has potentially complicating conditions like diabetes.

Payment − Activities the Company undertakes to obtain premiums, to determine our responsibility for coverage, or to obtain reimbursement for the health care provided the participant. For example, prior to providing health care services, the Company may need to provide to an insurance company or an HMO, information about a participant's medical condition to determine whether the proposed course of treatment will be covered.

The Company is also permitted to use or disclose participants' PHI in the following special circumstances:

Abuse, Neglect or Domestic Violence – The Company may disclose PHI about participants to appropriate authorities if we reasonably believe a participant to be a victim of abuse, neglect or domestic violence. This disclosure will only be made if required by law or if the participant agrees to the disclosure.

Averting a Serious Threat to Health or Safety – The Company may disclose to appropriate authorities PHI that we reasonably believe is necessary to prevent a serious and imminent threat to the health or safety of the public or of any individual.

Coroners and Funeral Home Directors – The Company may disclose PHI to a coroner, medical examiner or funeral director.

Disclosure to Family Members or Close Personal Friends – The Company may disclose PHI to family members, other relatives, close personal friends or any other individual identified by the participant if the PHI is relevant to the care or payment or for the purpose of notifying them about the participant's condition or location. If the participant is present at the time of the disclosure, they will have the opportunity to object to the disclosure. If the participant is not present, we may exercise our professional judgment to determine whether the disclosure is in the participant's best interest.

Health Oversight Activities – The Company may disclose PHI to federal or state health oversight agencies that oversee our activities.

Inmates − If a participant is an inmate of a correctional institution or under the custody of a law enforcement official, the Company may disclose PHI to the relevant facility or official.

Intelligence Activities and Protective Services for Government Officials – The Company may disclose PHI to appropriate government authorities in connection with intelligence activities or protective services for the president or other officials.

Judicial or Administrative Proceedings – The Company may disclose PHI to be used in legal proceedings, if required by a court order.

Law Enforcement Activities – The Company may disclose PHI if asked to do so by a law enforcement official as part of law enforcement activities; in investigations of criminal

conduct or of victims of crimes; in response to court orders; in emergency circumstances; or when required to do so by law.

Military and Veterans − If a participant is (or was) a member of the armed forces, the Company may disclose PHI as required by military command authorities.

Organ or Tissue Donation – If a participant is an organ donor, the Company may disclose PHI to organizations that handle organ procurement or transplantation.

Public Health Risks – The Company may disclose PHI to public health authorities for purposes of promoting public health activities, such as the prevention or control of disease, injury, or disability; reporting of child abuse or neglect; and reporting of reactions to medications or problems with products.

Research – In some circumstances, the Company may disclose PHI to researchers in connection with research projects that have been approved through an approval process that is required by law.

Uses and Disclosures Required by Law – The Company may use or disclose PHI to the extent required by federal, state or local law.

Workers' Compensation – The Company may disclose PHI to the extent necessary to comply with laws relating to workers' compensation for work-related injuries.

In any situation other than those described above, the Company will not use or disclose the participant's PHI without the participant's written consent. If a participant has given written consent to a use or disclosure, the participant may later revoke that consent by contacting the Company in writing. Participants may not revoke consent to a use or disclosure if action has already been taken in reliance on their written consent.

Rights

Participants may request that restrictions be placed on certain uses and disclosures of their PHI. The Company is not required to agree to any restriction that participants request, but if we do agree to a restriction, we must abide by the restriction unless otherwise necessary for emergency care.

Participants have the right to receive communications of PHI at an alternative address or through alternative contact methods. If participants wish to change the way the Company communicates PHI to the participant, they must submit a written request to the Privacy Officer identified in this section.

Participants have the right to inspect and copy their PHI. Usually, this includes medical and billing records, but does not include psychotherapy notes. To inspect and copy their PHI, participants must submit the request in writing to our Privacy Officer; refer to section below titled "Privacy Officer". Participants may request a copy of their PHI in electronic

form. In such a request, the Company will provide a readily producible electronic copy currently available on the Company's system. The Company may charge a fee for the costs of copying and mailing the information. The Company may also deny the request to inspect and copy in certain limited circumstances. The Company will select a health care professional to conduct reviews of the denials.

Participants have the right to request their PHI be amended if the participant feels that it is inaccurate or incomplete. To request an amendment, the request must be made in writing and submitted to our Privacy Officer. In addition, the participant must provide a reason that supports the request. If the Company denies the request, the participant will be provided with a written explanation of the basis for the denial and a description of further steps a participant may take if the participant feels the denial was in error.

