Dental Summary

Valero
$50 Deductible Dental Coverage

Effective: January 1, 2025
Group Number: 907816

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Healing health care. Together.®

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WELCOME

Valero is pleased to provide you with dental services available to you and your covered family members under and subject to the terms of the Valero Energy Corporation Retiree Benefits Plan, which health benefits are administered by UnitedHealthcare Dental (Claims Administrator). The benefits are referred to herein as the Retiree Plan.

INTRODUCTION

This summary provides more detailed information about the benefits available under the UnitedHealthcare dental coverage offered under the Retiree Plan. This document should be read in connection with the overall Retiree Benefits Handbook provided to retirees. All benefits are governed by formal plan documents.

For detailed information about eligibility, enrollment, effective dates, changing plan elections, refer to the Plan Administration section of the Retiree Benefits Handbook.

HOW THE COVERAGE WORKS

For detailed information about how the coverage works, refer to the *Highlights*.

EXCLUSIONS: WHAT THE DENTAL COVERAGE WILL NOT COVER

Except as may be specifically provided in the *Highlights* section through a rider to the coverage or through an Amendment to this Summary, the following are not covered:

1. Dental Services that are not necessary.

2. Hospitalization or other facility charges.

3. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)

4. Reconstructive Surgery regardless of whether or not the surgery which is incidental to a dental disease, injury, or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body. Coverage is allowed for congenitally missing teeth.

5. Any Dental Procedure not directly associated with dental disease.

6. Any Dental Procedure not performed in a dental setting.

7. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is

considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

8. Any implant procedures performed which are not listed as Covered implant procedures in *Highlights*.

9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.

10. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.

11. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.

12. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.

13. Replacement of complete dentures, and fixed and removable partial dentures or crowns, and implants, implant crowns, implant prosthesis and implant supporting structures (such as connectors), if damage or breakage was directly related to Dental error. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.

14. Fixed or removable prosthodontic restoration procedures or implant services for complete oral rehabilitation or reconstruction.

15. Services other than those listed in *Highlights* for diagnosis and treatment of temporomandibular joint disorders (TMD).

16. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours' notice.

17. Expenses for dental procedures begun prior to the Covered Person's eligibility with the Plan.

18. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.

19. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.

20. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).

21. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.

22. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.

23. Services rendered by a Dentist with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.

24. Dental Services otherwise Covered, but rendered after the date individual Coverage under the Plan terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Plan terminates.

25. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.

26. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the coverage.

27. In the event that a non-Network Dentist routinely waives Coinsurance and/or the Deductible for a particular Dental Service, the Dental Service for which the Coinsurance and/or Deductible are waived is reduced by the amount waived by the non-Network Dentist.

28. Foreign Services are not Covered unless required as an Emergency.

29. Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

CLAIMS PROCEDURES

Network Benefits

In general, if you receive Covered Dental Services from a Network Dentist, the Dentist will be paid directly. If a Network Dentist bills you for any Covered Health Service other than your Coinsurance, please contact the Dentist or call the phone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the annual deductible and paying any Coinsurance owed to a Network Dentist at the time of service, or when you receive a bill from the Dentist.

Non-Network Benefits

If you receive a bill for Covered Dental Services from a non-Network Dentist, you (or the Dentist if they prefer) must submit the bill for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to the address on your ID card.

If Your Dentist Does Not File Your Claim

You can obtain a claim form by visiting **www.myuhc.com**, calling the toll-free number on your ID card. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- your name and address;
- the patient's name, age and relationship to the Retiree;
- the number as shown on your ID card;
- the name, address and tax identification number of the Dentist of the service(s);
- a diagnosis from the Dentist;
- the date of service;
- an itemized bill from the Dentist that includes:
  - the American Dental Association (ADA) codes;
  - a description of, and the charge for, each service;
  - the date the sickness or injury began; and
  - a statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

After your claim has been processed, you will receive payment for Benefits that the coverage allows. It is your responsibility to pay the non-Network Dentist the charges you incurred, including any difference between what you were billed and what the coverage paid.

Non-Network Benefits will be paid to you unless:

- the Dentist provides notice that you have signed an authorization to assign Benefits directly to that Dentist; or
- you make a written request for the non-Network Dentist to be paid directly at the time you submit your claim.

