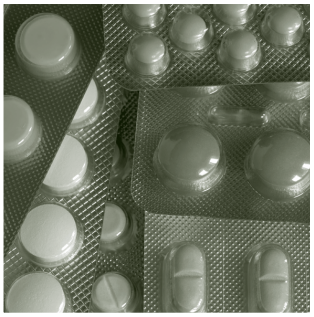
Employee Benefits

Resource Guide
2017



Lubrizol

The Notice of Creditable Coverage required by the Centers for Medicare and Medicaid Services for participants in Lubrizol's prescription program who are eligible for Medicare Part D is contained on page 31 of this Benefits Resource Guide. Please share this Notice with your Medicare-eligible family members who participate in Lubrizol's prescription drug program.

The part of this Benefits Resource Guide under the caption "Employees' Profit Sharing and Savings Plan" constitutes part of a prospectus covering securities that have been registered under the Securities Act of 1933.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website:http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since January 31, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

This page left blank intentionally

THE EMPLOYEE BENEFITS RESOURCE GUIDE INDEX

This page left blank intentionally

General Information Section

Table of Contents

Introduction

This Employee Benefits Resource Guide includes summary plan descriptions (SPDs) of the dental and vision benefit programs and descriptions of certain other benefit programs and practices sponsored by The Lubrizol Corporation. Please read this guide carefully to best understand the benefits available to you. The Employee Benefits Resource Guide is a helpful and ready reference to assist you in meeting and handling personal and family needs. As always, your local human resource representatives are available to answer any questions you may have about your benefits.

If you are a member of a Lubrizol medical program, you will receive your SPD from UnitedHealthcare, the administrator of the Lubrizol medical programs. This resource guide will provide you with general information about your medical program.

General Information

This section contains information that pertains to plans in the Lubrizol benefits program. Your rights under the Employee Retirement Income Security Act of 1974 (ERISA) and specific plan identification information are found on the following pages. The terms of each of the plans and practices described in this guide apply only to eligible employees of Lubrizol and its subsidiaries and affiliates that are covered under these plans or practices on or after January 1, 2017 unless otherwise provided.

Nothing in this guide or in the terms of any benefit plan or practice is intended or should be construed as a guarantee or contract of employment.

The administrator has the sole right and discretion to determine entitlement for benefits under each benefit plan and practice. Although Lubrizol expects to maintain each benefit plan as a permanent program, the company reserves the right to amend and/or terminate any plan or practice at any time.

Your Rights Under ERISA

The following information is included in this guide to comply with federal laws and regulations governing benefit plans. As a participant in the Lubrizol benefits program, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to the following:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and in your human resources office, 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 Pension and Welfare Benefit Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The plan administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.
- Obtain a statement telling you whether you have a right to receive a pension under The Lubrizol Corporation Pension Plan at normal retirement age (age 65), and if so, what your benefits would be at normal retirement age if you stop working under the Pension Plan now. If you do not have a right to a pension, this statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. The Pension Plan must provide the statement free of charge.

Continue Group Health Plan Coverage

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

You may reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive it within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $147 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

Assistance with Your Questions

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

The Lubrizol Benefits Program Plan Identification Information
Information That Applies to All Plans

Plan Sponsor, Plan Administrator and Agent for service of legal process:

The Lubrizol Corporation, 29400 Lakeland Blvd, Wickliffe, Ohio 44092
440-943-4200

Service of legal process may also be made upon the Trustee (the trustees for the plans are identified under "Specific Identification of Each Plan") or the day-to-day Plan Administrator.

Day-to-Day Plan Administrator:

Employee Benefits Administrative Committee, c/o Human Resources Director-Employee Benefits,
The Lubrizol Corporation, 29400 Lakeland Blvd, Wickliffe, Ohio 44092
440-943-4200

Plan Sponsor Employer Identification Number:

34–0367600

Specific Identification of Each Plan

The Lubrizol Corporation Employee Benefits Plan

Employers	The Lubrizol Corporation, Lubrizol Advanced Materials, Inc., Lipotec USA, Inc., Chemtool Incorporated, Lubrizol Specialty Products, Inc., LSP Transport LLC., Lubrizol Oilfield Chemistry LLC., Vesta Funding, Inc., Extrumed, Inc., SSP-SiMatrix, Inc., Particle Sciences, Inc., and P Chem, Inc.
Plan Number	506
Plan Fiscal Year	January 1 to December 31
Type of Administration	Self-Insured and Insurance Contract
Type of Plan	Group welfare plan, providing coverage for hospitalization and certain other medical services, prescription drug, dental services, vision services and health care and dependent care flexible spending accounts

The Lubrizol Corporation Long Term Disability Plan

Employers	The Lubrizol Corporation, Lubrizol Advanced Materials, Inc., Lipotec USA, Inc., Chemtool Incorporated, Lubrizol Specialty Products, Inc., LSP Transport LLC., Lubrizol Oilfield Chemistry LLC., Vesta Funding, Inc., Extrumed, Inc., SSP-SiMatrix, Inc., Particle Sciences, Inc., and P Chem, Inc.
Plan Number	501
Plan Fiscal Year	January 1 to December 31
Type of Administration	Self-Insured
Type of Plan	Group welfare plan, providing certain income-replacement benefits during periods of extended disability

The Lubrizol Corporation Group Life Insurance Plan

Employers	The Lubrizol Corporation, Lubrizol Advanced Materials, Inc., Lipotec USA, Inc., Chemtool Incorporated, Lubrizol Specialty Products, Inc., LSP Transport LLC., Integrity Delaware LLC., Lubrizol Oilfield Chemistry LLC., Vesta Funding, Inc., Extrumed, Inc., SSP-SiMatrix, Inc., Particle Sciences, Inc., and P Chem, Inc.
Plan Number	501
Plan Fiscal Year	August 1 to July 31
Type of Administration	Insurance Contract
Type of Plan	Group welfare plan, providing death and certain accidental injury benefits
Insurer	Aetna Life Insurance Company

The Lubrizol Corporation Business Travel and Accident Plan

Employers	The Lubrizol Corporation, Lubrizol Advanced Materials, Inc., Lipotec USA, Inc., Chemtool Incorporated, Lubrizol Specialty Products, Inc., LSP Transport LLC., Lubrizol Oilfield Chemistry LLC., Vesta Funding, Inc., Extrumed, Inc., SSP-SiMatrix, Inc., and Particle Sciences, Inc., and P Chem, Inc.
Plan Number	503
Plan Fiscal Year	October 1 to September 30
Type of Administration	Insurance Contract
Type of Plan	Group welfare plan, providing benefits for accidental injury or death which occurs while traveling on company business
Insurer	CHUBB

The Lubrizol Corporation Pension Plan

Employers	The Lubrizol Corporation, Lubrizol Advanced Materials, Inc., Lipotec USA, Inc. (only as to certain transferred employee participants)
Plan Number	001
Plan Fiscal Year	January 1 to December 31
Type of Plan	Defined benefit pension plan, providing retirement benefits based on a percentage of earnings
Plan Trustee	KeyBank National Association, 127 Public Square, Cleveland, OH 44101-4717

The Lubrizol Corporation Employees' Profit Sharing and Savings Plan

Employers	The Lubrizol Corporation, Lubrizol Advanced Materials, Inc., Lipotec USA, Inc., Chemtool Incorporated, Lubrizol Specialty Products, Inc., LSP Transport LLC., Lubrizol Oilfield Chemistry LLC., Vesta Funding, Inc., Extrumed, Inc., SSP-SiMatrix, Inc., Particle Sciences, Inc., and P Chem, Inc.
Plan Number	003
Plan Fiscal Year	January 1 to December 31
Type of Plan	Defined contribution pension plan, providing retirement benefits from contributions made from company profits ("profit sharing portion"), employee contributions and company matching contributions ("401(k) portion")
Plan Trustee	Voya Institutional Trust Company, One Orange Way, Windsor, CT 06095-4774

The Lubrizol Corporation Age-Weighted Defined Contribution Plan

Employers	The Lubrizol Corporation, Lubrizol Advanced Materials, Inc. Lipotec USA, Inc., Lubrizol Specialty Products, Inc., LSP Transport LLC.,Vesta Funding, Inc., Extrumed, Inc., SSP-SiMatrix, Inc., Chemtool Incorporated, and Particle Sciences, Inc.
Plan Number	005
Plan Fiscal Year	January 1 to December 31
Type of Plan	Defined contribution pension plan, providing retirement benefits from company contributions
Plan Trustee	Voya Institutional Trust Company, One Orange Way, Windsor, CT 06095-4774

Exclusions from Coverage for All Plans

Unless otherwise specifically included, the following persons are excluded from coverage under the plans and programs described in the Benefits Resource Guide.

- Temporary employees
- Intern – A university student
- Co-op – A recurring university student such as a student involved in a university sponsored work/study curriculum in chemical and mechanical engineering. Commonly, students alternate one semester in a work assignment and one semester in the classroom.
- Vo-ed – A non-university student
- Persons who render services solely as an independent contractor
- Persons who render services as workers through an agreement with a third party
- Directors
- Persons covered by a collective bargaining agreement unless the agreement specifically provides for coverage.

The Lubrizol Corporation Employee Benefits Plan

Table of Contents

General Information

This summary plan description (SPD) describes the major features of The Lubrizol Corporation Employee Benefits Plan for dental care, vision care, Flexible Spending Accounts (FSAs) and vacation buy and sell program. It includes important details about eligibility, covered expenses, and limitations and exclusions, as well as requirements that you must satisfy to obtain the greatest possible benefit. Read the entire SPD carefully to understand the benefits available under the plan. If there are any conflicts between this SPD and the plan document, the formal plan document will govern.

There is also a brief description of the Lubrizol EPO, Lubrizol OOA and the Lubrizol CDHP, but please refer to your UnitedHealthcare SPD for plan details. If you enroll in the Lubrizol EPO, Lubrizol OOA or Lubrizol CDHP you will receive an SPD directly from UnitedHealthcare.The covered employee and your employer share the cost of benefits under this plan. Employee and company contributions are used for the sole purpose of providing benefits under the plan in accordance with its terms.

Federal law provides you with certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). A summary of these rights, along with specific information identifying each benefit in the Lubrizol benefits program, is included in the "General" section of the Employee Resource Guide.

The plan may be amended by written action of the Board of Directors or its designee to add or limit future benefits and/or to change deductible or coinsurance amounts, to require employee contributions, or to change the level of employee contributions at any time and from time to time. The plan may also be terminated at any time by written action of the Board of Directors. Neither this SPD nor the Programs described herein, constitute a contract of employment or a promise of continuing employment.

Who is Eligible

As a regular employee of Lubrizol or of its participating subsidiaries or affiliates who works at least an average of 20 hours per week over a biweekly period, you and your dependents are eligible for coverage under this plan.

A regular employee includes the following:

- an employee on an employer approved long term disability leave of absence, salary continuation leave of absence, personal leave of absence; military leave of absence; or family and medical leave of absence;
- an employee who is participating in the phased-in retirement program;
- an employee of a foreign affiliate of Lubrizol who is on an employer-approved temporary U.S. assignment which has been scheduled to last for more than three months;

A regular employee does not include the following:

- any person employed solely to work during the summer or as a seasonal employee (meaning that his customary period of annual employment is six months or less);
- any person who renders service to Lubrizol or its participating subsidiaries solely as a director;
- any person who renders service solely as an independent contractor or as a temporary worker who provides services through an agreement with a third party regardless of whether any governmental entity determines that such independent contractor or temporary worker should be classified as a common law employee of Lubrizol or of its participating subsidiaries or a joint employee of Lubrizol or of its participating subsidiaries and a third party;
- any person who is classified by Lubrizol or its participating subsidiaries as a temporary worker;
- any person employed in connection with a cooperative educational program with any college, university, or other post-secondary school who is not reasonably anticipated to work at least an average of 20 hours per week over a bi-weekly period during his periods of active employment (see next paragraph);
- any person employed as a vo-educational student employee; and
- any person employed or providing services to Lubrizol or its participating subsidiaries in any other employee category which the Plan determines is not a regular employee category.

If you are employed in connection with a cooperative educational program with any college, university, or other post-secondary school or as a student intern, and you are reasonably anticipated to work at least an average of 20 hours per week over a bi-weekly period during your periods of active employment, you are eligible to participate in the Plan, even though you are not a regular employee.

Under Affordable Care Act rules, you may also be eligible to participate in the Plan if you are a regular employee who is not reasonably anticipated to work an average of 20 hours or more per week or have variable hours, but you actually work an average of at least 30 hours per week during an applicable "measurement period." If so, you will be eligible to participate in the Plan for the next "stability period." The terms "measurement period" and "stability period," and how eligibility is determined, are explained below.

For ongoing employees, there is a standard measurement period for which the employee's actual hours worked will be tracked. The standard measurement period is the 12-month period starting on October 15 and ending on the following October 14. The stability period – the period during which an employee may be eligible for medical and prescription coverage, depending upon hours worked during the measurement period – is January 1 through December 31.

> *Illustration:* Your normal weekly work schedule is 15 hours. During the standard measurement period starting October 15, 2016 and ending October 14, 2017, you actually work an average of 30.5 hours per week. Because you worked an average of at least 30 hours per week during the standard measurement period, you will be eligible to participate in the medical and prescription coverage portions of the Plan for the next stability period, which starts on January 1, 2018 and ends on December 31, 2018.

For newly hired and rehired employees, an initial measurement period will also apply. The initial measurement period is the 12-month period starting with the employee's date of hire or rehire. The stability period that corresponds to the initial measurement period is the 12-month period starting the first day of the full month following the initial measurement period.

> *Illustration:* You are hired as a regular employee on June 1, 2017, with a normal work schedule of 15 hours per week. Your *initial* measurement period will run from June 1, 2017 to May 31, 2018. The related stability period will start June 1, 2018, and end May 31, 2019.

A newly hired or rehired employee's first *standard* measurement period will start on the first October 15 of his or her employment or reemployment, and will end on the following October 14.

> *Illustration:* You are hired as a regular employee on June 1, 2017, with a normal work schedule of 15 hours per week. Your first *standard* measurement period will run from October 15, 2017 through October 14, 2018.

This means that, at certain times during the employee's first year of employment or reemployment, the initial and the first standard measurement periods will overlap.

> *Illustration:* You are hired as a regular employee on June 1, 2017, with a normal work schedule of 15 hours per week. Your *initial* measurement period will run from June 1, 2017 to May 31, 2018. Your first *standard* measurement period will run from October 15, 2017 through October 14, 2018. Therefore, from October 15, 2017 to May 31, 2018, your initial measurement period and your first standard measurement period will overlap.

The following illustration explains how eligibility to participate in the medical and prescription coverage portions of the Plan for a new or rehired employee is determined by looking at hours worked during the initial measurement period and standard measurement periods.

Illustration: You are a new employee hired June 1, 2017 and scheduled to work 15 hours per week. However, you actually worked an average of 30.5 hours per week during your *initial* measurement period, which ran from June 1, 2017 to May 31, 2018. Therefore, you will be eligible to participate in the Lubrizol CDHP for the stability period starting June 1, 2018 and ending June 30, 2019.

After June 30, 2019, your continued eligibility for medical coverage portions of the plan for the rest of 2018 will depend upon whether you actually worked an average of at least 30 hours per week during your first *standard* measurement period (October 15, 2017 through October 14, 2018). If your weekly hours during that standard measurement period averaged at least 30 hours, you will be eligible to participate in the medical and prescription coverage portions of the plan for the related stability period (January 1, 2019 through December 31, 2019). This means that you may continue to participate in the plan after June 30, 2019 for the remainder of 2019. However, if your average weekly hours during the standard measurement period fell short of 30 hours, your eligibility for medical and prescription coverage under the plan will end on June 30, 2019.

The next time your eligibility to participate in the medical portion of the plan will be considered is for the stability period that runs from January 1, 2020 through December 31, 2020. In other words, you will be treated in the same way as other ongoing employees who are regular employees who are not reasonably expected to work an average of 20 hours per week over a biweekly period. Your eligibility for medical and prescription coverage for the stability period starting January 1, 2020 will depend on whether your average weekly hours for the immediately preceding standard measurement period (October 15, 2018 through October 14, 2019) equaled or exceeded 30 hours. A similar analysis will apply for all subsequent standard measurement periods and related stability periods.

An employee may not be enrolled as both an employee and a dependent in this plan or a Lubrizol affiliate plan. No child of an employee may be covered as a dependent of more than one employee. Non-resident aliens are not eligible to participate in a health care and/or dependent care account.

Dependents Include:

- your lawful spouse;your domestic partner (your same-sex or opposite-sex partner, age 18 or older, with whom you have been cohabitating in a mutual, exclusive long-term relationship for a period of at least 12 months, who is not related by blood to you, and who is competent to enter into a contract. For your partner to be considered your domestic partner, you and your partner must be financially interdependent and have resided together for at least 12 months at an address that both of you treat as your principal residence. Your partner will not be considered to be your domestic partner if at any time within the past 12 months either you or your partner have been legally married to another person; have had a registered domestic partnership or civil union with another person; or have maintained, on a full or part time basis, a separate household (other than a vacation property or a temporary residence established solely due to job relocation or temporary work assignment);
- the following children under the age of 26: your natural or legally adopted child, a child lawfully placed with you for legal adoption, your foster child, your stepchild or your domestic partner's child; or
- any other unmarried child for whom you are the sole, legal guardian or sole legal custodian/conservator, or for whom you are legally responsible to provide health care coverage, or for whom you with your spouse or domestic partner, if applicable, are the sole legal guardian or sole legal custodian/conservator, or for whom you, with the child's natural parents, are a joint legal guardian or joint legal custodian and who lives with you in a normal parent-child relationship, and both of the following:
    - the child is a tax dependent for whom you claim as an exemption on your income tax return or for whom you are legally responsible to provide health care under a Qualified Medical Child Support Order (QMCSO) or other court or administrative order; and
    - the child is under the age of 26 unless the child has a disability (as defined under the plan) in existence at the time the child would otherwise have ceased to qualify for coverage under the plan. Documentation may be required.