Participants have the right to receive an accounting of disclosures the Company has made of their PHI. To request this accounting of disclosures, the participant must submit the request in writing to the Privacy Officer. The first accounting of disclosures the participant requests will be provided free of charge, but the Company may charge a fee (that will be disclosed in advance) for the cost of providing additional accountings.

Participants have the right to receive a paper copy of this notice upon request. To request a paper copy, contact the Privacy Officer identified later in this section.

Complaints

If participants believe their privacy rights have been violated, participants may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact the Privacy Officer. All complaints must be submitted in writing. Participants will not be penalized for filing a complaint.

Privacy Officer

Cristina Jennings
Valero Energy Corporation
P.O. Box 696000
San Antonio, TX 78269-6000
(210) 345-2000

Employer Certifications

The Company is the sponsor of the Plans described in this benefits summary. As required by HIPAA, the Plan sponsor will disclose PHI to the Company, or the appropriate subsidiary or affiliate of the Company, in its role as the employer only upon receipt of a certification from the Company that the relevant governing documents have been amended to incorporate the following provisions.

The Company agrees to:

- Not use or further disclose PHI other than as permitted or required by the governing document or as required by law,

- Ensure that any agents, including a subcontractor, to whom the plan sponsor provides PHI received from the plan agree to the same restrictions and conditions that apply to the plan sponsor with respect to such PHI,

- Not use or disclose PHI for employment-related actions and decisions unless authorized by an individual,

- Not use or disclose PHI in connection with any other benefit or retiree benefits plan of the plan sponsor unless authorized by an individual,

- Report to the Plan sponsor any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware,

- Make PHI available to an Individual in accordance with HIPAA's access requirements,

- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA,

- Make available the information required to provide an accounting of disclosures,

- Make internal practices, books and records relating to the use and disclosure of PHI received from the Plan sponsor available to the HHS Secretary for the purposes of determining the Plan sponsor's compliance with HIPAA, and

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

The Company further agrees to maintain adequate separation between the plan and the Company. In accordance with HIPAA, the only employees or classes of employees who may be given access to PHI are employees in the HR Department, the Legal Department, the Information Services Department, the Corporate Records Management Department, the Internal Audit Department, the Privacy Officer, the Chief Executive Officer and the Benefit Plans Administrative Committee (BPAC). These individuals only have access to and use and disclose PHI for plan administration functions that the Company performs for the plans. If any of these individuals do not comply with this SPD, the Company shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 (NMHPA)

Under federal law, group health care plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section delivery. However, federal law generally does not prohibit the mother's or newborn's attending physician from discharging the mother or her newborn child earlier than 48 hours (or 96 hours, as applicable). In any case, group health care plans may not require that a provider obtain authorization from the plan for prescribing a length of stay of less than 48 hours (or 96 hours) as described above.

Additionally plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

This plan requires precertification for stays longer than 48 hours (or 96 hours). Deductibles and other conditions of coverage, including co-insurance requirements, apply to hospital stays in connection with childbirth on the same terms as with any other covered benefits provided under the plan.

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

This plan provides coverage for:

- All stages of reconstruction of the breast on which the mastectomy has been performed,

- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and

- Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage.

THE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT (CHIPRA), EFFECTIVE APRIL 1, 2009

CHIPRA provides for certain special enrollment rights effective April 1, 2009. Eligible retirees, or any dependents of the eligible retiree, may enroll for group health insurance coverage under this plan if the:

- Individual's coverage under their respective Medicaid or state child health care plan is terminated as a result of loss of eligibility for the state plan(s); and/or

- Individual becomes eligible for premium assistance under Medicaid or state child health care plan.

If an individual qualifies under either of these events, the retiree must request coverage no later than 60 days after the qualifying event(s) occur.

THE GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA), EFFECTIVE JANUARY 1, 2010

GINA is a Federal Law that prohibits discrimination in group health care plan coverage and employment based on genetic information.

GINA, together with already existing nondiscrimination provisions of the HIPAA, generally prohibits health insurers or health plan administrators from requesting or requiring genetic information of an individual or an individual's family members, or using such information for decisions regarding coverage, rates or pre-existing conditions.

The Department of Health and Human Services is responsible for the health insurance provisions under GINA.

THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA), EFFECTIVE JANUARY 1, 2010

The Mental Health Parity and Addiction Equity Act requires insurers who offer mental health benefits to cover the diagnosis and treatment of certain mental health and substance use disorders to the same extent they cover the diagnosis and treatment of physical disorders.