Benefits will only be paid to you or, with written authorization by you, to your Dentist, and not to a third party, even if your Dentist has assigned Benefits to that third party.

Explanation of Benefits (EOB)

You may receive an Explanation of Benefits (EOB) after your claim is processed. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. You can also view and print all of your EOBs online at **www.myuhc.com**.

Important
All claim forms must be submitted within 12 months after the date of service. Otherwise, the coverage will not pay any Benefits for that Eligible Expense, or Benefits will be reduced. This 12-month requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your ID card before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If a claim for Benefits is denied in part or in whole, you may call the number on your ID card before requesting a formal appeal. If the issue cannot be resolved to your satisfaction over the phone, you have the right to file a formal appeal as described below.

- the patient's name and ID number as shown on the ID card;
- the Dentist's name;
- the date of dental service;
- the reason you disagree with the denial; and
- any documentation or other written information to support your request.

You or your enrolled Dependent may send a written request for an appeal to:

UnitedHealthcare Appeals
P.O. Box 30569
Salt Lake City, UT 84130-0569

Review of an Appeal

A full and fair review of your appeal will be conducted. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination; and
- a health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if the denial is upheld, you will receive a written explanation of the reasons and facts relating to the denial.

Types of claims
The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- urgent care;
- pre-service; or
- post-service claim.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent Care - a claim for Benefits provided in connection with Emergency services;
- Pre-Service - a claim for Benefits filed before non-Urgent Care is provided; and
- Post-Service - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

The tables below describe the time frames which you and the Claims Administrator are required to follow.

Urgent Care Claims*	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, you must be notified within	**24 hours**
You must then provide completed claim information to UnitedHealthcare within:	**48 hours** after receiving notice of additional information required
If your initial claim is denied, you must be notified of the denial:	
■ if the initial claim is complete, within:	**72 hours**
■ after receiving the completed claim (if the initial claim is incomplete), within:	**48 hours**
You must appeal the claim denial no later than:	**180 days** after receiving the denial benefit determination
You must be notified of the appeal decision within:	**72 hours** after receiving the appeal

*You do not need to submit Urgent Care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an Urgent Care claim.

Pre-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is filed improperly, you must be notified within:	**5 days**
If your claim is incomplete, you must be notified within:	**15 days**
You must then provide completed claim information within:	**45 days** after receiving an extension notice*
If your initial claim is denied, you must be notified of the denial:	
■ if the initial claim is complete, within:	**15 days**
■ after receiving the completed claim (if the initial claim is incomplete), within:	**15 days**
You must appeal the claim denial no later than:	**180 days** after receiving the denial

Pre-Service Claims	
Type of Claim or Appeal	**Timing**
You must be notified of the first level appeal decision within:	**15 days** after receiving the first level appeal

*A one-time extension of no more than 15 days may be required only if more time is needed due to uncontrollable circumstances.

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, you must be notified within:	**30 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days** after receiving an extension notice*
If your initial claim is denied, you must be notified of the denial:	
■ if the initial claim is complete, within:	**30 days**
■ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal the claim denial no later than:	**180 days** after receiving the denial
You must be notified of the first level appeal decision within:	**30 days** after receiving the first level appeal

* A one-time extension of no more than 15 days may be required only if more time is needed due to uncontrollable circumstances.

Limitation of Action

You cannot bring any legal action against the Plan Administrator, Valero Services, Inc. (or applicable affiliates), or the Claims Administrator, or Valero Energy Corporation, the Plan Sponsor, to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against the Plan Administrator, Valero Services, Inc., or the Claims Administrator, or Valero Energy Corporation, the Plan Sponsor, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against the Plan Administrator, Valero Services, Inc., or the Claims Administrator, or Valero Energy Corporation, the Plan Sponsor. See also the section in this handbook titled Plan Information.

You cannot bring any legal action against the Plan Administrator, Valero Services, Inc., or the Claims Administrator, or Valero Energy Corporation, the Plan Sponsor, for any other

reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against the Plan Administrator, Valero Services, Inc., or the Claims Administrator, or Valero Energy Corporation, the Plan Sponsor, you must do so within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against the Plan Administrator, Valero Services, Inc. or the Claims Administrator, or Valero Energy Corporation, the Plan Sponsor.