In order to enroll a dependent, you may be required to submit proof or certification of dependency. Failure to timely provide the required proof or certification of dependency may result in loss of eligibility and disenrollment of the dependent until such proof or certification is provided to the Plan. A dependent who loses eligibility and is disenrolled due solely to your failure to provide timely proof or certification of dependency will be enrolled upon the plan's receipt of the required documentation. Coverage will commence the first day of the month following the receipt of the required proof.

Note: Your dependents may not enroll in coverage unless you are also enrolled. If you and your spouse or domestic partner are both covered under Lubrizol medical coverage, you may each be enrolled as an employee or be covered as a dependent of the other person, but not both. In addition, if you and your spouse or domestic partner are both covered under Lubrizol coverage, only one parent may enroll your child(ren) as a dependent(s).

Cost of Coverage

In most cases, you and your employer share in the cost of coverage. Your contribution amount depends on the coverage level you select and the family members you choose to enroll.

Your contributions are deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld—and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.
If you go on an unpaid leave of absence, you may continue coverage under your elected benefits by pre-paying the premiums or paying them when you return. If you are on leave beyond the end of the year, however, you will have to pay the premiums for that year by the end of the year. If you do not pay your premiums that are due your coverage will be terminated, and you will not be able to enroll during any subsequent annual enrollment during your unpaid leave of absence.

Note: The Internal Revenue Service generally does not consider domestic partners and their children eligible dependents for tax purposes. Therefore, the value of your employer's cost in covering a domestic partner may be imputed to the employee as income. In addition, the share of the employee's contribution that covers a domestic partner and the domestic partner's children may be paid using after-tax payroll deductions.

Your contributions are subject to review and The Lubrizol Corporation reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by calling the Lubrizol Benefits Center at at 1-844-747-1641 or by going to http://benefits.lubrizol.com.

How to Enroll

To enroll, go online to http://Lubrizol.BenefitsNow.com, or call the Lubrizol Benefits Center at 1-844-747-1641, within 30 days of the date you first become eligible for coverage. If you do not enroll within 30 days, you will need to wait until the next annual enrollment to make your benefit elections.

New Hires

Medical, prescription drug, vision and dental care coverage is available for you and your qualified dependents. Coverage will be effective on your employment date.

If you enroll more than 30 days after your employment date, your coverage will be effective on January 1 of the next year. If you wish to participate in a health care and/or dependent care spending account under the plan, you must enroll and agree to contribute the amount you elect. Coverage under a health care or dependent care account will become effective on your employment date when you complete the enrollment process within the first 30 days of employment. Thereafter, you have the opportunity to enroll during the Annual Enrollment period for participation starting on the January 1 of the next calendar year. If you are rehired within 30 days of your termination, you will default to your prior elections and may make changes during Annual Enrollment.

Note: New hires are not eligible to participate in the Vacation Buy/Sell Program and may elect the Vacation Buy/Sell option during annual enrollment.

Annual Enrollments

In years in which a complete enrollment is not required, if you do not submit a new election during annual enrollment, you will continue the same medical, prescription, dental care and vision care benefits elections as you had during the previous year, provided those options are available. However, if you wish to participate in a health care and/or dependent care flexible reimbursement account, health savings account (employee deductions) or the vacation buy and sell program, you must make an election each year.

The company may require a complete enrollment in all applicable benefit options. When that occurs, it will be communicated and that communication will identify the different default enrollment options that may be used if you fail to enroll.

Change in Enrollment

Because your medical/prescription, dental care benefit premiums, vision benefit premiums and contributions to your health care and dependent care accounts are paid on a pre-tax basis, special rules limit you from changing your enrollment elections during the plan year unless you have had one of the qualifying changes in family or employment status during the year. A qualifying change is any one of the following:

- change in your marital or domestic partner status
- change in number of your dependents
- gain or loss of employment by you or your dependents
- increase or decrease in hours worked by you or your dependents
- your dependent becomes, or ceases to be, eligible for coverage
- change of your place of residence or work to a location not serviced by your coverage
- unpaid military leave (in addition, contributions will be waived)

Changes to your medical/prescription, dental and/or vision care elections due to these reasons can only be made if you or your dependents lose or gain eligibility for those benefits. The change must correspond to that gain or loss of coverage. You may not reduce your salary contributions to a Health Care Account if your covered expenses already incurred by you and your dependents, and reimbursed by the plan, would exceed your salary contributions for the plan year under the changed election. Any change to your dependent care account elections due to these reasons must correspond to a change that affects your dependent care expenses.

During the plan year, you may also change your elections to correspond to one of the following:

- a court order
- you or your dependent's entitlement to Medicare or Medicaid
- you take a leave of absence protected by the Family and Medical Leave Act
- you or your dependent lose other coverage (for a reason other than you stop paying premiums) including termination and other COBRA coverage
- for medical/prescription, dental and vision care coverage, a significant premium cost change upon going from full-time to part-time or part-time to full-time status
- for dependent care account, a significant change in the cost of dependent care imposed by the dependent care provider (other than your relative)
- there is a change under an employer plan that has a different period of coverage than the pan's period of coverage (e.g., your spouse's employer's plan has a plan year that starts June 1, and you would like to change your current election because of the election your spouse will make under the spouse's employer's plan)

Election changes become effective on the event date if you notify the Lubrizol Benefits Center (at 1-844-747-1641) within 30 days of the event (60 days in case of a birth). If notification is given more than 30 days after the event (60 days in the case of a birth), but within the same plan year, the change is effective the first day of the month following notification.

Special Enrollments

1. You may enroll yourself or you and your dependents within 30 days of acquiring a new dependent (60 days for a newborn). Coverage will begin on the date the dependent first becomes eligible for coverage (e.g., date of birth or marriage).
2. You may also enroll yourself and/or your dependent(s) for coverage within 30 days of the loss of other coverage unless the loss is due to failure to pay premiums or for cause. Satisfactory proof of the loss of other coverage must be provided. Coverage will be effective on the date of the loss of other coverage.
3. If you transfer to another work location, which results in a change in the medical and/or dental plan(s) to which you are eligible, you may enroll yourself and your dependents within 30 days of the transfer. Coverage will begin on the date of transfer.
4. If you or your dependents become ineligible for Medicaid or CHIP and lose coverage or if you or your dependents become eligible for a state's premium assistance program, you have 60 days from the event to request enrollment in your employer's plan. If you enroll within the 60 days, you or your dependents will be covered under Lubrizol's plan retroactive to the date of the triggering event. If these special circumstances apply to you, please contact your local benefit representative for further assistance.

If you or your dependents do not enroll within the time limits described above, you will be able to enroll for coverage in the same plan year of eligibility effective on the first day of the month following enrollment. You should promptly notify the Lubrizol Benefits Center, 1-844-747-1641 or visit http://Lubrizol.BenefitsNow.com for any change that may affect your coverage or the coverage of a dependent, such as:

- marriage
- adoption of a child
- transfer to another location
- dependent becomes eligible
- loss of domestic partner eligibility
- birth of a child
- death of dependent
- legal separation
- dependent ceases to be eligible

When Coverage Ends

Your medical, prescription, dental and vision coverage, and health care and dependent care flexible reimbursement account participation will end at the earliest of the following events:

1. The end of the month in which your employment terminates or when you retire.
2. Coverage is discontinued under the group plan.
3. You are no longer eligible for coverage under this plan.
4. The end of the month in which you voluntarily waive coverage, or fail to make payment of any required premium.
5. You or your dependent(s) are found to have committed an act, practice, or omission that constitutes fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to eligibility or status of a dependent.

You or your dependent commits an act of physical or verbal abuse that imposes a threat to a Lubrizol employee or the Plan Administrator.Ceasing active work is considered to be immediate termination of employment. If you are absent from active work because of sickness, injury, temporary layoff, or leave of absence, employment will be considered to continue for the purposes of the coverage for the duration of the leave.

An employee who pays premiums on an after-tax basis whose coverage is terminated due to failure to make payments of any required premiums may not re-enroll for the terminated coverage during any subsequent annual enrollment after which he would continue to pay premiums on an after-tax basis until past due premiums are paid.

A dependent's coverage will terminate at the earliest of the following dates:

1. Upon discontinuance of all dependents' coverage under the group plan.
2. The end of the month in which such person ceases to meet the definition of a dependent for purposes of coverage under the plan.
3. Upon the dependent's death.
4. The end of the month in which your employment terminates or when you retire.
5. If you stop making any required contribution for dependent coverage, at the end of the period for which contribution was last made.
6. Upon your spouse's or domestic partner's commencement of active duty in any military service of any country.
7. Your dependent is found to have committed an act, practice, or omission that constitutes fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to eligibility or status of a dependent.
8. Your dependent commits an act of physical or verbal abuse that imposes a threat to a Lubrizol employee or the Plan Administrator.

Coverage for your disabled child will not be terminated because the child reaches the maximum age for a dependent child as long as you provide satisfactory proof that the child continues to be incapacitated and meets the other criteria for covered children. Coverage may terminate for other reasons. See *Who Is Eligible* section for additional information.

Under certain circumstances, you or your dependents may be eligible to purchase continued coverage under the plan when one of these events occurs. See the sections titled *Continuation of Coverage* and *Temporary Extended Coverage*.

Conversion of the coverage to an individual policy is not available.

Continuation of Coverage

Retirement

When you retire from Lubrizol or a participating subsidiary, at or after age 55, with at least 15 years of service with the company, you may elect retiree healthcare coverage under this plan for yourself and your eligible dependents, provided you make the necessary contributions and are not eligible for Medicare. For Lubrizol acquisitions, the 15 years is generally counted from the date of acquisition by Lubrizol unless the purchase agreement provides for the original acquisition date of hire. Employees from the following acquisitions have their years of service based on the employee's date of hire at the acquisition: Amerchol, Avecia, Alox, Noveon, Phillips 66, Scher, Sentinel, and Thermoplastics Dow. For Lubrizol Advanced Materials, Inc. (LZAM) employees, this includes both Goodrich and Noveon/LZAM service.

If on January 1, 1995, you were a Lubrizol employee and were age 40 or over, you may be eligible for retiree healthcare coverage upon retirement at or after age 55 with at least five years of service provided you make the necessary contribution. No person may be covered under both this plan and another plan which provides health, dental, and vision benefits and which is maintained by your employer or an affiliate. No person may be covered as both a retiree and dependent, or as a dependent of more than one employee or retiree.

Employees covered by a collective bargaining agreement are eligible for this retiree healthcare coverage only if their collective bargaining agreement specifically provides for this coverage.

For any employee who is rehired, your total years of service for purposes of retiree healthcare coverage eligibility will be the same as your reinstated years of vesting service under The Lubrizol Corporation Pension Plan, The Lubrizol Age-Weighted Defined Contribution Plan or The Lubrizol Corporation Wage Employees' Pension Plan.

Effect of Total Disability

If you are totally disabled and on Long-Term Disability leave (LTD), benefits for you and your family will continue to be available while you qualify for LTD benefits, remain on disability leave, and continue your contributions.

Death of Covered Employee

If you die while you are employed at a Lubrizol location or a subsidiary or affiliate your surviving spouse may elect COBRA coverage and receive the first 12 months of COBRA continuation coverage with the premium waived.

Temporary Extended Coverage (COBRA)

Certain employment status changes and other events can result in a loss of coverage. If such coverage is lost, only expenses incurred prior to the termination date are eligible for reimbursement. However, under certain circumstances, you and/or your eligible dependents may be entitled to purchase temporary medical, prescription, dental, and vision coverage in which you or your covered dependents are enrolled for the time period shown below. In addition, if you are enrolled in a Health Care Reimbursement Account, you may elect to continue that coverage for the remainder of the calendar year.

Contributions for dependents who elect COBRA coverage are made on an after tax basis through the COBRA billing center at Conexis. If you leave the company (other than on account of your gross misconduct) and lose coverage, or if your hours are reduced and your premium is increased because of the reduction of hours, you and/or your dependents will be eligible to purchase extended medical, prescription, dental, and/or vision care coverage for up to 18 months. If either you or your dependent(s) were determined under Title II or XVI of the Social Security Act to have been disabled within 60 days from the time you left the company, you and your dependents will be eligible to purchase medical, prescription, EAP, dental and/or vision care coverage for up to an additional 11 months (total 29 months), so long as you or your dependent provides the company with notice of the determination within 60 days of the determination but prior to the end of the original 18 months. If you leave the company (other than on account of your gross misconduct) within 18 months after you become entitled to Medicare and lose coverage, your dependents will be eligible to purchase medical, prescription, dental, EAP and/or vision care coverage for up to 36 months from the date you became entitled to Medicare. If your dependent is no longer eligible for coverage under this plan because of divorce, your death, or ceasing to be a dependent child under the terms of the plan, the dependent may purchase medical, prescription, and/or dental care benefit coverage for up to 36 months. A dependent also may purchase coverage for the balance of the 36 month period if coverage was extended on account of the death of the employee (as previously described) and the coverage under that extension is subsequently lost.

Eligible employees or dependents are called "qualified beneficiaries" below. Circumstances that entitle a qualified beneficiary to extended coverage are called "qualifying events."

Notification and Election Requirements

Employees and their dependents are responsible for notifying the appropriate parties within 60 days of the end of the month after a divorce or legal separation, the termination of a domestic partnership, or when a child ceases to be eligible under the terms of the plan. Lubrizol will notify a qualified beneficiary of the right to continue coverage within 44 days of the employee's termination of employment or death, or a dependent child's 26th birthday.

Detailed information can be found on the Life Events quick link on the benefits website (http://benefits.lubrizol.com). Within 14 days of notification or loss of coverage, whichever is later, Lubrizol will notify all qualified beneficiaries of the right to continue medical, prescription drug, dental and/or vision care benefit coverage under the plan. Any notification to the spouse of an employee will be treated as notification to all other qualified beneficiaries residing with the spouse.

You and/or your dependent(s) must elect temporary extended coverage on a form provided by the Benefits Center within the period that begins on the later of the date coverage would otherwise terminate or the date notice of continuation rights has been mailed to the qualified beneficiary, and ends 60 days thereafter.

Length of Temporary Extended Coverage

In the case of termination of employment, coverage of the "qualified beneficiaries" may be continued for up to 18 months (29 months in certain cases of disability). For all other qualifying events, coverage for dependents may be continued for up to 36 months.

Coverage will stop before the end of the maximum period if any of the following occur:

1. Failure to pay premiums for coverage within 30 days of the date due.
2. The start of health, dental, or vision coverage for the qualified beneficiary under any other group plan that does not have a pre-existing condition clause that would affect the qualified beneficiary.
3. The qualified beneficiary's entitlement to Medicare benefits.
4. The termination of benefits under The Lubrizol Corporation Employee Benefits Plan.

Cost of Temporary Extended Coverage

The coverage offered is identical to the coverage available to employees. The premium charge is 102% of the total cost of the coverage (150% after the 18th month of COBRA continuation of coverage when a disability arises after COBRA began).

How to File a Claim

In most cases, your claims will be filed automatically when you use network providers for medical, prescription drugs, dental, and/or vision. If you need to file a claim, claim forms, complete with instructions, are available on the Forms page of the Benefits website (benefits.lubrizol.com). To facilitate claim payment, be certain all forms are completed properly and claims are filed promptly with the appropriate claims payer. Claims must be received no later than shown below (unless your legal incapacity prevented you from filing the claim):

Medical – Within one year after the date of medical treatment
Prescription – Within one year after the date of prescription was dispensed
Dental – Within one year after the date of the dental treatment
Vision – Within one year after the date of the vision treatment

How Benefits are Paid

By submitting acceptable proof of payment, you may have benefits reimbursed directly to you. Benefits may instead be paid directly to the provider of services (physician, dentist, hospital, lab, etc.), who will then bill you for any remaining balance due to deductibles, coinsurance, etc.

Subrogation Rights of the Plan

Subrogation applies when the plan has paid benefits on your behalf for a sickness or injury for which a third party is alleged to be responsible. The right to subrogation means that the plan is substituted to and will succeed to any and all legal claims that you may be entitled to pursue against any third party for benefits that the plan has paid that are related to the sickness or injury for which a third party is alleged to be 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 a third party causes or is alleged to have caused 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 received for that Sickness or Injury.

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 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 (this list is not exclusive):

- 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;
- your employer (for example, workers' compensation cases);
- 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; and
- 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; and
    - 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 a 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, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, 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, "Attorney's Fund Doctrine," "Common Fund Doctrine," "Fund Doctrine,""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 shall hold those funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the benefits the plan has paid.
- The plan's rights to recovery will not be reduced due to your own negligence.
- Upon the plan's request, you will assign to the plan all rights of recovery against third parties, to the extent of benefits the plan has paid for the sickness or injury.
- The plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party and filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits paid on your behalf out of any settlement, judgment or other recovery from any third party considered responsible; and filing suit in your 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 the plan's written approval.
- The plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated in this SPD or the plan.
- In the case of your 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.
- 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 a 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 a third party causes or is alleged to have caused you to suffer a sickness or injury while you are covered under the plan, the provisions of this section continue to apply, even after you are no longer covered.
- 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 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, or
- reduce a future benefit payment for you or your dependent by the amount of the overpayment.