AFFORDABLE CARE ACT (ACA), EFFECTIVE MARCH 23, 2010

The Retiree Benefits Plan is a stand-alone retiree benefits plan and is not subject to the terms of ACA. Questions regarding which protections apply and which protections do not apply to the health care plan can be directed to the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform.

GOVERNING DOCUMENTS

The descriptions of the benefits contained herein are summaries of certain relevant provisions of the Retiree Benefits Plan, as applicable and may be subject to the more detailed provisions of the benefit programs under the Retiree Benefits Plan. There may be various limitations and special provisions that could affect eligibility and the payment

of benefits under the Valero Energy Corporation Retiree Benefits Plan benefit programs. In the case of any variance or conflict, the provisions of the applicable formal benefit program documents taken as a whole and the programs' administrative procedures control over the information herein. Participants who have any questions at any time concerning their benefits are strongly urged to contact the plan administrator to obtain clarification regarding their plan benefits.

PLAN ADMINISTRATION AND FUNDING

VALERO ENERGY CORPORATION RETIREE BENEFITS PLAN

Plan Number: 525
Common Name: Valero Energy Corporation Retiree Benefits Plan
Plan Type: Welfare Plans

Common Name & Type of Benefit	Plan Administration & Funding Method	Contact Information
Amwins Benefit Type: Retiree Health Care Administration	Third-party administered. Paid through the general assets of the Company	Amwins Group Benefits 50 Whitecap Drive North Kingstown, RI 02852 (877) 422-4170
UnitedHealthcare Benefit Type: COBRA Administration	Third-party administered. Paid through the general assets of the Company	UnitedHealthcare P.O. Box 740221 Atlanta, GA 30374-0221
UnitedHealthcare $1,000 Deductible Retiree Choice Plus, UnitedHealthcare Copay/$500 Deductible Retiree Choice Plus & UnitedHealthcare $500 Deductible Retiree OOAPPO Benefit type: Medical (Non-Medicare)	Third-party administered. Paid through general assets of the Company	UnitedHealthcare P.O. Box 30555 Salt Lake City, UT 84130-0555 (844) 634-1235
United American Basic, Enhanced & Premium Supplements Benefit type: Medicare Supplement Medical (Medicare)	Insurer- administered. Paid through retiree and/or employer premiums	United American P.O. Box 8080 McKinney, TX 75070 (877) 422-4170 Administered by Amwins*

Common Name & Type of Benefit	Plan Administration & Funding Method	Contact Information
UnitedHealthcare Group Medicare Advantage with Prescription Drug (MAPD) Benefit type: Medical (Medicare)	Insurer-administered. Paid through retiree and/or employer premiums	UnitedHealth Care Medicare Advantage P.O. Box 30770 Salt Lake City, UT 84130 (844) 481-8836
Express Scripts Benefit type: Prescription (Non-Medicare)	Third-party administered. Paid through general assets of the Company	Express Scripts, Inc. One Express Way St. Louis, MO 63121 (800) 294-5060
Express Scripts Medicare Rx Drug Program Benefit type: Prescription (Medicare Supplement)	Insurer-administered. Paid through retiree and/or employer premiums.	Express Scripts Medicare Rx Drug Program One Express Way St. Louis, MO 63121 (800) 294-5060
Optum Rx Medicare Drug Program Benefit type: Prescription (MAPD)	Insurer- administered. Paid through retiree and/or employer premiums.	UnitedHealthcare Medicare Advantage P.O. Box 30770 Salt Lake City, UT 84130 (844) 481-8836
UnitedHealthcare Dental $50 Deductible Benefit type: Dental	Third-party administered. Paid through general assets of the Company	UnitedHealthcare P.O. Box 30567 Salt Lake City, UT 84130-0567 (844) 634--1235
VSP Vision Benefit type: Vision	Third-party administered. Paid through general assets of the Company	VSP 3333 Quality Drive Rancho Cordova, CA 95670 (800) 877-7195
Company-Paid Life Insurance Benefit type: Life insurance	Insurer-administered. Paid through employer premiums	Metropolitan Life Insurance Company 177 South Commons Drive Aurora, IL 60507 (800) 638-6420

Common Name & Type of Benefit	Plan Administration & Funding Method	Contact Information
Legal Benefit Type: Legal Services	Insurer-administered. Paid through retiree premiums	ARAG 400 Locust Street Des Moines, IA 50309 (800) 247-4184