SUBROGATION AND REIMBURSEMENT

The plan has a right to subrogation and reimbursement. References to "you" or "your" in this section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the plan has paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly responsible. The right to subrogation means that the plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the plan has paid that are related to the Sickness or Injury for which any third party is considered responsible.

Subrogation – Example
Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the plan to treat your injuries. Under subrogation, the plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the plan 100% of any Benefits you receive for that Sickness or Injury. The right of reimbursement shall apply to any Benefits received at any time until the rights are extinguished, resolved or waived in writing.

Reimbursement – Example
Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- The Plan Sponsor in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide Benefits or payments to you, including Benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.

- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
  - Providing any relevant information requested by the plan.
  - Signing and/or delivering such documents as the plan or its agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining the plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

  Your failure to cooperate with the plan is considered a breach of contract. As such, the plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the plan due to you or your representative not cooperating with the plan. If the plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the plan.
- The plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the plan's recovery without the plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

- Regardless of whether you have been fully compensated or made whole, the plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the plan's subrogation and reimbursement rights.
- Benefits paid by the plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the plan alleges some or all of those funds are due and owed to the plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits from the plan, you agree that (i) any amounts recovered by you from any third party shall constitute plan assets to the extent of the amount of plan Benefits provided on behalf of the Covered Person, (ii) you and your representative shall be fiduciaries of the plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the plan to enforce its reimbursement rights.
- The plan's rights to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from the plan, you agree to assign to the plan any Benefits, claims or rights of recovery you have under any automobile policy - including no-fault Benefits, PIP Benefits and/or medical payment Benefits - other coverage or against any third party, to the full extent of the Benefits the plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, you acknowledge and recognize the plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- The plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical Benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible and filing suit in your name or your estate's name, which does not obligate the plan in any way to pay you part of any recovery the plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the plan is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse the plan, without its written approval.
- The plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the plan for 100% of its interest unless the plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If any third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this plan, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the plan pertaining to reimbursement, the plan may terminate Benefits to you and your dependents, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the plan due to your failure to abide by the terms of the plan. If the plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the plan.
- The plan and all Administrators administering the terms and conditions of the plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the plan.

Right of Recovery

The plan also has the right to recover Benefits it has paid on you or your Dependent's behalf that were:

- Made in error.
- Due to a mistake in fact.
- Advanced during the time period of meeting the calendar year Deductible; or

- Advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the plan will:

- Require that the overpayment be returned when requested.
- Reduce a future Benefit payment for you or your Dependent by the amount of the overpayment.

If the plan provides an advancement of Benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The plan has the right to recover Benefits it has advanced by:

- Submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the plan.
- Conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the plan.

WHEN COVERAGE ENDS

For detailed information regarding when plan coverage ends, qualified change events or continuation of coverage, refer to the Plan Administration section of the Valero Retiree Benefits Handbook.

COORDINATION OF BENEFITS

Coordination of Benefits Applicability

This coordination of benefits (COB) provision applies when a person has health or dental coverage under more than one Coverage. "Coverage" is defined below.

The order of benefit determination rules below determine which Coverage will pay as the primary Coverage. The primary Coverage that pays first pays without regard to the possibility that another Coverage may cover some expenses. A secondary Coverage pays after the primary Coverage and may reduce the benefits it pays so that payments from all group Coverages do not exceed 100% of the total allowable expense.

Definitions

For purposes of this Section, Coordination of Benefits, terms are defined as follows:

- "Coverage" is any of the following that provides benefits or services for dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Coverage and there is no COB among those separate contracts.
  - "Coverage" includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); dental benefits under group or individual automobile contracts; and Medicare or other governmental benefits, as permitted by law.
  - "Coverage" does not include: individual or family insurance; closed panel or other individual coverage (except for group-type coverage); school accident type coverage; benefits for non-dental components of group long-term care policies; Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.

  Each contract for coverage under either definition of "Coverage" is a separate Coverage. If Coverage has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Coverage.
- The order of benefit determination rules determine whether this Coverage is "primary Coverage" or "secondary Coverage" when compared to another Coverage covering the person.