If the overpayment is due from someone other than you, you must help the plan recover the amount of the overpayment if the plan asks you to do so.

If the plan provides an advancement of benefits to you or your dependent during the time period of 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; and
- conducting courtesy calls to you or a covered dependent to discuss any outstanding balance owed to the plan.

Failure to Cooperate

If you (or your dependents) are covered by another plan or you (or your dependents) incur a claim for which this plan may have subrogation rights, the claim will not be paid until you provide the appropriate information.

If this plan has already paid the claim despite the fact that you did not provide the appropriate information, or if the plan pays a claim in error or in excess of the correct amount and you do not reimburse the plan the difference, your (or your dependents') future claims may be offset by the amount of the claim paid in error until you provide the information or reimburse the plan.

If you ultimately fail to provide the appropriate information or reimburse the plan for claims paid in error, you and your dependents will permanently lose coverage under the plan.

Lawsuits Against the Plan

Before bringing any lawsuit seeking benefits under the plan, you must complete the applicable claims procedure under the component benefit program to which the claim relates (and comply with all applicable deadlines established as part thereof). Failure to properly exhaust the claims procedure will extinguish your right to file a lawsuit with respect to the claim.

Except as provided in the next paragraph, any lawsuit seeking benefits must be brought within the shorter of (i) one year from the date of the final appeal denial (or the final denial by an Independent Review Organization, if applicable) or (ii) three years from the date of the services giving rise to the claim. All claims other than claims for benefits (such as claims for penalties, equitable relief, interference with protected rights, or production of documents; claims arising under state law; claims against nonfiduciaries; and claims for breach of fiduciary duty that are not governed by Section 413 of ERISA) must be brought within one year of the act or omission giving rise to the claim.

Any lawsuit brought against Blue Cross Blue Shield of Michigan or CIGNA International must be brought within the time period indicated by the terms of that insurer's insurance policy or applicable law. However, the time periods described above will apply to any claims that are asserted against Lubrizol (including in its capacity as administrator); any officer of Lubrizol or any affiliate of Lubrizol; or any employee, director, committee, or member of Lubrizol or any affiliate of Lubrizol.

Lawsuits against the plan must be brought in the District Court for the Southern District of Texas. If that court lacks jurisdiction, then the suit must be brought in the District Court for the Northern District of Ohio, or if that court lacks jurisdiction, the lawsuit may be brought in any federal or state court that does have jurisdiction.

Notice Regarding Privacy of Protected Health Information

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

Federal regulations under the Health Insurance Portability and Accountability Act (HIPAA) require that the pplan provide you with this Notice Regarding Privacy of Protected Health Information. This notice describes (1) how the plan may use and disclose your protected health information, (2) your rights to access and control your protected health information and (3) the plan's duties and contact information.

Protected Health Information

"Protected health information" is health information created or received by the plan that contains information that may be used to identify you, such as your name or address. It includes written or verbal health information that relates to your past, present or future physical or mental health; the provision of health care to you; and your past, present or future payment for health care.

The Use and Disclosure of Protected Health Information in Payment and Health Care Operations

Your protected health information may be used and disclosed by the plan in the course of providing payment for treatment and conducting medical, prescription, vision and dental claims operations. Any disclosures may be made in writing, electronically, by facsimile, or orally. The plan may also use or disclose your protected health information in other circumstances if you authorize the use or disclosure, or if state law or the HIPAA privacy regulations authorize the use or disclosure.

Treatment. The plan may use or disclose your protected health information in connection with your treatment, which includes the provision, coordination or management of health care and related services. For example, the plan may disclose information to a treating specialist the name of your regular doctor so that the specialist may request the transfer of your test results from your doctor.

Payment. The plan may use or disclose your protected health information to provide payment to you or your health care providers for services rendered to you by your health care providers. These uses or disclosures may include disclosures to your health care provider or to another group health care plan or insurer to obtain the information needed to process your claim for benefits.

Operations. The plan may use or disclose your protected health information when needed for the plan's medical, prescription, and dental claims operations for the purposes of management and administration of the plan. For example, the plan may use your information for claims operations including: utilization management; disease management program activities; administration of the plan's subrogation provisions; coordination of benefits; claims management; reviewing provider performance and plan performance; activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits; conducting or arranging for medical review, legal services, actuarial services and auditing functions, including fraud and abuse detection and compliance programs; business planning and development; systems maintenance; and management activities.

Other Uses and Disclosures. The plan may also use or disclose your protected health information to provide appointment reminders; to describe or recommend treatment alternatives or to provide information about other health-related benefits and services that may be of interest to you.

The plan may use or disclose protected health information for underwriting purposes as permitted by law, but the plan cannot use or disclose your genetic information for that purpose. Underwriting purposes include eligibility rules or determinations, including eligibility for enrollment or continued enrollment and for benefits under the plan; calculating premium or contribution amounts under the plan; applying pre-existing condition exclusions, if any; or activities related to creating, renewing or replacing any health insurance contract or health benefits. The plan may also disclose protected health information to The Lubrizol Corporation, the sponsor of the plan. Any disclosure to The Lubrizol Corporation will be in accordance with the HIPAA privacy regulations.

Additional Uses and Disclosures Permitted without Authorization or an Opportunity to Object

In addition to payment and health care operations, the plan may use or disclose your protected health information without your permission or authorization in certain circumstances, including:

When Legally Required. The plan will comply with any federal, state or local law that requires it to disclose your protected health information.

For Judicial and Administrative Proceedings. The plan may disclose your protected health information for any judicial or administrative proceeding if the disclosure is expressly authorized by an order of a court or administrative tribunal as expressly authorized by the order or a signed authorization is provided.

For Workers' Compensation. The plan may disclose your protected health information to comply with workers' compensation laws or similar Programs.

Uses and Disclosures Permitted with an Opportunity to Object

Subject to your objection, the plan may disclose your protected health information to a family member or close personal friend if the disclosure is directly relevant to the person's involvement in your care or payment related to your care. The plan will inform you orally or in writing of these uses and disclosures of your protected health information as well as provide you with an opportunity to object in advance. Your agreement or objection to the uses and disclosures can be oral or in writing. If you do not respond to these disclosures, the plan is able to infer from the circumstances that you do not object, or the plan determines that it is in your best interests for the plan to disclose information that is directly relevant to the person's involvement with your care, then the plan may disclose your protected health information. If you are incapacitated or in an emergency situation, the plan may determine if the disclosure is in your best interests and, if that determination is made, may only disclose information directly relevant to your health care.

Uses and Disclosures Authorized by You

Other than the circumstances described above, the plan will not disclose your health information unless you provide written authorization. In particular the plan will not, without your authorization, use or disclose your health information that consists of psychotherapy notes, except to defend itself in a legal action or other proceeding brought by you or as otherwise permitted by law. The plan must also obtain your authorization to use or disclose your information for most marketing purposes or to sell your information. You may revoke your authorization in writing at any time except to the extent that the plan has taken action in reliance upon the authorization.

Your Rights

You have certain rights regarding your protected health information under the HIPAA privacy regulations.

These rights include:

The right to inspect and copy your protected health information. For as long as the plan holds your protected health information, you may inspect and obtain a copy of the information included in a designated record set. A "designated record set" contains enrollment, payment, claims adjudication and case or medical management records systems maintained by or for the plan, as well as any other records the plan uses to make decisions regarding health care benefits provided to you. The plan may deny your request to inspect or copy your protected health information if the plan determines that the access requested is likely to endanger your life or safety or that of another person, or that it is likely to cause substantial harm to another person referred to in the information. You have the right to request a review of this decision.

In addition, you may not inspect or copy certain records by law, including:
(1) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and
(2) protected health information that is subject to a law that prohibits access to protected health information.

You have the right to have a decision to deny access reviewed in some situations. You must submit a written request to the plan's Privacy Officer to inspect and copy your health information. The plan may charge you a fee for the costs of copying, mailing, or other costs incurred by the plan in complying with your request. Please contact the Privacy Officer at the number given at the end of this notice if you have any questions about access to your medical information.

The right to request a restriction on uses and disclosures of your protected health information. You may request that the plan not use or disclose specific sections of your protected health information for the purposes of payment or health care operations. Additionally, you may request that the plan not disclose your health information to family members or friends who may be involved in your care or for notification purposes described in this notice. In your request, you must specify the scope of restriction requested as well as the individuals for whom you want the restriction to apply. Your request should be directed to the Privacy Officer. The plan may choose to deny your request for a restriction, in which case the plan will notify you of its decision.

Once the plan agrees to the requested restriction, the plan may not violate that restriction unless use or disclosure of the relevant information is needed to provide emergency treatment. The plan may terminate the agreement to a restriction in some cases.

The right to request to receive confidential communications from the plan by alternative means or at an alternative location. You have the right to request to receive communications of protected health information from the plan through alternative means or at an alternative location if you clearly state that the disclosure of all or part of that information could endanger you. The plan will make every effort to comply with reasonable requests. However, the plan may condition its compliance by asking you for information regarding the procurement of payment or specific information regarding an alternative address or other method of contact.

You are not required to provide an explanation for your request. Requests should be made in writing to the Privacy Officer.

The right to request an amendment of your protected health information. During the time that the plan holds your protected health information, you may request an amendment of your information in a designated record set. The plan may deny your request in some instances. However, should the plan deny your request for amendment, you have the right to file a statement of disagreement with the plan. In turn, the plan may develop a rebuttal to your statement. If it does so, the plan will provide you with a copy of the rebuttal. Requests for amendment must be submitted in writing to the Privacy Officer. Your written request must supply a reason to support the requested amendments.

The right to request an accounting of certain disclosures. You have the right to request an accounting of the plan's disclosures of your protected health information made for the purposes other than payment or health care operations as described in this notice. The plan is not required to account for disclosures (1) you requested, (2) you authorized by signing an authorization form, (3) to friends or family members involved in your care and (4) certain other disclosures the plan is permitted to make without your authorization. The request for an accounting must be made in writing to the Privacy Officer and should state the time period that you wish the accounting to include, up to a six year period. The plan is not required to provide an accounting for disclosures that took place prior to April 14, 2003. The plan will not charge you for the first accounting you request in any 12-month period. Subsequent accountings may require a fee based on the plan's reasonable costs for compliance of the request.

The right to receive a paper copy of this notice. The plan will provide a separate paper copy of this notice upon request even if you have already been given a copy of it or have agreed to review it electronically.

The Plan's Duties

The plan is required by law to ensure the privacy of your protected health information, to provide you with this notice of your rights and the plan's legal duties and privacy practices, and to notify you in the event of a breach of your unsecured protected health information. The plan must abide by the terms of this notice, as may be amended periodically. The plan reserves the right to change the terms of this notice and to make the new notice provisions effective for all protected health information that the plan collects and maintains. If the plan alters its notice, the plan will provide a copy of the revised notice through regular mail or in person.

Complaints

If you believe that your privacy rights have been violated, you have the right to relay complaints to the plan and to the Secretary of the Department of Health and Human Services. You may provide complaints to the plan verbally or in writing. These complaints should be directed to the Privacy Officer. The planencourages you to relay any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Contact Person

The Plan's contact person regarding the plan's duties and your rights under the HIPAA privacy regulations is the Privacy Officer. The Privacy Officer can provide information regarding issues related to this notice by request. Complaints to the plan should be directed to the Privacy Officer at the following address:

HIPAA Privacy Officer
The Lubrizol Corporation
29400 Lakeland Boulevard – 491A
Wickliffe, OH 44092

The Privacy Officer can be contacted by telephone at 440-347-5151.

The Lubrizol OOA

The Lubrizol Out-of-Area (OOA) option is administered by UnitedHealthcare and is available to a small number of employees who live in areas where network coverage is not extensive. You may receive care from any provider, but you will receive a higher benefit if you use a provider that is part of the network.

Please review the UnitedHealthcare Summary Plan Description (SPD) for details on the Lubrizol OOA.

Network Providers

To locate a provider in the UnitedHealthcare network, visit www.myuhc.com and click on "Find Physician, Laboratory or Facility" link. Choose the "UnitedHealthcare Options PPO" from the list of available networks. If you have questions please contact UnitedHealthcare's customer service at **1-877-706-1735**. You can also call HealthAdvocate at **1-866-799-2731** for help finding in-network doctors, hospitals and other facilities.

Behavioral Health and Substance Abuse Coverage

Behavioral health and substance abuse coverage is included in the Lubrizol OOA. Services received for behavioral health or substance abuse are subject to the applicable deductibles, coinsurance or copays as designated by the Lubrizol OOA.

Prescription Drug Coverage

Prescription drug coverage is included in your medical coverage and is administered by CVS Caremark. A prescription drug SPD is included in your medical SPD mailed to your home.

If you or your dependents have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 31 for more details.

Enrollment

The availability of the Lubrizol OOA to a participating employee shall be in accordance with the plan's eligibility rules. The company reserves the right to add new OOAs or discontinue coverage with existing OOAs at any time.

Newborns' and Mothers' Health

Group health plans and health insurance issuers may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal alw generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights

If you have had or are going to have a mastectomy and are enrolled in plan coverage, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: $500 / $1,000 / $1,500 and 10% coinsurance. If you would like more information on WHCRA benefits, call UnitedHealthcare at **1-877-706-1735.**

The Lubrizol EPO

The Lubrizol Exclusive Provider Organization (EPO) provides coverage for services received in the Lubrizol EPO network. No referrals are required and you are not required to designate a primary care physician. In order to receive benefits under the Lubrizol EPO you must use the UnitedHealthcare network of physicians and facilities.

Please review the UnitedHealthcare Summary Plan Description (SPD) for details on the Lubrizol EPO.

Network Providers

To locate network providers visit www.myuhc.com, click on "Find Physician, Laboratory or Facility" link and choose the "UnitedHealthcare Choice" network. If you have questions please contact UnitedHealthcare's customer service at **1-877-706-1735**. You can also call HealthAdvocate at **1-866-799-2731** for help finding in-network doctors, hospitals and other facilities.

Behavioral Health and Substance Abuse Coverage

Behavioral health and substance abuse coverage is included in the Lubrizol EPO. Services received for behavioral health or substance abuse are subject to the applicable deductibles, coinsurance or copays as designated by the Lubrizol EPO.

Prescription Drug Coverage

Prescription drug coverage is included in your medical coverage and is administered by CVS Caremark. A prescription drug SPD will be included in your medical SPD mailed to your home.

If you or your dependents have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 31 for more details.

Enrollment

The availability of the Lubrizol EPO to a participating employee shall be in accordance with the plan's eligibility rules. The company reserves the right to add new EPOs or discontinue coverage with existing EPOs at any time.

Newborns' and Mothers' Health

Group health plans and health insurance issuers may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights

If you have had or are going to have a mastectomy and are enrolled in plan coverage, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: $500 / $1,000 / $1,500 and 10% coinsurance (in-network). If you would like more information on WHCRA benefits, call UnitedHealthcare at **1-877-706-1735.**

The Lubrizol CDHP

Administered by UnitedHealthcare, the Lubrizol Consumer Driven Health Plan (CDHP) offers the protection of a medical plan plus a tax-free health savings account (HSA) that helps you pay for your current and future out-of-pocket medical expenses. Lubrizol puts money in the account each year and you can also add your own savings through bi-weekly pre-tax contributions or post-tax lump sum contributions. The account grows with interest, rolls over year to year and goes with you if you leave Lubrizol. After you meet the annual deductible, the plan pays a percentage of covered services through either network or non-network providers.

Please review the UnitedHealthcare Summary Plan Description (SPD) for details on the Lubrizol CDHP.

Network Providers

To locate Lubrizol CDHP network providers visit www.myuhc.com, click on "Find Physician, Laboratory or Facility" link and choose the "UnitedHealthcare Choice Plus" network. If you have questions please contact UnitedHealthcare's customer service at **1-877-706-1735**. You can also call HealthAdvocate at **1-866-799-2731** for help finding in-network doctors, hospitals and other facilities.

Behavioral Health and Substance Abuse Coverage

Behavioral health and substance abuse coverage is included in the Lubrizol CDHP. Services received for behavioral health or substance abuse are subject to the applicable deductibles, coinsurance or copays as designated by the Lubrizol CDHP.

Prescription Drug Coverage

Prescription drug coverage is included in your medical coverage and is administered by CVS Caremark. A prescription drug SPD will be included in your medical SPD mailed to your home.

If you or your dependents have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 31 for more details.

Enrollment

The availability of the Lubrizol CDHP to a participating employee shall be in accordance with the plan's eligibility rules. The company reserves the right to add new CDHPs or discontinue coverage with existing CDHPs at any time.

Newborns' and Mothers' Health

Group health plans and health insurance issuers may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights

If you have had or are going to have a mastectomy and are enrolled in plan coverage, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: $2,000 / $3,000 / $4,200 and 10% coinsurance (in-network). If you would like more information on WHCRA benefits, call UnitedHealthcare at **1-877-706-1735.**

Important Notice from The Lubrizol Corporation About Your Prescription Drug Coverage and Medicare

If you or your dependents have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.

If you or your family members are not currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice does not apply to you.

Please read this notice carefully. This notice has information about your current prescription drug coverage with The Lubrizol Corporation and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an EPO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The Lubrizol Corporation has determined that the prescription drug coverage offered by CVS Caremark is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan? You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st. However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan? If you or your dependent(s) decide to join a Medicare drug plan, your Lubrizol prescription drug plan will be affected. For those individuals who enroll in a Medicare Part D plan, coverage under the Lubrizol prescription drug plan will end for the individual and all covered dependents.

See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.)

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with The Lubrizol Corporation and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice or Your Current Prescription Drug Coverage
Contact your local benefits representative for additional information or call the Lubrizol Benefits Center at 1-866-889-7948.