  When this Coverage is primary, its benefits are determined before those of any other Coverage and without considering any other Coverage's benefits. When this Coverage is secondary, its benefits are determined after those of another Coverage and may be reduced because of the primary Coverage's benefits.
- "Allowable expense" means a health care service or expense, including deductibles and coinsurance,that is covered at least in part by any of the Coverages covering the person. When Coverage provides benefits in the form of services, (for example a dental HMO) the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the Coverages is not an

allowable expense. The following are examples of expenses or services that are not allowable expenses:

- If a person is covered by two or more Coverages that compute their benefit payments on the basis of Usual and Customary fees, any amount in excess of the highest of the Usual and Customary fees for a specific benefit is not an allowable expense.
- If a person is covered by two or more Coverages that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.
- If a person is covered by one Coverage that calculates its benefits or services on the basis of Usual and Customary fees and another Coverage that provides its benefits or services on the basis of negotiated fees, the primary Coverage's payment arrangements will be the allowable expense for all Coverages.

■ "Claim determination period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under this Coverage, or before the date this COB provision or a similar provision takes effect.

■ "Closed panel Coverage" is Coverage that provides health or dental benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Coverage, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

■ "Custodial parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Order of Benefit Determination Rules

When two or more Coverages pay benefits, the rules for determining the order of payment are as follows:

■ The primary Coverage pays or provides its benefits as if the secondary Coverage or Coverages did not exist.

■ Coverage that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage will be excess to any other parts of the Coverage provided by the contract holder. Examples of these types of situations are major dental coverages that are superimposed over base Coverage hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel Coverage to provide out-of-network benefits.

■ Coverage may consider the benefits paid or provided by another Coverage in determining its benefits only when it is secondary to that other Coverage.

■ The first of the following rules that describes which Coverage pays its benefits before another Coverage is the rule to use.

- **Non-Dependent or Dependent**. The Coverage that covers the person other than as a dependent, for example as an employee, member, Subscriber or retiree is primary and the Coverage that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Coverage covering the person as a dependent; and primary to the Coverage covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Coverages is reversed so that the Coverage covering the person as an employee, member, Subscriber or retiree is secondary and the other Coverage is primary.
- **Child Covered Under More Than One Coverage**. The order of benefits when a child is covered by more than one Coverage is:
  - ♦ The primary Coverage is the Coverage of the parent whose birthday is earlier in the year if:
    - the parents are married;
    - the parents are not separated (whether or not they ever have been married); or
    - a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

    If both parents have the same birthday, the Coverage that covered either of the parents longer is primary.
  - ♦ If the specific terms of a court decree state that one of the parents is responsible for the child's health or dental care expenses or health or dental care coverage and the Coverage of that parent has actual knowledge of those terms, that Coverage is primary. This rule applies to claim determination periods or Coverage years commencing after the Coverage is given notice of the court decree.
  - ♦ If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
    - the Coverage of the custodial parent;
    - the Coverage of the spouse of the custodial parent;
    - the Coverage of the noncustodial parent; and then
    - the Coverage of the spouse of the noncustodial parent.
- **Active or inactive employee**. The Coverage that covers a person as an employee who is neither laid off nor retired is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other Coverage does not have this rule, and if, as a result, the Coverages do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule for "Non-Dependent or Dependent"
- **Continuation coverage**. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Coverage, the Coverage covering the person as an employee, member, Subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is

secondary. If the other Coverage does not have this rule, and if, as a result, the Coverages do not agree on the order of benefits, this rule is ignored.
- **Longer or shorter length of coverage**. The Coverage that covered the person as an employee, member, Subscriber or retiree longer is primary.
- If the preceding rules do not determine the primary Coverage, the allowable expenses will be shared equally between the Coverages meeting the definition of Coverage under this provision. In addition, this Coverage will not pay more than it would have paid had it been primary.

Effect on the Benefits of This Coverage

When this Coverage is secondary, it may reduce its benefits so that the total benefits paid or provided by all Coverages during a claim determination period are not more than 100 percent of total allowable expenses.

When this Coverage is the secondary carrier, this Coverage will only pay the difference between what this Coverage would have paid as primary minus what the other carrier paid.