NOTE: You will get this notice each year and if the Lubrizol Prescription Drug Plan has any changes which affect Medicare Part D. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

U.S. Expatriate Coverage

Regular employees who are U.S. expatriates on temporary assignment, and their dependents, have medical and dental coverage under an insurance policy with CIGNA Global. A summary plan description with detailed information about this coverage will be provided to you.

The coverage will last until the employee and all dependents are relocated back to the United States. The expatriate coverage is in accordance with the insurance policy terms and conditions. The company reserves the right to change insurance policies or to discontinue separate medical and dental coverage for expatriates at any time. Specific information about the coverage is provided by CIGNA Global. You may call CIGNA at **302-797-3100** (outside the U.S.) or **1-800-441-2668** (within the U.S. and Canada).

Flexible Spending Accounts

Flexible Spending Accounts Highlights

There are two Flexible Spending Accounts ("FSAs") for eligible employees that allow you to make before-tax contributions from your salary, which can then be used to reimburse yourself for eligible expenses.

The Health Care Account ("HCA") is a type of FSA used for reimbursement of Eligible Health Care Expenses (defined in the Health Care Account section), including certain medical and dental expenses for you, your spouse, your dependent children, and any other dependents as determined by The Lubrizol Corporation and in compliance with the Internal Revenue Code (IRC). If you are enrolled in a high-deductible plan, like the Lubrizol CDHP, you are not eligible for the HCA.

The Dependent Care Account ("DCA") is a type of FSA used for reimbursement of Eligible Dependent Care Expenses (defined in the Dependent Care Account section), such as day care. You can elect to participate in the HCA, the DCA, or both. Each plan year (January 1 through December 31) you can contribute to your HCA and/or DCA, and then, during the plan year, you can receive reimbursement from the appropriate account for Eligible Expenses that are not otherwise reimbursed. Contribution levels are set forth as described under Section, Contributions.

Who is Eligible

As a regular employee of Lubrizol or of its participating subsidiaries or affiliates, who works at least an average of 20 hours per week or is participating in a phased-in retirement program, you and your dependents are eligible for coverage under the Flexible Spending Accounts. These include employees on an employer approved long term disability leave of absence; employees on an employer approved salary continuation leave of absence; employees on an employer approved personal leave of absence; employees on an employer approved military leave of absence; employees on an employer approved family and medical leave of absence; and employees of foreign affiliates of Lubrizol who are on an employer-approved temporary U.S. assignment.

An employee may not be enrolled as both an employee and a dependent in a Flexible Spending Account or a Lubrizol affiliate plan. No child of an employee may be covered as a dependent of more than one employee. Non-resident aliens are not eligible to participate in a health care and/or dependent care account.

When You May Enroll

You may elect to participate in a Flexible Spending Account during your first 30 days of employment or during any subsequent Annual Enrollment period. If timely elected, the Flexible Spending Account will be effective on your date of hire. If you do not elect to participate in a Flexible Spending Account during your first 30 days of employment, you must wait until the next Annual Enrollment period to elect to participate in a Flexible Spending Account, unless you have experienced a qualified change in status. You will need to enroll each year, even if you enrolled in a Flexible Spending Account the year before.

Changing Your Coverage Contributions

You may make coverage changes during the year only if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g., you increase your HCA following your marriage; you increase your DCA following an adoption, etc.). The following are considered family status changes for purposes of the Flexible Spending Accounts:

- your marriage, divorce, legal separation or annulment;
- the birth, adoption, placement for adoption or legal guardianship of a child;
- a change in your spouse's or domestic partner's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan;
- loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis;
- the death of a dependent;
- your dependent child no longer qualifying as an eligible dependent;
- a change in your or your spouse or domestic partner's position or work schedule that impacts eligibility for health coverage;
- you or your eligible dependent who were enrolled in an Exclusive Provider Organization (EPO) no longer live or work in that EPO service area and no other benefit option is available to you or your eligible dependent;
- termination of your or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must contact the Lubrizol Benefits Center within 60 days of termination);
- you or your dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact the Lubrizol Benefits Center within 60 days of determination of subsidy eligibility);

- a court or administrative order;
- If you become entitled to Medicare or Medicaid, you may elect to revoke your HCA coverage. If you lose coverage under Medicare or Medicaid, you may increase your coverage;
- If you take a leave of absence protected by the Family and Medical Leave Act; or
- You may change your DCA coverage if a significant change in the cost of dependent care is imposed by the dependent care provider (other than your relative).

Unless otherwise noted above, if you wish to change your elections, you must contact the Lubrizol Benefits Center at **1-844-747-1641** within 30 days of the change in family status. Otherwise, you will need to wait until the next Annual Enrollment.

While some of these changes in status are similar to qualifying events under COBRA, you or your eligible dependent do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed above. These will also be available to you or your eligible dependent if COBRA is elected.

Changes in contribution amounts made during the plan year are effective the day of your qualifying event, and you will see your per pay deductions as soon as administratively possible.

How to Enroll

To enroll, visit http://Lubrizol.BenefitsNow.com or call the Lubrizol Benefits Center at **1-844-747-1641** within 30 days of the date you first become eligible to participate. If you do not enroll within 30 days, you will need to wait until the next Annual Enrollment period to participate in the FSA.

Contributions

Each year, you must decide on the amount of before-tax dollars you want to contribute to the FSAs. Please note that these accounts are not "funded". Rather, the amount you elect to "contribute" remains in the employer's general assets until claims are reimbursed. You may contribute to the HCA or DCA, or both. However, amounts contributed to one account cannot be used to reimburse expenses under the other account. You should carefully estimate your Eligible Health Care and Dependent Care Expenses, collectively referred to throughout this booklet as "Eligible Expenses"", for the upcoming plan year because consistent with Internal Revenue Service (IRS) regulations, you will forfeit any unused funds remaining in either account after the end of the plan year. You have until March 31 of the next year to request reimbursement for Eligible Expenses incurred during the Plan year.

For the Health Care Account (HCA), the most you can contribute to the HCA in 2017 is $2,550.

For the Dependent Care Account (DCA), the most you can contribute to the DCA in 2017 is $5,000. If you and your spouse/ both elect a DCA, the maximum total annual contribution per couple is $5,000 if you file a joint tax return or $2,500 each if you are married and file taxes separately.

Health Care Account

Eligible Health Care Expenses

To be eligible for reimbursement from your HCA, the health care expenses must be:

- Incurred for medical care, defined in Section 213(d) of the Internal Revenue Code for amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body including prescription medicine and drugs and over-the-counter medicine and drugs prescribed by a health care provider.
- Incurred during the plan year while you are participating in the HCA.

Please note: Any reimbursement you receive through your HCA cannot be reimbursed under any other plancovering health benefits, including a spouse's or dependent's plan.

Below is a partial list of the types of health care expenses eligible for reimbursement from your HCA. Generally, Eligible Health Care Expenses are those for which you could have claimed a tax deduction on an itemized federal income tax return (without regard to any threshold limitation) including any copayment, coinsurance or deductible amounts.

Some guidance regarding what constitutes eligible medical expenses (including additional examples) is provided in IRS Publication 502 which is available from any regional IRS office or the IRS website, www.irs.gov.

Eligible Medical Expenses

- Copayments, coinsurance and deductible amounts;
- Routine physical exams;
- Routine lab and x-rays performed for medical reasons;
- Birth control items prescribed by your doctor;
- Childbirth classes;
- Cardiac rehabilitation classes;
- Drug abuse treatment centers;
- Sterilization unless prohibited by law;
- Other qualified 213(d) medical expenses not covered by the underlying medical plan.

Eligible Vision Expenses

- Routine eye examinations;
- Eye glasses;
- Contact lenses, including all necessary supplies and equipment.

Eligible Hearing Expenses

- Routine hearing examinations;
- Hearing aids and repairs;
- Cost and repair of special telephone equipment for the deaf.

Eligible Dental Expenses

- Copayments, coinsurance and deductible amounts;
- Preventive Care;
- Exams, cleanings, x-rays, root canals and bridges;
- Dentures and fillings.

Eligible Prescription Drugs

- Copayments, coinsurance and deductible amounts;
- Cost for allowable prescription drugs.

Ineligible Expenses

The partial list below includes examples of expenses that are not eligible for reimbursement:

- Expenses incurred for cosmetic surgery or other similar procedures, unless the procedure is necessary to improve deformities directly related to a congenital condition, a personal injury or a disfiguring disease.
- Expenses for custodial care in a nursing home.
- Insurance premiums, including Medicare Part B premiums, long term care premiums, and other payments or contributions for health coverage (such as contributions for coverage under an employer-sponsored group health plan or health maintenance organization (HMO) or other health plan).
- Expenses incurred for general good health (such as vitamins and other dietary supplements, and toothpaste).
- Expenses incurred before the effective date of your account.
- Over the counter non-prescription drugs and medicines incurred for medical care (such as allergy medicines, antacids, cold medicines and pain relievers), unless prescribed by a health care provider.

In addition, as with any other expense reimbursed under an employer-sponsored medical or dental plan, health expenses reimbursed through your HCA cannot be claimed as deductions on your income tax return.

Dependent Care Account

Eligible Dependent Care Expenses

Eligible Dependent Care Expenses that can be reimbursed from your DCA are expenses incurred for household and dependent care services that enable you and (if married) your spouse to be gainfully employed, which generally means working or actively looking for work.

If your spouse has no earned income, you cannot use a DCA unless your spouse is physically or mentally incapable of caring for himself or herself, is looking for work or is a full-time student for at least five months during the Plan year.

To qualify for reimbursement, Dependent Care Expenses cannot exceed your earned income or, if married, the earned income of the lesser earning spouse. Earned income (including any self-employment earnings) is generally the remaining salary after all pre-tax salary reductions have been made. If you are married and your spouse is physically or mentally incapable of caring for himself or herself or is a full-time student, the IRS considers your spouse to have a monthly income of $250 (as adjusted from time to time) if you have one dependent, or $500 (as adjusted from time to time) if you have two or more dependents, for each month that your spouse is incapable of caring for himself or herself or is a full-time student.

Dependent Care Expenses must be incurred for a qualified dependent. Qualified dependents are:

- A dependent under federal tax law who is a child under age 13; or
- A spouse of a participant, if the spouse is physically or mentally incapable of caring for himself or herself and lives with you for more than one-half of such taxable year; or
- A dependent under federal tax law who is physically or mentally incapable of caring for himself or herself; provided that such dependent lives in your home for more than one-half of the year, if you provide over one-half of the individual's support for the taxable calendar year.

Eligible Dependent Care Expenses include, but are not limited to, the following expenses if not otherwise excluded:

- Expenses for care at a day care center and day care transportation that complies with all applicable state and local regulations.
- Expenses for licensed nursery school fees.
- Expenses for care provided by a housekeeper, babysitter or other person in your home who primarily cares for eligible children or an eligible adult dependent.
- Expenses for care provided by a relative who cares for your qualified dependents, so long as that relative is over the age of 19 and is not your dependent under federal tax law.
- Expenses for care for a qualified dependent age 13 or over, including a spouse or adult dependent, who is physically or mentally incapable of caring for himself or herself. If you are claiming reimbursement for care outside your home for such dependent, the dependent must spend at least 8 hours each day in your home.
- Expenses for care at a day camp to which you send your children (under age 13) during school vacations so that you and your spouse, if you are married, can be gainfully employed or attend school full-time.

Health Care Spending Card Debit MasterCard®

You will be provided with a Health Care Spending Card Debit MasterCard® that may be used to pay for certain Eligible Expenses directly from your HCA and/or DCA. The Health Care Spending Card Debit MasterCard® allows for direct payment to qualified locations and providers and can be used at any approved location that accepts MasterCard®. Use of the Health Care Spending Card Debit MasterCard® is voluntary.

Important: You should familiarize yourself with the specific products and services that are eligible for card use. Go to www.myuhc.com to learn how to get the most out of your Health Care Spending Card Debit MasterCard®.

Receiving Your Health Care Spending Card Debit MasterCard®

You will automatically receive two Health Care Spending Card Debit MasterCards®. Read the terms and conditions found on the card insert and sign the back of your card. You may call the customer service number listed on the back of the Health Care Spending Card Debit MasterCard® to order additional cards.

Activating Your Health Care Spending Card Debit MasterCard®

If you choose to activate the Health Care Spending Card Debit MasterCard® you will need to call the toll-free number indicated on the sticker affixed to the card and follow the voice prompts to activate. The card will be ready to use one (1) business day following activation.

If you decide not to activate the Health Care Spending Card Debit MasterCard®, simply destroy and discard both cards. However, you can be reimbursed for Eligible Expenses by completing a paper reimbursement form available from The Lubrizol Corporation or found on www.myuhc.com and as described under Section, Requesting a Reimbursement from Your Flexible Spending Account or for Eligible Health Care Expenses by using the automatic reimbursement (auto-rollover) feature described under the Section, Automatic Reimbursement (Auto-Rollover).

Please note: You will need to wait until your FSA's effective date before attempting to activate your card.

Qualified Locations and Providers

The Health Care Spending Card Debit MasterCard® may be used at any approved provider or merchant with a Point-of-Service (POS) bankcard terminal that accepts MasterCard® or your Health Care Spending Card Debit MasterCard® number can be entered online or on an order form, similar to using a credit card number. You can even use your Health Care Spending Card Debit MasterCard® to pay for a bill you receive in the mail if the merchant or provider accepts MasterCard®. Examples of qualified locations and providers include hospitals, physician and dental offices, vision care providers, retail pharmacy counters, and child and adult day care facilities.

You may choose to use your Health Care Spending Card Debit MasterCard® for eligible over-the-counter items by going to an online pharmacy at Drugstore.com via www.myuhc.com. Additionally, your Health Care Spending Card Debit MasterCard® can be used at participating retailers as described under the Section, Retailers with Inventory Information Approval System (IIAS).

Using the Health Care Spending Card Debit MasterCard®

In order to use the Health Care Spending Card Debit MasterCard®, you will need to enter 'credit' on the POS bankcard terminal just as if you were purchasing an item using a credit card. Each time the card is used for payment, you will sign a receipt. Your FSA and card are regulated by the IRS, therefore you should retain all itemized receipts generated from the Health Care Spending Card Debit MasterCard®, because certain payments must be verified and UnitedHealthcare may request this receipt from you to ensure that payment was made for a qualified health care or dependent care expense. Credit card receipts that do not itemize expenses are not sufficient to verify payment. Amounts paid that cannot be verified may be considered taxable income to you.

Once you swipe the Health Care Spending Card Debit MasterCard® through the POS bankcard terminal, your available benefit balance is verified. The card validates your purchases real-time and automatically debits your FSA account based on the guidelines established by the IRS and your specific FSA design as described under Sections Health Care Account and Dependent Care Account. A claim number is assigned to the transaction.

Eligible Expenses Reimbursed through the Health Care Spending Card Debit MasterCard®

Your card can be used for certain Eligible Dependent Care Expenses and Eligible Health Care Expenses including pharmacy prescriptions and copayments, deductibles and coinsurance at medical physician locations associated with medical, dental, vision at UnitedHealthcare in-network providers. Additionally, your card can be used for out-of-network copayments if your copayment is the same as the in-network copayment. While in-network provider transactions can be used for coinsurance and deductibles the card does not determine patient responsibility or eligible benefits.

Partial Payment Authorization

Partial authorization capability allows you to use your Health Care Spending Card Debit MasterCard® with transaction amounts greater than the funds available in your HCA for a portion of the transaction at providers or merchants that accept partial authorization. For example, if you purchase an item that costs $20 and you only have $10 remaining in your HCA, the HCA balance of $10 will be authorized towards the purchase and you are responsible for paying the remaining balance of $10 with another form of payment. Note: Not all providers or merchants accept partial authorization.

Retailers with Inventory Information Approval System (IIAS)

IRS regulations require that retailers comply with IRS Inventory Information Approval System (IIAS) swipe technology as a method to identify and substantiate Eligible Health Care Expenses, per Section 213(d) of the Internal Revenue Code. The IIAS allows you to use your Health Care Spending Card Debit MasterCard® to pay for 213(d) Eligible Health Care Expenses without having to provide any additional documentation or request reimbursement after a purchase is made, as transactions will be verified at the point of sale and payment will be made right from your HCA. Additionally, IIAS compatibility allows you to use your Health Care Spending Card Debit MasterCard® at participating retailers to pay for both Ineligible Expenses and Eligible Health Care Expenses on the same transaction with Eligible Health Care Expenses being approved via the Health Care Spending Card Debit MasterCard® and remaining Ineligible Expenses may be paid using another form of payment. When you use your card at participating retailers, Eligible Health Care Expenses will be identified and noted on your receipt. You will not have to submit receipts for reimbursement as long as the purchases are made at a participating retailer and you use your Health Care Spending Card Debit MasterCard®. IRS guidelines still require you to save your itemized receipts as part of your tax records. You can see a full list of participating retailers at www.sig-is.org. If you go to a non-participating retailer you can still buy Eligible Health Care Expenses that don't provide itemized sales receipts, however you will need to pay using another form of payment, and then submit receipts for reimbursement as described under the Section, Requesting a Reimbursement from your Flexible Spending Account.

Monthly Health Statements and FSA Yearly Statements

Explanation of Benefits (EOBs) will not be issued for card transactions. Instead, you will receive monthly health statements and a FSA yearly statement which will include your card activity. You will also be able to view card transactions on www.myuhc.com. If you note a discrepancy on the monthly health statement or FSA yearly statement, call the number on the back of your Health Care Spending Card Debit MasterCard® to resolve the issue.