- If a covered person is enrolled in two or more closed panel Coverages and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel Coverage, COB will not apply between that Coverage and other closed panel Coverages.

Right to Receive and Release Needed Information

Certain facts about health or dental care coverage and services are needed to apply these COB rules and to determine benefits payable under this Coverage and other Coverages. The Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Coverage and other Coverages covering the person claiming benefits.

The Company does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Coverage must give the Claims Administrator any facts it needs to apply those rules and determine benefit payable. If you do not provide the Claims Administrator the information it needs to apply these rules and determine the benefits payable, your claim for benefits will be denied.

Payments Made

A payment made under another Coverage may include an amount that should have been paid under this Coverage. If it does, the Claims Administrator (on behalf of the Plan Administrator) may pay that amount to the organization that made the payment. That amount will then be treated as though it was a benefit paid under this Coverage. The Claims Administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by the Claims Administrator (on behalf of the Plan Administrator) is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it had paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

OTHER IMPORTANT INFORMATION

Qualified Medical Child Support Orders (QMCSOs)

For detailed information regarding qualified medical child support orders, refer to the Plan Administration section of the Valero Retiree Benefits Handbook.

Your Relationship with UnitedHealthcare and Valero

In order to make choices about your dental coverage and treatment, Valero believes that it is important for you to understand how UnitedHealthcare interacts with the Plan Sponsor's benefit and how it may affect you. UnitedHealthcare helps administer the Plan Sponsor's benefit in which you are enrolled. UnitedHealthcare does not provide dental services or make treatment decisions. This means:

- Valero and UnitedHealthcare do not decide what care you need or will receive. You and your Dentist make those decisions;
- UnitedHealthcare communicates to you decisions about whether the benefit will cover or pay for the Dental Services that you may receive (the coverage pays for Covered Dental Services, which are more fully described in this Summary); and
- This coverage may not pay for all treatments you or your Dentist may believe are necessary. If this coverage does not pay, you will be responsible for the cost.

Valero and UnitedHealthcare may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. Valero and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. Valero and UnitedHealthcare will use de-identified data for commercial purposes including research.

Relationship with Dentists

The relationships between Valero, UnitedHealthcare and Network Dentists are solely contractual relationships between independent contractors. Network Dentists are not Valero's agents or employees, nor are they agents or employees of UnitedHealthcare. Valero and any of its employees are not agents or employees of Network Dentists, nor are UnitedHealthcare and any of its employees agents or employees of Network Dentists.

Valero and UnitedHealthcare do not provide dental services or supplies, nor do they practice dentistry. Instead, Valero and UnitedHealthcare arranges for Dentists to participate in a Network and pay Benefits. Network Dentists are independent practitioners who run their own offices and facilities. UnitedHealthcare's credentialing process confirms public information about the Dentists' licenses and other credentials, but does not assure the quality of the services provided. They are not Valero's employees nor are they employees of UnitedHealthcare. Valero and UnitedHealthcare do not have any other relationship with Network Dentists such as principal-agent or joint venture. Valero and UnitedHealthcare are not liable for any act or omission of any Dentist.

UnitedHealthcare is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this coverage.

Valero and the Plan Administrator are solely responsible for:

- enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage);
- the timely payment of Benefits; and
- notifying you of the termination or modifications to the coverage.

Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and Valero is that of employer and retiree, dependent or other classification as defined in the Valero Retiree Benefits Handbook.

Your Relationship with Dentists

The relationship between you and any Dentist is that of Dentist and patient. Your Dentist is solely responsible for the quality of the services provided to you. You:

- are responsible for choosing your own Dentist;
- are responsible for paying, directly to your Dentist, any amount identified as a member responsibility, including Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses;
- are responsible for paying, directly to your Dentist, the cost of any non-Covered Dental Service;
- must decide if any Dentist treating you is right for you (this includes Network Dentists you choose and Dentists to whom you have been referred); and
- must decide with your Dentist what care you should receive.

Interpretation of Benefits

Valero and UnitedHealthcare have the sole and exclusive discretion to:

- interpret Benefits under the coverage;
- interpret the other terms, conditions, limitations and exclusions of the coverage, including this Summary and any riders and/or Amendments; and
- make factual determinations related to the coverage and its Benefits.