Contacting a Customer Care Professional is easy. Simply call our toll-free number at 1-866-755-2648 available 24 hours a day to:

- Order Additional cards
- Report a lost or stolen card
- Get answers concerning Eligible Expenses or your account balances

Requesting a Reimbursement From Your Flexible Spending Account

If you do not activate your Health Care Spending Card Debit MasterCard® or choose not to use your card, you will need to submit a reimbursement form, called a request for withdrawal, to be reimbursed from your HCA and/or DCA for the Eligible Expenses that have been incurred. A request for withdrawal form is available from The Lubrizol Corporation or can be found on www.myuhc.com. However, if the automatic reimbursement (auto-rollover) feature described below under Automatic Reimbursement (Auto-Rollover) is turned "on" you will not have to submit a reimbursement form for certain HCA expenses.

For reimbursement from your HCA, you must include proof of the expenses incurred. Proof can include a bill, invoice, or an Explanation of Benefits (EOB) from any group medical/dental/vision program under which you are covered. An EOB will be required if the expenses are for services usually covered under group medical, dental and vision programs, for example, charges by surgeons, doctors and hospitals. In such cases, an EOB will verify what your out-of-pocket expenses were after payments under other group medical/dental/vision programs are made.

For reimbursement from your DCA, you must submit proof of the services rendered, such as a bill, receipt, or invoice and Social Security or Tax Identification Number of the care provider. Only expenses which are incurred while you are participating in an FSA may be reimbursed from a Flexible Spending Account. In addition, expenses which are incurred during one plan year cannot be reimbursed from funds contributed to your HCA or DCA during another plan year. An expense is considered incurred when services are provided, not when you are billed or when you pay for care.

You can submit a reimbursement form as often as daily. You will be reimbursed for Eligible Expenses as long as the amount requested from either account is at least $25, except for reimbursement with respect to the last month of the Plan year. Amounts below $25 will be accumulated and processed with future payments. However, if the automatic reimbursement (auto-rollover) feature as described under Section, Automatic Reimbursement (Auto-Rollover) is turned “on” you will not have to submit a reimbursement form for certain HCA expenses. If you have established a HCA, your total annual contribution amount is available immediately. You can request reimbursement for Eligible Expenses up to your annual contribution amount as soon as such Eligible Expenses have been incurred.

If you have established a DCA, only the amounts you have actually contributed to the account are available for reimbursement. If you request reimbursement for more than what you have in your account, you will receive only the amount in your account (if it is at least $25). As additional contributions are made to your account, outstanding reimbursements will be processed automatically. Requests for withdrawal will be accepted and processed through March 31 of the following year for expenses incurred during the Plan year.

In accordance with IRS regulations, you must exhaust other benefit sources from other group health plan coverage before accessing your HCA for reimbursement. In accordance with IRS regulations, amounts contributed to your HCA or DCA during the plan year but remaining in your account at the end of the processing period (March 31 of the following year) cannot be returned to you or used to reimburse expenses incurred in a subsequent plan year. These amounts are forfeited.

Any benefit checks for reimbursements from a Health Care Account or a Dependent Care Account that are not cashed within twelve (12) months from the date of issuance will be cancelled, and the amount underlying the check will be forfeited.

Important: Myuhc.com includes many features such as the options to:

- View Explanation of Benefits (EOB)/Health Statements
- Utilize a savings calculator for FSA
- View your FSA summary page detailing contributions and amount left in your FSA
- View your FSA Claims Summary including claim transaction details

Automatic Reimbursement (Auto-Rollover)

Lubrizol has elected to have Eligible Expenses for medical that are not covered under your UnitedHealthcare administered plans automatically submitted to your HCA for reimbursement. This eliminates extra paperwork and makes it more convenient for you to use your HCA. Automatic Reimbursement (Auto-rollover) is turned "on" at the start of the Plan year. You can turn automatic reimbursement (auto-rollover) of claims "off" or back "on" by going on to www.myuhc.com. All claims must still be verified and UnitedHealthcare may request additional substantiation.

However, if you have coverage administered through another carrier, the automatic reimbursement (auto-rollover) feature does not apply. Further, the automatic reimbursement (auto-rollover) feature does not apply to your domestic partner covered under your employer's group health plan, unless your domestic partner is your federal tax dependent for health coverage purposes, as defined under Section 105(b) of the IRS Code. An FSA withdrawal request must be submitted for any other types of expenses such as dependent care expenses and any health expenses not submitted to your health benefits carrier.

Claims Procedures

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 Health Care Spending Card Debit MasterCard® before requesting a formal appeal. UnitedHealthcare will try to resolve the issue over the phone; however, if you are not satisfied you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied claim, you must submit your appeal in writing within 180 days of receiving the denial. This written communication should include:

- the patient's name and ID number as shown on the ID card;
- the provider's name;
- the date of medical service;
- the reason you think your claim should be paid; and
- any documentation or other written information to support your request.

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

UnitedHealthcare – Appeals
Attn: Appeals
P.O. Box 981512
El Paso, TX 79998-1512

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

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

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

Filing a Second Appeal

Your FSA offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare within 60 days from receipt of the first level appeal. UnitedHealthcare must notify you of the benefit determination within 30 days after receiving the completed appeal.

Note: Upon written request and free of charge, any covered persons may examine documents relevant to their claims and/or appeals and submit opinions and comments. UnitedHealthcare will review all claims in accordance with the rules established by the U.S. Department of Labor (DOL). UnitedHealthcare's decision will be final.

The table below describes the time frames in an easy to read format which you and UnitedHealthcare are required to follow.

Claim Denial and Appeals	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days** after receiving an extension notice*
If UnitedHealthcare denies your initial claim, they must notify you 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
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**90 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

*UnitedHealthcare may require a one-time extension of no more than fifteen (15) days only if more time is needed due to circumstances beyond its control.

When Participation Ends

You will cease to participate in the Flexible Spending Accounts as of the earliest of:

- The date on which the Flexible Spending Account terminates.
- The date your employment with the Company ends.
- The date you cease to be an eligible employee.
- The date you fail to make a required contribution under the terms of the Flexible Spending Account.
- The date you retire, unless the plan is available for retired persons and you are eligible for the plan.

Health Care Account

You may submit a claim for reimbursement of Eligible Expenses which were incurred during the plan year of employment termination, as long as those expenses were incurred prior to the date of your termination and your claim for reimbursement was submitted within 90 days of termination.

The requirements of the Consolidated Omnibus Budget Reconciliation Act ("COBRA") may apply to the Health Care Account. You should call The Lubrizol Corporation to find out whether the HCA is subject to COBRA. If the HCA is subject to COBRA see "Optional Continuation Coverage under your Health Care Account (COBRA)".

Optional Continuation Coverage Under Your Health Care Account (COBRA)

This optional continuation coverage only applies if it has been made available by The Lubrizol Corporation. The Lubrizol Corporation may be required to offer this continuation coverage in certain cases as a result of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). This provision is intended to comply with the law and any pertinent regulations, and its interpretation is governed by them. In no event will UnitedHealthcare be obligated to provide continuation coverage to a participant if The Lubrizol Corporation or its designated plan administrator fails to perform its responsibilities under federal law. These responsibilities include but are not limited to notifying the participant in a timely manner of the right to elect continuation coverage and notifying UnitedHealthcare in a timely manner of the participant's election of continuation coverage.

In general, COBRA continuation coverage must be offered with respect to a participant's HCA if the participant has a positive balance in such account at the time of a qualifying event such as termination of employment (other than by reason of gross misconduct) or reduction in work hours. A "positive balance" for this purpose generally means that the contributions made to the account prior to the qualifying event exceed the eligible claims for reimbursement submitted prior to the qualifying event. If this COBRA continuation coverage is available to a participant who experiences a qualifying event and continuation coverage is elected by the participant, such coverage will cease at the end of the plan year in which the qualifying event occurs and coverage cannot be continued into the next Plan year. premiums for such continuation coverage (i.e., contributions to the account) will be paid by the participant on an after-tax basis unless otherwise permitted by The Lubrizol Corporation on a uniform and consistent basis plus a 2% administrative fee or other cost as permitted by law.

Dependent Care Account

You may submit claims for the Eligible Expenses you have incurred during that plan year before your termination date against what is in your DCA when you leave employment. Any such claims must be submitted on or before March 31 of the Plan year following your termination.

The Essentials Balance Program - EAP and Work/Life

This summary plan description (SPD) describes the major features of The Lubrizol Employee Assistance Program/Work Life program (The Essentials Balance Program). It includes important details about eligibility, covered expenses, and limitations and exclusions. Read the entire SPD carefully to understand the benefits available under the program. If there are any conflicts between this SPD and the plan document, the formal plan document will govern.

Federal law provides you with certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). A summary of these rights, along with specific information identifying each benefit in the Lubrizol benefits program, is included in the "General" section of the Employee Resource Guide.

The plan may be amended by written action of the Board of Directors or its designee to add or limit future benefits and/or to change deductible or coinsurance amounts, to require employee contributions, or to change the level of employee contributions at any time and from time to time. The plan may also be terminated at any time by written action of the Board of Directors. Neither this SPD nor the program described herein, constitute a contract of employment or a promise of continuing employment.

Cost of Coverage
Lubrizol pays 100% of the cost of the program for active employees. There is a cost associated with the program if you choose to elect the plan while on COBRA continuation coverage.

How to Enroll
If you are an active, Lubrizol employee you will not need to enroll in this program. All active employees are eligible for the program regardless if they chose to elect benefits or waive this option.

If you are on COBRA, to be enrolled in the program you must choose this option on your COBRA election worksheet. If you choose not to enroll in the program during your initial election period, you may choose the program during Annual Enrollment.

How the Program Works
The Essentials Balance program is administered by OptumHealth, a subsidiary of UnitedHealthcare.

What can the Program do for Me?
You may be struggling with stress at work, seeking financial or legal advice, or coping with the death of a loved one. Maybe you just want to strengthen your relationships with your family. The Essentials Balance program offers assistance and support for all these concerns and more:

- Depression, anxiety and stress
- Substance abuse
- Relationship problems
- Workplace conflicts
- Parenting and family issues
- Living with chronic conditions
- Child and elder care support

To access the program visit www.liveandworkwell.com or call 1-866-248-4094.

Program Overview
The EAP portion of the Essentials Balance program includes the following:

- Unlimited twenty-four (24) hour toll-free telephone access at 1-866-248-4094,
- Assessment of the Participant's needs during the Participant's initial phone call,
- Telephonic EAP services,
- Up to three (3) sessions per participant per problem per calendar year, and
- Referral to community resources.

Accessing the Program
When a participant calls the Essentials Balance program line (1-866-248-4094) a specialist will ask the participant a few questions to help identify the nature of the participant's problem and the appropriate resources to address it. If the participant needs financial or legal services, the specialist will refer the participant to an expert in that field. If the participant wants to see a clinician, the participant will be matched up with a network clinician who has the appropriate experience to help.

Participants may also access the resources online by visiting www.liveandworkwell.com. This interactive Web site provides participants with access to their benefits and tools to help enhance their work, health and life.

Participants can:

- Check their benefit information and submit an online request for services,
- Search OptumHealth's online directory of clinicians,
- Access information and resources for hundreds of everyday work and life issues in a virtual help center
- Participate in interactive, customizable self-improvement programs.

Covered Services

Telephonic EAP Services

Once a participant is identified as a telephonic EAP candidate, the participant is transferred to a telephonic EAP clinician directly or a telephonic appointment is scheduled with a telephonic EAP clinician. As part of the initial telephonic EAP consultation, the telephonic EAP Clinician and the participant shall discuss the participant's expectations and goals for telephonic EAP, including agreement about follow-up consultations. The telephonic EAP clinician will work with the participant to measure the participant's progress in achieving goals, to identify challenges to progress, to offer motivation, and to support the participant by providing information pertaining to the participant's goals.

Please Note: A participant will not be considered a telephonic EAP candidate if the participant is a danger to self or others (for example, suicidal, homicidal, domestic violence, child abuse), appears to be suffering from a major psychiatric disorder (such as major depression, generalized anxiety disorder, bipolar disorder, schizophrenia, personality disorders), has an active substance abuse issue, currently is involved in psychotherapy, has chronic psychological problems, is seeking marital or family counseling with multiple participants, or is a minor.

Legal and Financial Services

Mediation Services

Mediation services shall provide participants with access to a mediator for one (1) initial, thirty (30)-minute office or telephone consultation per dispute at no charge, to help resolve a dispute when it is determined that mediation would be a good alternative to litigation. Topics may include, but are not limited to, child custody, child support, property disputes, and landlord tenant issues. If additional services are required after the initial consultation, the Participant will be offered ongoing services with the initial mediator at 75% of the mediator's standard charge.

Financial Counseling Referral Services

Financial counseling referral services shall provide participants with access to telephonic consultations with financial counselors, at no charge, on the basis of one (1) consultation for each separate subject matter, with each consultation lasting from thirty (30) to sixty (60) minutes. Local referrals are available for more complex financial planning matters. Topics may include, but are not limited to, financial coaching, debt consolidation and credit counseling, homeowners facing foreclosure, financial planning and tax services.

Legal Counseling Referral Services

- **Services.** Legal Counseling Referral Services shall provide participants with access to an attorney to consult about a legal matter. Each participant shall be entitled to one (1) initial, thirty (30)-minute office or telephone consultation for each separate legal matter at no cost with a network attorney. In the event that a participant wishes to retain a participating attorney after an initial consultation, the participant will be provided with a preferred rate reduction of 25% from the attorney's normal hourly rate. Topics for legal counseling referral services may include, but are not limited to, civil and consumer issues, personal family business issues, real estate matters, criminal matters, IRS matters and estate planning matters.
- **Limitation of Legal Counseling Referral Services.** Legal Counseling Referral Services are not available for a participant seeking a second legal opinion, a third party consultation, medical malpractice or health insurance issue advice, legal action against any governmental or quasi-governmental entity, or assistance with employment law related questions.

Work/Life Services

Child/Parenting Support Services

- **Child/Parenting Referrals.** Child/Parenting Support Services shall provide participants with access to referrals to Childcare Providers, Community Assistance Resources or other Child/Parenting Care Services. Participants are responsible for payment of any services received by a Childcare Provider.
- **Consultation with Participants.** Child/Parenting Support Services may include OptumHealth consultation with the participant about his/her concerns or questions regarding child development or parenting.

Adult/Elder Support Services

- **Adult/Elder Referrals.** Adult/Elder Support Services shall provide Participants with access to referrals to Adult/Elder Care Providers, Community Assistance Resources or other Adult/Elder Support Services. Participants are responsible for payment of any services received by an Adult/Elder Care Provider.
- **Consultation with Participants.** Adult/Elder Support Services may include OptumHealth consultation with the Participant about his/her concerns or questions regarding the care and nurture of an adult/elder dependent.
- **Optional Services.** If the participant has accessed the Adult/Elder Care On-Site Assessment, participant and selected elder dependent will be given the opportunity to purchase the following Adult/Elder Care Services on a fee-for-service basis:
    - Ongoing Monitoring Services - $115 per hour:
        - Routine communication with client to re-assess needs
        - Ongoing, proactive identification of new and future issues and revision of care plan as appropriate
        - Assistance with coordination of medical issues
        - Identification of additional services and products to meet needs
        - Regular communication with family members
    - On-site assessment and care conference. Call for additional family members - $580.00 per adult/elder.

Chronic Condition Support Services

- **Chronic Condition Support Services.** Chronic Condition Support Services shall provide participants with access to referral resources and support services for daily living with, or support for someone with, a chronic illness.
- **Consultation with Participants.** Chronic Condition Support Services may include OptumHealth consultation with the participant about his/her concerns or questions with regard to support for daily living with illness, social services, support groups, housing, travel special needs, or assistive technology and advocacy.

Life Learning Education

- **Life Learning Education Services.** Life Learning Education Services shall provide participants with access to referral resources and support services for school concerns.
- **Consultation with Participants.** Life Learning Education Services may include OptumHealth consultation with the participant about his/her concerns or questions with regard to educational goals and needs.

Exclusions

Eligible Expenses shall not include, and the Plan shall make no payments for, the following Incurred Charges or Expenses:

- Physician services, including services from a psychiatrist,
- Hospital services (inpatient and outpatient services),
- Diagnostic laboratory and diagnostic and therapeutic radiological services,
- Home health services,
- Emergency health care services, and
- Drugs and medications.

Temporary Extended Coverage (COBRA)

Certain employment status changes and other events can result in a loss of coverage. If such coverage is lost, only expenses incurred prior to the termination date are eligible for reimbursement. However, under certain circumstances, you and/or your eligible dependents may be entitled to purchase temporary medical, prescription, dental, and vision coverage in which you or your covered dependents are enrolled for the time period shown below. In addition, if you are enrolled in a Health Care Reimbursement Account, you may elect to continue that coverage for the remainder of the calendar year.

Contributions for dependents who elect COBRA coverage are made on an after tax basis through the COBRA billing center at Conexis. If you leave the company (other than on account of your gross misconduct) and lose coverage, or if your hours are reduced and your premium is increased because of the reduction of hours, you and/or your dependents will be eligible to purchase extended medical, prescription, dental, and/or vision care coverage for up to 18 months. If either you or your dependent(s) were determined under Title II or XVI of the Social Security Act to have been disabled within 60 days from the time you left the company, you and your dependents will be eligible to purchase medical, prescription, dental, and/or vision care coverage for up to an additional 11 months (total 29 months), so long as you or your dependent provides the company with notice of the determination within 60 days of the determination but prior to the end of the original 18 months. If you leave the company (other than on account of your gross misconduct) within 18 months after you become entitled to Medicare and lose coverage, your dependents will be eligible to purchase medical, prescription, dental, and/or vision care coverage for up to 36 months from the date you became entitled to Medicare. If your dependent is no longer eligible for coverage under this plan because of divorce, your death, or ceasing to be a dependent child under the terms of the plan, the dependent may purchase medical, prescription, and/or dental care benefit coverage for up to 36 months. A dependent also may purchase coverage for the balance of the 36 month period if coverage was extended on account of the death of the employee (as previously described) and the coverage under that extension is subsequently lost.