Valero and UnitedHealthcare may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of this coverage.

In certain circumstances, for purposes of overall cost savings or efficiency, Valero may, in its discretion, offer Benefits for services that would otherwise not be Covered Dental Services.

The fact that Valero does so in any particular case shall not in any way be deemed to require Valero to do so in other similar cases.

Information and Records

Valero and UnitedHealthcare may use your individually identifiable health information to administer the coverage and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. Valero and UnitedHealthcare may request additional information from you to decide your claim for Benefits. Valero and UnitedHealthcare will keep this information confidential. Valero and UnitedHealthcare may also use your de-identified data for commercial purposes, including research, as permitted by law.

By accepting Benefits under the coverage, you authorize and direct any person or institution that has provided services to you to furnish Valero and UnitedHealthcare with all information or copies of records relating to the services provided to you. Valero and UnitedHealthcare have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Retiree's enrollment form. Valero and UnitedHealthcare agree that such information and records will be considered confidential.

Valero and UnitedHealthcare have the right to release any and all records concerning dental services which are necessary to implement and administer the terms of this coverage, for appropriate dental review or quality assessment, or as Valero is required to do by law or regulation. During and after the term of this coverage, Valero and UnitedHealthcare and its related entities may use and transfer the information gathered under this coverage in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your records or billing statements Valero recommends that you contact your Dentist. Dentists may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request dental forms or records from UnitedHealthcare, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, Valero and UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as does the Plan Administrator.

Incentives to Dentists

Network Dentists may be provided financial incentives by UnitedHealthcare to promote the delivery of dental care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to dental care.

Examples of financial incentives for Network Dentists are:

- bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness; or
- a practice called capitation which is when a group of Network Dentists receives a monthly payment from UnitedHealthcare for each Covered Person who selects a Network Dentist within the group to perform or coordinate certain dental services. The Network Dentists receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's dental care is less than or more than the payment.

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your Network Dentist is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network Dentist.

Incentives to You

Sometimes you may be offered coupons or other incentives that may impact your benefits to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but Valero recommends that you discuss participation with your Dentist. You may call the number on the back of your ID card if you have any questions.

Workers' Compensation Not Affected

Benefits provided under this coverage do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Future of the Plan

For detailed information regarding amendment and termination, refer to the section of the handbook titled Plan Information.

Plan Document

Refer to the Introduction section of the Valero Retiree Benefits Handbook.

GLOSSARY

This Section defines the terms used throughout this Summary and is not intended to describe Covered or uncovered services.

Amendment – any attached description of additional or alternative provisions to the coverage. Amendments are subject to all conditions, limitations and exclusions of the coverage except for those which are specifically amended.

Annual Deductible – the amount a Covered Person must pay for Dental Services in a plan year before the coverage will begin paying for Network and Non-Network Benefits in that plan year.

Annual Maximum Benefit – the maximum amount paid for Covered Dental Services during a calendar year for a Covered Person under any Plan offered by Valero. The Maximum Benefit is stated in *Highlights*.

Claims Administrator – UnitedHealthcare (also known as United Healthcare Services, Inc.) and its affiliates, who provide certain claim administration services for the coverage.

Coinsurance – the percentage of Eligible Expenses you are required to pay for certain Covered Dental Services as described in *How the Coverage Works*.

Company – Valero

Congenital Anomaly – a physical developmental defect that is present at birth and identified within the first twelve months from birth.

Coverage or **Covered** – the entitlement by a Covered Person to reimbursement for expenses incurred for Dental Services covered under the benefit, subject to the terms, conditions, limitations and exclusions of the coverage. Dental Services must be provided: (1) when the coverage is in effect; and (2) prior to the date that any of the individual termination conditions as stated in the Section entitled Termination of Coverage occur; and (3) only when the recipient is a Covered Person and meets all eligibility requirements specified in the Plan.

Covered Person – either the Retiree or an Enrolled Dependent while Coverage of such person is in effect. References to "you" and "your" throughout this Summary are references to a Covered Person.

Deductible – see Annual Deductible.