Eligible employees or dependents are called “qualified beneficiaries” below. Circumstances that entitle a qualified beneficiary to extended coverage are called “qualifying events.”

Notification and Election Requirements

Employees and their dependents are responsible for notifying the appropriate parties within 60 days of the end of the month after a divorce or legal separation or when a child ceases to be eligible under the terms of the plan. Lubrizol will notify a qualified beneficiary of the right to continue coverage within 44 days of the employee’s termination of employment or death, or a dependent child’s 26th birthday.

Detailed information can be found on the Life Events quick link on the benefits website (http://benefits.lubrizol.com). Within 14 days of notification or loss of coverage, whichever is later, Lubrizol will notify all qualified beneficiaries of the right to continue medical, prescription drug, dental and/or vision care benefit coverage under the plan. Any notification to the spouse of an employee will be treated as notification to all other qualified beneficiaries residing with the spouse.

You and/or your dependent(s) must elect temporary extended coverage on a form provided by the Benefits Center within the period that begins on the later of the date coverage would otherwise terminate or the date notice of continuation rights has been mailed to the qualified beneficiary, and ends 60 days thereafter.

Length of Temporary Extended Coverage

In the case of termination of employment, coverage of the "qualified beneficiaries" may be continued for up to 18 months (29 months in certain cases of disability). For all other qualifying events, coverage for dependents may be continued for up to 36 months.

Coverage will stop before the end of the maximum period if any of the following occur:

1. Failure to pay premiums for coverage within 30 days of the date due.
2. The start of health, dental, or vision coverage for the qualified beneficiary under any other group plan that does not have a pre-existing condition clause that would affect the qualified beneficiary.
3. The qualified beneficiary's entitlement to Medicare benefits.
4. The termination of benefits under The Lubrizol Corporation Employee Benefits Plan.

Cost of Temporary Extended Coverage

The coverage offered is identical to the coverage available to employees. The premium charge is 102% of the total cost of the coverage (150% after the 18th month of COBRA continuation of coverage when a disability arises after COBRA began).

Notice Regarding Privacy of Protected Health Information

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

Federal regulations under the Health Insurance Portability and Accountability Act (HIPAA) require that the plan provide you with this Notice Regarding Privacy of Protected Health Information. This notice describes (1) how the plan may use and disclose your protected health information, (2) your rights to access and control your protected health information and (3) the plan's duties and contact information.

Protected Health Information

"Protected health information" is health information created or received by the plan that contains information that may be used to identify you, such as your name or address. It includes written or verbal health information that relates to your past, present or future physical or mental health; the provision of health care to you; and your past, present or future payment for health care.

The Use and Disclosure of Protected Health Information in Payment and Health Care Operations

Your protected health information may be used and disclosed by the plan in the course of providing payment for treatment and conducting medical, prescription, vision and dental claims operations. Any disclosures may be made in writing, electronically, by facsimile, or orally. The plan may also use or disclose your protected health information in other circumstances if you authorize the use or disclosure, or if state law or the HIPAA privacy regulations authorize the use or disclosure.

Treatment. The plan may use or disclose your protected health information in connection with your treatment, which includes the provision, coordination or management of health care and related services. For example, the plan may disclose information to a treating specialist the name of your regular doctor so that the specialist may request the transfer of your test results from your doctor.

Payment. The plan may use or disclose your protected health information to provide payment to you or your health care providers for services rendered to you by your health care providers. These uses or disclosures may include disclosures to your health care provider or to another group health care plan or insurer to obtain the information needed to process your claim for benefits.

Operations. The plan may use or disclose your protected health information when needed for the plan's medical, prescription, and dental claims operations for the purposes of management and administration of the plan. For example, the plan may use your information for claims operations including: utilization management; disease management program activities; administration of the plan's subrogation provisions; coordination of benefits; claims management; reviewing provider performance and plan performance; activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits; conducting or arranging for medical review, legal services, actuarial services and auditing functions, including fraud and abuse detection and compliance programs; business planning and development; systems maintenance; and management activities.

Other Uses and Disclosures. The plan may also use or disclose your protected health information to provide appointment reminders; to describe or recommend treatment alternatives or to provide information about other health-related benefits and services that may be of interest to you.

The plan may use or disclose protected health information for underwriting purposes as permitted by law, but the plan cannot use or disclose your genetic information for that purpose. Underwriting purposes include eligibility rules or determinations, including eligibility for enrollment or continued enrollment and for benefits under the plan; calculating premium or contribution amounts under the plan; applying pre-existing condition exclusions, if any; or activities related to creating, renewing or replacing any health insurance contract or health benefits. The plan may also disclose protected health information to The Lubrizol Corporation, the sponsor of the plan. Any disclosure to The Lubrizol Corporation will be in accordance with the HIPAA privacy regulations.

Additional Uses and Disclosures Permitted without Authorization or An Opportunity to Object

In addition to payment and health care operations, the plan may use or disclose your protected health information without your permission or authorization in certain circumstances, including:

When Legally Required. The plan will comply with any federal, state or local law that requires it to disclose your protected health information.

For Judicial and Administrative Proceedings. The plan may disclose your protected health information for any judicial or administrative proceeding if the disclosure is expressly authorized by an order of a court or administrative tribunal as expressly authorized by the order or a signed authorization is provided.

For Workers' Compensation. The plan may disclose your protected health information to comply with workers' compensation laws or similar Programs.

Uses and Disclosures Permitted with an Opportunity to Object

Subject to your objection, the plan may disclose your protected health information to a family member or close personal friend if the disclosure is directly relevant to the person's involvement in your care or payment related to your care. The plan will inform you orally or in writing of these uses and disclosures of your protected health information as well as provide you with an opportunity to object in advance. Your agreement or objection to the uses and disclosures can be oral or in writing. If you do not respond to these disclosures, the plan is able to infer from the circumstances that you do not object, or the plan determines that it is in your best interests for the plan to disclose information that is directly relevant to the person's involvement with your care, then the plan may disclose your protected health information. If you are incapacitated or in an emergency situation, the plan may determine if the disclosure is in your best interests and, if that determination is made, may only disclose information directly relevant to your health care.

Uses and Disclosures Authorized by You

Other than the circumstances described above, the plan will not disclose your health information unless you provide written authorization. In particular the plan will not, without your authorization, use or disclose your health information that consists of psychotherapy notes, except to defend itself in a legal action or other proceeding brought by you or as otherwise permitted by law. The plan must also obtain your authorization to use or disclose your information for most marketing purposes or to sell your information. You may revoke your authorization in writing at any time except to the extent that the plan has taken action in reliance upon the authorization.

Your Rights

You have certain rights regarding your protected health information under the HIPAA privacy regulations.

These rights include:

The right to inspect and copy your protected health information. For as long as the plan holds your protected health information, you may inspect and obtain a copy of the information included in a designated record set. A "designated record set" contains enrollment, payment, claims adjudication and case or medical management records systems maintained by or for the plan, as well as any other records the plan uses to make decisions regarding health care benefits provided to you. The plan may deny your request to inspect or copy your protected health information if the plan determines that the access requested is likely to endanger your life or safety or that of another person, or that it is likely to cause substantial harm to another person referred to in the information. You have the right to request a review of this decision.

In addition, you may not inspect or copy certain records by law, including:
(1) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and
(2) protected health information that is subject to a law that prohibits access to protected health information.
You have the right to make a decision to deny access reviewed in some situations. You must submit a written request to the plan's Privacy Officer to inspect and copy your health information. The plan may charge you a fee for the costs of copying, mailing, or other costs incurred by the plan in complying with your request. Please contact the Privacy Officer at the number given at the end of this notice if you have any questions about access to your medical information.

The right to request a restriction on uses and disclosures of your protected health information. You may request that the plan not use or disclose specific sections of your protected health information for the purposes of payment or health care operations. Additionally, you may request that the plan not disclose your health information to family members or friends who may be involved in your care or for notification purposes described in this notice. In your request, you must specify the scope of restriction requested as well as the individuals for whom you want the restriction to apply. Your request should be directed to the Privacy Officer. The plan may choose to deny your request for a restriction, in which case the plan will notify you of its decision. Once the plan agrees to the requested restriction, the plan may not violate that restriction unless use or disclosure of the relevant information is needed to provide emergency treatment. The plan may terminate the agreement to a restriction in some cases.

The right to request to receive confidential communications from the plan by alternative means or at an alternative location. You have the right to request to receive communications of protected health information from the plan through alternative means or at an alternative location if you clearly state that the disclosure of all or part of that information could endanger you. The plan will make every effort to comply with reasonable requests. However, the plan may condition its compliance by asking you for information regarding the procurement of payment or specific information regarding an alternative address or other method of contact. You are not required to provide an explanation for your request. Requests should be made in writing to the Privacy Officer.

The right to request an amendment of your protected health information. During the time that the plan holds your protected health information, you may request an amendment of your information in a designated record set. The plan may deny your request in some instances. However, should the plan deny your request for amendment, you have the right to file a statement of disagreement with the plan. In turn, the plan may develop a rebuttal to your statement. If it does so, the plan will provide you with a copy of the rebuttal. Requests for amendment must be submitted in writing to the Privacy Officer. Your written request must supply a reason to support the requested amendments.

The right to request an accounting of certain disclosures. You have the right to request an accounting of the plan's disclosures of your protected health information made for the purposes other than payment or health care operations as described in this notice. The plan is not required to account for disclosures (1) you requested, (2) you authorized by signing an authorization form, (3) to friends or family members involved in your care and (4) certain other disclosures the plan is permitted to make without your authorization. The request for an accounting must be made in writing to the Privacy Officer and should state the time period that you wish the accounting to include, up to a six year period. The plan is not required to provide an accounting for disclosures that took place prior to April 14, 2003. The plan will not charge you for the first accounting you request in any 12-month period. Subsequent accountings may require a fee based on the plan's reasonable costs for compliance of the request.

The right to receive a paper copy of this notice. The plan will provide a separate paper copy of this notice upon request even if you have already been given a copy of it or have agreed to review it electronically.

The Plan's Duties

The plan is required by law to ensure the privacy of your protected health information, to provide you with this notice of your rights and the plan's legal duties and privacy practices, and to notify you in the event of a breach of your unsecured protected health information. The plan must abide by the terms of this notice, as may be amended periodically. The plan reserves the right to change the terms of this notice and to make the new notice provisions effective for all protected health information that the plan collects and maintains. If the plan alters its notice, the plan will provide a copy of the revised notice through regular mail or in person.

Complaints

If you believe that your privacy rights have been violated, you have the right to relay complaints to the plan and to the Secretary of the Department of Health and Human Services. You may provide complaints to the plan verbally or in writing. These complaints should be directed to the Privacy Officer. The plan encourages you to relay any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Contact Person

The plan's contact person regarding the plan's duties and your rights under the HIPAA privacy regulations is the Privacy Officer. The Privacy Officer can provide information regarding issues related to this notice by request. Complaints to the plan should be directed to the Privacy Officer at the following address:

HIPAA Privacy Officer
The Lubrizol Corporation
29400 Lakeland Boulevard, 491A
Wickliffe, OH 44092

The Privacy Officer can be contacted by telephone at 440-347-5151.

Wellness

This summary plan description (SPD) describes the major features of the Lubrizol Wellness program. It includes important details about eligibility, covered expenses, and limitations and exclusions. Read the entire SPD carefully to understand the benefits available under the program. If there are any conflicts between this SPD and the plan document, the formal plan document will govern.

The Wellness program is committed to helping you achieve your best health. In some cases, rewards for participating in certain aspects of the Wellness program may be available.

Federal law provides you with certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). A summary of these rights, along with specific information identifying each benefit in the Lubrizol benefits program, is included in the "General" section of the Employee Resource Guide.

The plan may be amended by written action of the Board of Directors or its designee to add or limit future benefits and/or to change deductible or coinsurance amounts, to require employee contributions, or to change the level of employee contributions at any time and from time to time. The plan may also be terminated at any time by written action of the Board of Directors. Neither this SPD nor the program described herein, constitute a contract of employment or a promise of continuing employment.

Cost of Coverage

Lubrizol pays 100% of the cost of the Wellness program for active employees. There is a cost associated with the program if you choose to elect the plan while on COBRA continuation coverage.

Eligibility

As a regular employee of Lubrizol or of its participating subsidiaries, who works at least an average of 20 hours per week or is participating in a phased-in retirement Program, you are eligible to participate in the Wellness program. Eligible employees include employees on an employer approved long term disability leave of absence; employees on an employer approved salary continuation leave of absence; employees on an employer approved personal leave of absence; employees on an employer approved family and medical leave of absence. Certain aspects of the Wellness program may be available to eligible dependents of employees.

Your participation in the Wellness Program is completely voluntary. You have the option to stop participating in the Wellness Program at any time. Any personal medical information that you share in connection with the Wellness Program will be protected and confidential and may not be used for employment purposes.

Overview of the Program

The Wellness program offers the following support to help you stay healthy:

- **Health Screenings:** Completing a Health Screening, which is a brief appointment during which you will learn about your health by getting your health numbers—things like your blood pressure, weight, cholesterol levels and more. Health Screenings may be available onsite at your workplace (employees only), but can also be obtained through a personal physician.
- **Health Coaching:** Coaching may be available onsite at your location and is available to all eligible employees online or via the telephone. Your health coach can help you get active, eat healthier, reduce stress, lose weight, quit using tobacco, improve cholesterol levels, or lower blood pressure. Your coach can also serve as a bridge to your health care team, including your doctor. The health coaches may include registered nurses, diabetes educators, dietitians, exercise physiologists, respiratory therapists, behavioral health coaches and other specialists, with an average of 10 or more years of experience.

The purpose of the Wellness Program is to improve your general health and welfare. The Wellness Program will not diagnose or treat any injury, illness or condition. You should discuss any health concerns that may be identified through the Wellness Program with your physician.

Accessing the Wellness Program

The aspects of the Wellness program described in this SPD can be accessed through the Lubrizol *Essentials* portal. To sign-up on the portal (http://lzessentials.livehealthier.com) you must have your employee ID number available. If you have difficulty enrolling you can contact LiveHealthier's customer service at LZessentials@livehealthier.com or by calling 1-888-960-0432.

Rewards

Lubrizol may offer an array of programs to encourage engagement in your health, and therefore reward positive actions. For example, Lubrizol may offer opportunities to earn rewards. The type, amount and requirements to earn incentives are determined by Lubrizol in its sole and absolute discretion, and are described in the communication materials.

Exclusions

Lubrizol will not pay for your subsequent treatment for a condition that was identified in a screening or through coaching. If the program specifies that you must use a specific provider or program, the plan will not pay for a different program or provider offering similar services unless approved in advance by the plan (for example, if you advise us that your medical condition makes you unable to use the provider or program, and you are requesting an alternative method for meeting the medical standard necessary to earn a reward being offered by the wellness program).

Temporary Extended Coverage (COBRA)

Certain employment status changes and other events can result in a loss of coverage. If such coverage is lost, only expenses incurred prior to the termination date are eligible for reimbursement. However, under certain circumstances, you and/or your eligible dependents may be entitled to purchase temporary medical, prescription, dental, and vision coverage in which you or your covered dependents are enrolled for the time period shown below. In addition, if you are enrolled in a Health Care Reimbursement Account, you may elect to continue that coverage for the remainder of the calendar year.

Contributions for dependents who elect COBRA coverage are made on an after tax basis through the COBRA billing center at Conexis. If you leave the company (other than on account of your gross misconduct) and lose coverage, or if your hours are reduced and your premium is increased because of the reduction of hours, you and/or your dependents will be eligible to purchase extended medical, prescription, dental, and/or vision care coverage for up to 18 months. If either you or your dependent(s) were determined under Title II or XVI of the Social Security Act to have been disabled within 60 days from the time you left the company, you and your dependents will be eligible to purchase medical, prescription, dental, and/or vision care coverage for up to an additional 11 months (total 29 months), so long as you or your dependent provides the company with notice of the determination within 60 days of the determination but prior to the end of the original 18 months. If you leave the company (other than on account of your gross misconduct) within 18 months after you become entitled to Medicare and lose coverage, your dependents will be eligible to purchase medical, prescription, dental, and/or vision care coverage for up to 36 months from the date you became entitled to Medicare. If your dependent is no longer eligible for coverage under this plan because of divorce, your death, or ceasing to be a dependent child under the terms of the plan, the dependent may purchase medical, prescription, and/or dental care benefit coverage for up to 36 months. A dependent also may purchase coverage for the balance of the 36 month period if coverage was extended on account of the death of the employee (as previously described) and the coverage under that extension is subsequently lost.

Eligible employees or dependents are called "qualified beneficiaries" below. Circumstances that entitle a qualified beneficiary to extended coverage are called "qualifying events."

Notification and Election Requirements

Employees and their dependents are responsible for notifying the appropriate parties within 60 days of the end of the month after a divorce or legal separation or when a child ceases to be eligible under the terms of the plan. Lubrizol will notify a qualified beneficiary of the right to continue coverage within 44 days of the employee's termination of employment or death, or a dependent child's 26th birthday.

Detailed information can be found on the Life Events quick link on the benefits website (http://benefits.lubrizol.com). Within 14 days of notification or loss of coverage, whichever is later, Lubrizol will notify all qualified beneficiaries of the right to continue medical, prescription drug, dental and/or vision care benefit coverage under the plan. Any notification to the spouse of an employee will be treated as notification to all other qualified beneficiaries residing with the spouse.