Dental Service or Dental Procedures – dental care or treatment provided by a Dentist to a Covered Person while the coverage is in effect, provided such care or treatment is recognized by the Plan Administrator as a generally accepted form of care or treatment according to prevailing standards of dental practice.

Dentist – any dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render dental services, perform dental surgery or administer anesthetics for dental surgery.

Eligible Expenses – Eligible Expenses for Covered Dental Services, incurred while the coverage is in effect, are determined as stated below:

- For Network Benefits, when Covered Dental Services are received from Network Dentists, Eligible Expenses are UnitedHealthcare's contracted fee(s) for the Dental Service with that Dentist.
- For Non-Network Benefits, when Covered Dental Services are received from non-Network Dentist, Eligible Expenses are the Usual and Customary fees as defined below.

Eligible Expenses must not exceed the fees that the Dentist would charge any similarly situated payor for the same services. In the event that a Dentist routinely waives Coinsurance and/or the Annual Deductible for Benefits, Dental Services for which the Coinsurance and/or the Annual Deductible are waived are not considered to be Eligible Expenses.

Emergency – a dental condition or symptom resulting from dental disease which arises suddenly and, in the judgment of a reasonable person, requires immediate care and treatment, and such treatment is sought or received within 24 hours of onset.

Experimental, Investigational or Unproven Services – medical, dental, surgical, diagnostic, or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time UnitedHealthcare makes a determination regarding coverage in a particular case, are determined to be:

- not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or
- subject to review and approval by any institutional review board for the proposed use; or
- the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
- not demonstrated through prevailing peer-reviewed professional literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

Foreign Services – are defined as services provided outside the U.S. and U.S. territories.

Lifetime Maximum Benefit – the maximum amount paid for Network and Non-Network Benefits during the entire period of time that the Covered Person is Covered under the benefit or any Plan, offered by Valero. The Lifetime Maximum Benefit is stated in the *Highlights* section.

Medicare – Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Necessary – Dental Services and supplies which are determined to be appropriate, and

- necessary to meet the basic dental needs of the Covered Person; and
- rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service; and
- consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by UnitedHealthcare; and
- consistent with the diagnosis of the condition; and
- required for reasons other than the convenience of the Covered Person or his or her Dentist; and
- demonstrated through prevailing peer-reviewed dental literature to be either:
  - safe and effective for treating or diagnosing the condition or sickness for which their use is proposed, or,
  - safe with promising efficacy
    - for treating a life threatening dental disease or condition,
    - in a clinically controlled research setting; and
    - using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

    (For the purpose of this definition, the term "life threatening" is used to describe a dental disease, sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dentist has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined in this Summary. The definition of Necessary used in this Summary relates only to Coverage and differs from the way in which a Dentist engaged in the practice of dentistry may define necessary.

Network – a group of Dentists who are subject to a participation agreement to provide Dental Services to Covered Persons. The participation status of Dentists will change from time to time.

Network Benefits – benefits available for Covered Dental Services when provided by a Dentist who is a Network Dentist.

Non-Network Benefits – coverage available for Dental Services obtained from Non-Network Dentists.

Procedure in Progress – all treatment for Covered Services that results from a recommendation and an exam by a Dentist. A treatment procedure will be considered to start on the date it is initiated and will end when the treatment is completed.

Usual and Customary – Usual and Customary fees are calculated based on available data resources of competitive fees in that geographic area.

Usual and Customary fees must not exceed the fees that the Dentist would charge any similarly situated payor for the same services. In the event that a Dentist routinely waives Coinsurance and/or the Annual Deductible for benefits, Dental Services for which the Coinsurance and/or the Annual Deductible are waived are not considered to be Usual and Customary.

Usual and Customary fees are determined solely in accordance with reimbursement policy guidelines. The reimbursement policy guidelines are developed following evaluation and validation of all Dentist billings in accordance with one or more of the following methodologies:

- as indicated in the most recent edition of the Current Dental Terminology (publication of the American Dental Association);
- as reported by generally recognized professionals or publications;
- as utilized for Medicare;
- as determined by dental staff and outside dental consultants; or
- pursuant to other appropriate source or determination.

IMPORTANT ADMINISTRATIVE INFORMATION: ERISA

For information regarding ERISA, refer to the Plan Information section of the Valero Retiree Benefits Handbook.