You and/or your dependent(s) must elect temporary extended coverage on a form provided by the Benefits Center within the period that begins on the later of the date coverage would otherwise terminate or the date notice of continuation rights has been mailed to the qualified beneficiary, and ends 60 days thereafter.

Length of Temporary Extended Coverage

In the case of termination of employment, coverage of the "qualified beneficiaries" may be continued for up to 18 months (29 months in certain cases of disability). For all other qualifying events, coverage for dependents may be continued for up to 36 months.

Coverage will stop before the end of the maximum period if any of the following occur:

1. Failure to pay premiums for coverage within 30 days of the date due.
2. The start of health, dental, or vision coverage for the qualified beneficiary under any other group plan that does not have a pre-existing condition clause that would affect the qualified beneficiary.
3. The qualified beneficiary's entitlement to Medicare benefits.
4. The termination of benefits under The Lubrizol Corporation Employee Benefits Plan.

Cost of Temporary Extended Coverage

The coverage offered is identical to the coverage available to employees. The premium charge is 102% of the total cost of the coverage (150% after the 18th month of COBRA continuation of coverage when a disability arises after COBRA began).

Notice Regarding Privacy of Protected Health Information

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

Federal regulations under the Health Insurance Portability and Accountability Act (HIPAA) require that the plan provide you with this Notice Regarding Privacy of Protected Health Information. This notice describes (1) how the plan may use and disclose your protected health information, (2) your rights to access and control your protected health information and (3) the plan's duties and contact information.

Protected Health Information

"Protected health information" is health information created or received by the plan that contains information that may be used to identify you, such as your name or address. It includes written or verbal health information that relates to your past, present or future physical or mental health; the provision of health care to you; and your past, present or future payment for health care.

The Use and Disclosure of Protected Health Information in Payment and Health Care Operations

Your protected health information may be used and disclosed by the plan in the course of providing payment for treatment and conducting medical, prescription, vision and dental claims operations. Any disclosures may be made in writing, electronically, by facsimile, or orally. The plan may also use or disclose your protected health information in other circumstances if you authorize the use or disclosure, or if state law or the HIPAA privacy regulations authorize the use or disclosure.

Treatment. The plan may use or disclose your protected health information in connection with your treatment, which includes the provision, coordination or management of health care and related services. For example, the plan may disclose information to a treating specialist the name of your regular doctor so that the specialist may request the transfer of your test results from your doctor.

Payment. The plan may use or disclose your protected health information to provide payment to you or your health care providers for services rendered to you by your health care providers. These uses or disclosures may include disclosures to your health care provider or to another group health care plan or insurer to obtain the information needed to process your claim for benefits.

Operations. The plan may use or disclose your protected health information when needed for the plan's medical, prescription, and dental claims operations for the purposes of management and administration of the plan. For example, the plan may use your information for claims operations including: utilization management; disease management program activities; administration of the plan's subrogation provisions; coordination of benefits; claims management; reviewing provider performance and plan performance; activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits; conducting or arranging for medical review, legal services, actuarial services and auditing functions, including fraud and abuse detection and compliance programs; business planning and development; systems maintenance; and management activities.

Other Uses and Disclosures. The plan may also use or disclose your protected health information to provide appointment reminders; to describe or recommend treatment alternatives or to provide information about other health-related benefits and services that may be of interest to you.

The plan may use or disclose protected health information for underwriting purposes as permitted by law, but the plan cannot use or disclose your genetic information for that purpose. Underwriting purposes include eligibility rules or determinations, including eligibility for enrollment or continued enrollment and for benefits under the plan; calculating premium or contribution amounts under the plan; applying pre-existing condition exclusions, if any; or activities related to creating, renewing or replacing any health insurance contract or health benefits. The plan may also disclose protected health information to The Lubrizol Corporation, the sponsor of the plan. Any disclosure to The Lubrizol Corporation will be in accordance with the HIPAA privacy regulations.

Additional Uses and Disclosures Permitted without Authorization or An Opportunity to Object

In addition to payment and health care operations, the plan may use or disclose your protected health information without your permission or authorization in certain circumstances, including:

When Legally Required. The plan will comply with any federal, state or local law that requires it to disclose your protected health information.

For Judicial and Administrative Proceedings. The plan may disclose your protected health information for any judicial or administrative proceeding if the disclosure is expressly authorized by an order of a court or administrative tribunal as expressly authorized by the order or a signed authorization is provided.

For Workers' Compensation. The plan may disclose your protected health information to comply with workers' compensation laws or similar Programs.

Uses and Disclosures Permitted with an Opportunity to Object

Subject to your objection, the plan may disclose your protected health information to a family member or close personal friend if the disclosure is directly relevant to the person's involvement in your care or payment related to your care. The plan will inform you orally or in writing of these uses and disclosures of your protected health information as well as provide you with an opportunity to object in advance. Your agreement or objection to the uses and disclosures can be oral or in writing. If you do not respond to these disclosures, the plan is able to infer from the circumstances that you do not object, or the plan determines that it is in your best interests for the plan to disclose information that is directly relevant to the person's involvement with your care, then the plan may disclose your protected health information. If you are incapacitated or in an emergency situation, the plan may determine if the disclosure is in your best interests and, if that determination is made, may only disclose information directly relevant to your health care.

Uses and Disclosures Authorized by You

Other than the circumstances described above, the plan will not disclose your health information unless you provide written authorization. In particular the plan will not, without your authorization, use or disclose your health information that consists of psychotherapy notes, except to defend itself in a legal action or other proceeding brought by you or as otherwise permitted by law. The plan must also obtain your authorization to use or disclose your information for most marketing purposes or to sell your information. You may revoke your authorization in writing at any time except to the extent that the plan has taken action in reliance upon the authorization.

Your Rights

You have certain rights regarding your protected health information under the HIPAA privacy regulations. These rights include:

The right to inspect and copy your protected health information. For as long as the plan holds your protected health information, you may inspect and obtain a copy of the information included in a designated record set. A "designated record set" contains enrollment, payment, claims adjudication and case or medical management records systems maintained by or for the plan, as well as any other records the plan uses to make decisions regarding health care benefits provided to you. The plan may deny your request to inspect or copy your protected health information if the plan determines that the access requested is likely to endanger your life or safety or that of another person, or that it is likely to cause substantial harm to another person referred to in the information. You have the right to request a review of this decision.

In addition, you may not inspect or copy certain records by law, including:
(1) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and
(2) protected health information that is subject to a law that prohibits access to protected health information.
You have the right to make a decision to deny access reviewed in some situations. You must submit a written request to the plan's Privacy Officer to inspect and copy your health information. The plan may charge you a fee for the costs of copying, mailing, or other costs incurred by the plan in complying with your request. Please contact the Privacy Officer at the number given at the end of this notice if you have any questions about access to your medical information.

The right to request a restriction on uses and disclosures of your protected health information. You may request that the plan not use or disclose specific sections of your protected health information for the purposes of payment or health care operations. Additionally, you may request that the plan not disclose your health information to family members or friends who may be involved in your care or for notification purposes described in this notice. In your request, you must specify the scope of restriction requested as well as the individuals for whom you want the restriction to apply. Your request should be directed to the Privacy Officer.

The plan may choose to deny your request for a restriction, in which case the plan will notify you of its decision. Once the plan agrees to the requested restriction, the plan may not violate that restriction unless use or disclosure of the relevant information is needed to provide emergency treatment. The plan may terminate the agreement to a restriction in some cases.

The right to request to receive confidential communications from the plan by alternative means or at an alternative location. You have the right to request to receive communications of protected health information from the plan through alternative means or at an alternative location if you clearly state that the disclosure of all or part of that information could endanger you. The plan will make every effort to comply with reasonable requests. However, the plan may condition its compliance by asking you for information regarding the procurement of payment or specific information regarding an alternative address or other method of contact. You are not required to provide an explanation for your request. Requests should be made in writing to the Privacy Officer.

The right to request an amendment of your protected health information. During the time that the plan holds your protected health information, you may request an amendment of your information in a designated record set. The plan may deny your request in some instances. However, should the plan deny your request for amendment, you have the right to file a statement of disagreement with the plan. In turn, the plan may develop a rebuttal to your statement. If it does so, the plan will provide you with a copy of the rebuttal. Requests for amendment must be submitted in writing to the Privacy Officer. Your written request must supply a reason to support the requested amendments.

The right to request an accounting of certain disclosures. You have the right to request an accounting of the plan's disclosures of your protected health information made for the purposes other than payment or health care operations as described in this notice. The plan is not required to account for disclosures (1) you requested, (2) you authorized by signing an authorization form, (3) to friends or family members involved in your care and (4) certain other disclosures the plan is permitted to make without your authorization. The request for an accounting must be made in writing to the Privacy Officer and should state the time period that you wish the accounting to include, up to a six year period. The plan is not required to provide an accounting for disclosures that took place prior to April 14, 2003. The plan will not charge you for the first accounting you request in any 12-month period. Subsequent accountings may require a fee based on the plan's reasonable costs for compliance of the request.

The right to receive a paper copy of this notice. The plan will provide a separate paper copy of this notice upon request even if you have already been given a copy of it or have agreed to review it electronically.

The Plan's Duties

The plan is required by law to ensure the privacy of your protected health information, to provide you with this notice of your rights and the plan's legal duties and privacy practices, and to notify you in the event of a breach of your unsecured protected health information. The plan must abide by the terms of this notice, as may be amended periodically. The plan reserves the right to change the terms of this notice and to make the new notice provisions effective for all protected health information that the plan collects and maintains. If the plan alters its notice, the plan will provide a copy of the revised notice through regular mail or in person.

Complaints

If you believe that your privacy rights have been violated, you have the right to relay complaints to the plan and to the Secretary of the Department of Health and Human Services. You may provide complaints to the plan verbally or in writing. These complaints should be directed to the Privacy Officer. The plan encourages you to relay any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Contact Person

The plan's contact person regarding the plan's duties and your rights under the HIPAA privacy regulations is the Privacy Officer. The Privacy Officer can provide information regarding issues related to this notice by request. Complaints to the plan should be directed to the Privacy Officer at the following address:

HIPAA Privacy Officer
The Lubrizol Corporation
29400 Lakeland Boulevard – 491A
Wickliffe, OH 44092

The Privacy Officer can be contacted by telephone at 440-347-5151.

The Lubrizol Dental Option

Introduction

This section provides you and your dependents with a description of your benefits. Certain limitations and exclusions may apply to any benefit or benefit amount. It is important that you and your dependents refer to the provisions contained in this document for details about your benefits.

Below is a comparison of dental benefits:

Plan Feature	The Lubrizol Preventive Dental Option	The Lubrizol Comprehensive Dental Option
Annual Deductible	N/A	$25/person $75/family
Annual Maximum Benefit	$500	$1,500
Preventive Care (Type A) ■ Oral Exams ■ Cleanings ■ X-rays	Plan pays 100%	Plan pays 100% (deductible does not apply) Plan pays for 2 exams per year
Basic (Type B) ■ Fillings ■ Extractions	N/A	Plan pays 80% after annual deductible
Major Restorative (Type C) ■ Crowns ■ Inlays ■ Dentures	N/A	Plan pays 50% after annual deductible
Orthodontia ■ Children under age 26	N/A	Plan pays 50%
Orthodontia Lifetime Maximum Benefit	N/A	$1,500/child

How Your Dental Benefits Work

If you or a dependent incur a charge for a covered service, proof of such service must be sent to the claim administrator. When the claim administrator receives such proof, the claim administrator will review the claim and if it is approved, dental benefits will be paid based on the dental benefit you elected.

Both the Lubrizol Comprehensive Dental option and the Lubrizol Preventive Dental option give you access to dentists through the MetLife Preferred Dentist Program (PDP). Dentists participating in the PDP have agreed to limit their charge for a dental service to the maximum allowed charge for such service. Under the PDP, the dental Program pays benefits for covered services performed by either in-network dentists or out-of-network dentists. However, you may be able to reduce your out-of-pocket costs by using an in-network dentist because out-of-network dentists have not entered into an agreement with MetLife to limit their charges. You are always free to receive services from any dentist. You do not need any authorization from your dental option to choose a dentist.

You and your dentist have the right and are responsible at all times for choosing the course of treatment and services to be performed. Whether or not benefits are available for a particular service, does not mean you should or should not receive the service. After services have been performed, the claim administrator will determine the extent to which benefits, if any, are payable.

When requesting a covered service from an in-network dentist, it is recommended that you:

- identify yourself as covered in the Preferred Dentist Program; and
- confirm that the dentist is currently an in-network dentist at the time that the covered service is performed.

The amount of the benefit will not be affected by whether or not you identify yourself as a member in the PDP.

You can obtain a customized listing of MetLife's in-network dentists either by calling 1-800-942-PDP1 (7371) or by visiting MetLife's website at www.metlife.com/dental.

Benefit Amounts

Your dental option will pay benefits in an amount equal to the covered percentage for charges incurred by you or a dependent for a covered service as shown in the *Lubrizol Dental Comparison of Benefits*. The benefit you receive will be dependent upon which Lubrizol dental option you selected.

In-Network

If a covered service is performed by an in-network dentist, your dental option will base the benefit on the covered percentage of the maximum allowed charge.

If an in-network dentist performs a covered service, you will be responsible for paying any other part of the maximum allowed charge for which your dental option does not pay benefits.

Out-of-Network

If a covered service is performed by an out-of-network dentist, your dental option will base the benefit on the covered percentage of the reasonable and customary charge.

Out-of-network dentists may charge you more than the reasonable and customary charge. If an out-of-network dentist performs a covered service, you will be responsible for paying:

- any part of the reasonable and customary charge for which your dental option does not pay benefits; and
- any amount in excess of the reasonable and customary charge charged by the out-of-network dentist.

Pretreatment Estimate of Benefits

If a planned dental service is expected to cost more than $300, you have the option of requesting a pretreatment estimate of benefits. The dentist should submit a claim detailing the services to be performed and the amount to be charged. After the claim administrator receives this information, the claim administrator will provide you with an estimate of the dental benefits available for the service. The estimate is not a guarantee of the amount your dental option will pay. Under the alternate benefit provision, benefits may be based on the cost of a service other than the service that you choose. You are required to submit proof on or after the date the dental service is completed in order for your dental option to pay a benefit for such service.

The pretreatment estimate of benefits is only an estimate of benefits available for proposed dental services. You are not required to obtain a pretreatment estimate of benefits. As always, you or your dependent and the dentist are responsible for choosing the services to be performed.

The Lubrizol Preventive Dental Option Covered Services

Below is a list of covered service for the Lubrizol Preventive Dental Option. For more information on this plan, please refer to the *Dental Comparison of Benefits*.

1. Oral exams and problem-focused exams but no more than twice in a year.
2. Full mouth or panoramic x-rays once every 36 months.
3. Bitewing x-rays two sets in a year.
4. Intraoral-periapical x-rays.
5. Extraoral x-rays.
6. Pulp vitality and bacteriological studies for determination of bacteriologic agents.
7. Diagnostic casts.
8. Cleaning of teeth (oral prophylaxis) twice in a year.
9. Emergency palliative treatment to relieve tooth pain.
10. Topical fluoride treatment.
11. Space maintainers for a Child under age 19.
12. Sealants for a Child under age 15, which are applied to non-restored, non-decayed first and second permanent molars, once per tooth every 36 months.

The Lubrizol Preventive Dental Option Exclusions

Below is a list of exclusions for the Lubrizol Preventive Dental Option. For more information on this plan, please refer to the *Dental Comparison of Benefits*.

1. Services which are not dentally necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or those which are deemed experimental in nature.
2. Services for which you would not be required to pay in the absence of dental benefits.
3. Services or supplies received by you or your dependent before the dental benefits start for that person.
4. Services which are neither performed nor prescribed by a dentist, except for those services of a licensed dental hygienist which are supervised and billed by a dentist, and which are for:
   - scaling and polishing of teeth; or
   - fluoride treatments.
5. Services which are primarily cosmetic.
6. Services or appliances which restore or alter occlusion or vertical dimension.
7. Restoration of tooth structure damaged by attrition, abrasion or erosion, unless caused by disease.
8. Restorations or appliances used for the purpose of periodontal splinting.
9. Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco.
10. Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss.
11. Initial installation of a denture to replace one or more teeth which were missing before such person was covered for dental benefits.
12. Decoration or inscription of any tooth, device, appliance, crown or other dental work.
13. Missed appointments.
14. Services:
    - covered under any workers' compensation or occupational disease law;
    - covered under any employer liability law;
    - for which the employer of the person receiving such services is not required to pay; or
    - received at a facility maintained by the employer, labor union, mutual benefit association, or VA hospital.
15. Services covered under other coverage provided by the employer.
16. Biopsies of hard or soft oral tissue.
17. Temporary or provisional restorations.
18. Temporary or provisional appliances.
19. Prescription drugs.
20. Services for which the submitted documentation indicates a poor prognosis.

21. The following, when charged by the dentist on a separate basis:
    - claim form completion;
    - infection control, such as gloves, masks, and sterilization of supplies; or
    - local anesthesia, non-intravenous conscious sedation or analgesia, such as nitrous oxide.
22. Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food.
23. Caries susceptibility tests.
24. Cone beam imaging.
25. Amalgam fillings.
26. Sedative fillings.
27. Composite fillings.
28. Initial installation of, or repairs to, cast restorations.
29. Prefabricated stainless steel crown or prefabricated resin crown.
30. Repair of cast restorations.
31. Re-cementing of cast restorations or dentures.
32. Labial veneers.
33. Core buildup and cast post and core.
34. Pulp capping.
35. Therapeutic pulpotomy.
36. Pulp therapy.
37. Apexification/recalcification.
38. Root canal treatment.
39. Periodontal maintenance.
40. Periodontal surgery, including gingivectomy, gingivoplasty, gingival curettage and osseous surgery.
41. Periodontal scaling and root planing.
42. Full mouth debridements.
43. Local chemotherapeutic agents.
44. Initial installation or replacement of dentures or implants.
45. Addition of teeth to a partial denture.
46. Adjustments and repairs of dentures.
47. Relinings and rebasings of dentures.
48. Tissue conditioning.
49. Modification of removable prosthodontic and other removable prosthetic services.
50. Implants including, but not limited to any related surgery, placement, restorations, maintenance, and removal.
51. Repair of implants.
52. Fixed partial dentures.
53. Other fixed denture services.
54. Simple extractions.
55. Surgical extractions.
56. Oral surgery, except as specified elsewhere as a covered expense.
57. General anesthesia or intravenous sedation.
58. Consultations.
59. Injections of therapeutic drugs.
60. Application of desensitizing agents.
61. Occlusal adjustments.
62. Fixed and removable appliances for correction of harmful habits.
63. Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.

64. Precision attachments associated with fixed and removable prostheses.
65. Orthodontic services or appliances.
66. Repair or replacement of an orthodontic device.
67. Diagnosis and treatment of temporomandibular joint disorders.
68. Intra and extraoral photographic images.

The Lubrizol Comprehensive Dental Option Covered Services

Below is a list of covered service for the Lubrizol Comprehensive Dental Option. For more information on this option, please refer to the *Dental Comparison of Benefits*.

Type A Covered Services:

1. Oral exams and problem-focused exams but no more than twice in a year.
2. Full mouth or panoramic x-rays once every 36 months.
3. Bitewing x-rays 2 sets in a year.
4. Intraoral-periapical x-rays.
5. Extraoral x-rays.
6. Pulp vitality and bacteriological studies for determination of bacteriologic agents.
7. Caries susceptibility tests.
8. Diagnostic casts.
9. Cleaning of teeth (oral prophylaxis) twice in a year.
10. Emergency palliative treatment to relieve tooth pain.
11. Topical fluoride treatment.
12. Space maintainers for a Child under age 19.
13. Sealants for a Child under age 15, which are applied to non-restored, non-decayed first and second permanent molars, once per tooth every 36 months.

Type B Covered Services:

1. Amalgam fillings.
2. Resin-based composite fillings.
3. Sedative fillings.
4. Biopsies of hard or soft oral tissue.
5. Oral Surgery, if not eligible for benefits under the employer's medical plan and except as mentioned elsewhere in this Summary Plan Description.
6. Consultations.
7. Root canal treatment.
8. Periodontal scaling and root planing.
9. Full mouth debridements but not more than once per lifetime.
10. Periodontal surgery, including gingivectomy, gingivoplasty, gingival curettage and osseous surgery.
11. Simple extractions.
12. Surgical extractions.
13. Periodontal maintenance, where periodontal treatment (including scaling, root planing, and periodontal surgery, such as gingivectomy, gingivoplasty, gingival curettage and osseous surgery) has been performed.
14. Pulp capping (excluding final restoration).
15. Therapeutic pulpotomy (excluding final restoration).
16. Pulp therapy.
17. Apexification/recalcification.
18. Local chemotherapeutic agents.
19. General anesthesia or intravenous sedation in connection with oral surgery, extractions or other covered services, when the claim administrator determines such anesthesia is necessary in accordance with generally accepted dental standards.
20. Injections of therapeutic drugs.

21. Relinings and rebasings of existing removable dentures:
    - if at least 6 months have passed since the installation of the existing removable Denture; and
    - not more than once in any 36 month period.
21. Re-cementing of cast restorations or dentures.
22. Adjustments of dentures, if at least 6 months have passed since the installation of the denture.
24. Addition of teeth to a partial removable denture to replace natural teeth removed while these dental benefits were in effect for the person receiving such services.
25. Tissue conditioning.
26. Simple repairs of cast restorations or dentures other than recementing.
27. Application of desensitizing medicaments where periodontal treatment (including scaling, root planing, and periodontal surgery, such as osseous surgery) has been performed.
28. Occlusal adjustments.
29. Temporary or provisional restorations.
30. Analgesia for simple extractions for two or more teeth for a Child up to age 18.

Type C Covered Services:

1. Cone beam imaging.
2. Initial installation of full or partial dentures (other than implant supported prosthetics), when needed to replace natural teeth that are lost while the person receiving such benefits was covered for dental benefits under this Summary Plan Description.
3. Replacement of a non-serviceable fixed denture if such denture was installed more than 5 years prior to replacement.
4. Replacement of a non-serviceable removable denture if such denture was installed more than 5 years prior to replacement.
5. Replacement of an immediate, temporary, full denture with a permanent, full denture, if the immediate, temporary, full denture cannot be made permanent and such replacement is done within 12 months of the installation of the immediate, temporary, full denture.
6. Other fixed denture prosthetic services not described elsewhere.
7. Precision attachments.
8. Initial installation of cast restorations.
9. Replacement of any cast restoration with the same or a different type of cast restoration, but no more than one replacement for the same tooth surface within 5 years of a prior replacement.
10. Prefabricated stainless steel crown or prefabricated resin crown, but no more than one replacement for the same tooth surface within 5 years.
11. Core buildup.
12. Posts and cores.
13. Labial veneers, but no more than once per tooth in a period of 5 years.
14. Implant services (including sinus augmentation and bone replacement and graft for ridge preservation), when needed to replace natural teeth that are lost while the person receiving such benefit was covered for dental benefits under this Summary Plan Description.
15. Repair of implants.
16. Implant supported cast restorations, but no more than once for the same tooth position in a 5 year period.
17. Implant supported fixed dentures, but no more than once for the same tooth position in a 5 year period.
18. Implant supported removable dentures, but no more than once for the same tooth position in a 5 year period.
19. Temporary or provisional appliances.
20. Non-surgical treatment of temporomandibular joint disorders.

Orthodontic Covered Services:

Orthodontia, for a Child under age 26.

The Lubrizol Comprehensive Dental Option Exclusions

The Lubrizol Comprehensive Dental Option will not pay for charges incurred for:

1. Services which are not dentally necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which are deemed experimental in nature.
2. Services for which you would not be required to pay in the absence of dental benefits.
3. Services or supplies received by you or your dependent before the dental benefits start for that person.
4. Services which are neither performed nor prescribed by a dentist, except for those services of a licensed dental hygienist which are supervised and billed by a dentist, and which are for:
   - scaling and polishing of teeth; or
   - fluoride treatments.
5. Services which are primarily cosmetic.
6. Services or appliances which restore or alter occlusion or vertical dimension.
7. Restoration of tooth structure damaged by attrition, abrasion or erosion, unless caused by disease.
8. Restorations or appliances used for the purpose of periodontal splinting.
9. Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco.
10. Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss.
11. Initial installation of a denture or implant to replace one or more teeth which were missing before such person was covered for dental benefits.
12. Decoration or inscription of any tooth, device, appliance, crown or other dental work.
13. Missed appointments.
14. Services:
    - Covered under any workers' compensation or occupational disease law;
    - Covered under any employer liability law;
    - For which the employer of the person receiving such services is not required to pay; or
    - Received at a facility maintained by the employer, labor union, mutual benefit association, or VA hospital.
15. Services covered under other coverage provided by the employer.
16. Prescription drugs.
17. Services for which the submitted documentation indicates a poor prognosis.
18. The following, when charged by the dentist on a separate basis:
    - claim form completion;
    - infection control, such as gloves, masks, and sterilization of supplies; or
    - local anesthesia, non-intravenous conscious sedation or analgesia, such as nitrous oxide.
19. Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food.
20. Fixed and removable appliances for correction of harmful habits.
21. Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.
22. Adjustment of a denture made within 6 months after installation by the same dentist who installed it.
23. Duplicate prosthetic devices or appliances.
24. Replacement of a lost or stolen appliance, cast restoration or denture.
25. Replacement of an orthodontic device.
26. Intra and extraoral photographic images.
27. X-rays for temporomandibular joint disorders.

Please Note: The following apply to the Lubrizol Comprehensive Dental Option Only.

Deductibles

The deductible amounts are shown in the *Lubrizol Dental Comparison of Benefits*. Annual deductibles only apply for members of the Lubrizol Comprehensive Dental Option.

The annual deductible is the amount that you and each dependent must pay for covered services to which such deductible applies each year before the Lubrizol Comprehensive Dental Option will pay benefits for such covered services. Amounts used to satisfy your annual individual deductible are applied to the annual family deductible. Once the annual family deductible is satisfied, no further annual individual deductibles are required to be met.

The amount the Lubrizol Comprehensive Dental Option applies toward satisfaction of a deductible for a covered service is the amount the claim administrator uses to determine benefits for such service.

Alternate Benefit

If the Claim Administrator determines that a service, less costly than the Covered Service the dentist performed, could have been performed to treat a dental condition, the Lubrizol ComprehensiveDental Option will pay benefits based upon the less costly service if such service:

- would produce a professionally acceptable result under generally accepted dental standards; and
- would qualify as a covered service.

For example:

- when an amalgam filling and a composite filling are both professionally acceptable methods for filling a molar, the Claim Administrator may base the benefit determination upon the amalgam filling which is the less costly service;
- when a filling and an inlay are both professionally acceptable methods for treating tooth decay or breakdown, the Claim Administrator may base the benefit determination upon the filling which is the less costly service;
- when a filling and a crown are both professionally acceptable methods for treating tooth decay or breakdown, the Claim Administrator may base the benefit determination upon the filling which is the less costly service; and
- when a partial denture and fixed bridgework are both professionally acceptable methods for replacing multiple missing teeth in an arch, the Claim Administrator may base the benefit determination upon the partial denture which is the less costly service.

If the Lubrizol Comprehensive Dental Option provides benefits based upon a less costly service in accordance with this subsection, the Dentist may charge you or your dependent for the difference between the service that was performed and the less costly service. This is the case even if the service is performed by an In-Network Dentist.

Certain comprehensive dental services have multiple steps associated with them. These steps can be completed at one time or during multiple sessions. For benefit purposes under this Summary Plan Description, these separate steps of one service are considered to be part of the more comprehensive service. Even if the dentist submits separate bills, the total benefit payable for all related charges will be limited by the maximum benefit payable for the more comprehensive service. For example, root canal therapy includes x-rays, opening of the pulp chamber, additional x-rays, and filling of the chamber. Although these services may be performed in multiple sessions, they all constitute root canal therapy. Therefore, the Lubrizol Comprehensive Dental Option will only pay benefits for the root canal therapy.

Orthodontic Covered Services

Orthodontic treatment generally consists of initial placement of an appliance and periodic follow-up visits.

The benefit payable for the initial placement and periodic visits will be in the form of a lump sum payment up to the Maximum Benefit Amount for Orthodontia.

Benefits for Orthodontic Services Begun Prior to these Dental Benefits
If the initial placement and periodic follow-up visits commenced prior to these dental benefits being in effect, the benefit payable will be reduced proportionately.

Benefits the Lubrizol Comprehensive Dental Option Will Pay After Coverage Ends
This option will pay benefits for a 31 day period after your coverage ends for the completion of installation of a prosthetic device if:

- the dentist prepared the abutment teeth or made impressions before your coverage ends; and
- the device is installed within 31 days after the date the coverage ends.

This option will pay benefits for a 31 day period after your coverage ends for the completion of installation of a cast restoration if:

- the dentist prepared the tooth for the cast restoration before your coverage ends; and
- the cast restoration is installed within 31 days after the date the coverage ends.

This option will pay benefits for a 31 day period after your coverage ends for completion of root canal therapy if:

- the dentist opened into the pulp chamber before your coverage ends; and
- the treatment is finished within 31 days after the date the coverage ends.

The Lubrizol Dental Options Coordination of Benefits
When you or a dependent incur charges for covered services, there may be other Programs that also provide benefits for those same charges. In that case, your Lubrizol dental option may reduce what is paid based on what the other Programs pay. This Coordination of Benefits section explains how and when your Lubrizol dental option does this.

Definitions
In this section, the terms set forth below have the following meanings:

Allowable Expense means a necessary dental expense for which both of the following are true:

- a covered person must pay it; and
- it is at least partly covered by one or more of the Programs that provide benefits to the covered person.

If a Program provides fixed benefits for specified events or conditions (instead of benefits based on expenses incurred), such benefits are Allowable Expenses.

If a Program provides benefits in the form of services, your Lubrizol dental option treats the reasonable cash value of each service performed as both an Allowable Expense and a benefit paid by that Program.

The term does not include:

- expenses for services performed because of a Job-Related Injury or Sickness.
- any amount of expenses in excess of the higher reasonable and customary fee for a service, if two or more Programs compute their benefit payments on the basis of reasonable and customary fees.
- any amount of expenses in excess of the higher negotiated fee for a service, if two or more Programs compute their benefit payments on the basis of negotiated fees; and
- any amount of benefits that a primary Program does not pay because the covered person fails to comply with the primary Program's managed care or utilization review provisions, these include provisions requiring:
    - second surgical opinions;
    - pre-certification of services;
    - use of providers in a Program's network of providers; or
    - any other similar provisions.

Your Lubrizol dental option will not use this provision to refuse to pay benefits because an HMO member has elected to have dental services provided by a non-HMO provider and the HMO's contract does not require the HMO to pay for providing those services.

Claim Determination Period means a period that starts on any January 1 and ends on the next December 31. A Claim Determination Period for any covered person will not include periods of time during which that person is not covered under a Lubrizol dental option.

Custodial Parent means a Parent awarded custody, other than joint custody, by a court decree. In the absence of a court decree, it means the Parent with whom the child resides more than half of the year without regard to any temporary visitation.

HMO means a Health Maintenance Organization or Dental Health Maintenance Organization.

Job-Related Injury or Sickness means any injury or sickness:

- for which You are entitled to benefits under a workers' compensation or similar law, or any arrangement that provides for similar compensation; or
- arising out of employment for wage or profit.

Parent means a person who covers a child as a dependent under a Plan.

Program means any of the following, if it provides benefits or services for an Allowable Expense:

- a group insurance plan;
- an HMO;
- a blanket plan;
- uninsured arrangements of group or group type coverage;
- a group practice plan;
- a group service plan;
- a group prepayment plan;
- any other plan that covers people as a group;
- motor vehicle no fault coverage, if the coverage is required by law; and
- any other coverage required or provided by any law or any governmental Program, except Medicaid.

The term does not include any of the following:

- individual or family insurance or subscriber contracts;
- individual or family coverage through closed panel Plans or other prepayment, group practice or individual practice Plans;
- hospital indemnity coverage;
- a school blanket plan that only provides accident-type coverage on a 24 hour basis, or a "to and from school basis," to students in a grammar school, high school or college;
- disability income protection coverage;
- accident only coverage;
- specified disease or specified accident coverage;
- nursing home or long term care coverage; or
- any government Program or coverage if, by state or Federal law, its benefits are excess to those of any private insurance plan or other non-government plan.

The provisions of your Lubrizol dental option, which limit benefits based on benefits or services provided under the following will not be affected by these coordination of benefits provisions:

- Government Plans; or
- Plans which the Employer (or an affiliate) contributes to or sponsors;

Each policy, contract or other arrangement for benefits is a separate Program. If part of a Program reserves the right to reduce what it pays based on benefits or services provided by other Programs, that part will be treated separately from any parts which do not.

Primary Program means a Program that pays its benefits first under the "Rules to Decide Which Program Is Primary" section. A Primary Program pays benefits as if the Secondary Programs do not exist.

Secondary Program means a Program that is not a Primary Program. A Secondary Program may reduce its benefits by amounts payable by the Primary Program. If there are more than two Programs that provide coverage, a Program may be primary to some plans, and secondary to others.

Rules to Decide Which Program is Primary

When more than one Program covers the person for whom Allowable Expenses were incurred, the claim administrator determines which Program is primary by applying the rules in this section.

When there is a basis for claim under your Lubrizol dental option and another Program, your Lubrizol dental option is Secondary unless:

- the other Program has rules coordinating its benefits with those of your Lubrizol dental option; and
- your Lubrizol dental option is primary under the Lubrizol dental option rules.

The first rule below, which will allow the claim administrator to determine which Program is Primary, is the rule that the claim administrator will use.

Dependent or non-dependent: A Program that covers a person other than as a dependent (for example, as an employee, member, subscriber, or retiree) is Primary and shall pay its benefits before a Program that covers the person as a dependent; except that if the person is a Medicare beneficiary and, as a result of federal law or regulations, Medicare is:

- Secondary to the Program covering the person as a dependent; and
- Primary to the Program covering the person as other than a dependent (e.g., a retired employee);

Then the order of benefits between the two Programs is reversed and the Program that covers the person as a dependent is Primary.

Child Covered under More than one Program – Court Decree

When the Lubrizol dental option and another Program cover the same child as the dependent of two or more Parents, and the specific terms of a court decree state that one of the Parents must provide health coverage or pay for the child's health care expenses, that Parent's Program is Primary, if the Program has actual knowledge of those terms. This rule applies to Claim Determination Periods that start after the Program is given notice of the court decree.

Child Covered Under More Than One Program – The Birthday Rule

When your Lubrizol dental option and another Program cover the same child as the dependent of two or more Parents, the Primary Program is the Program of the Parent whose birthday falls earlier in the year if:

- the Parents are married; or
- the Parents are not separated (whether or not they have ever married); or
- a court decree awards joint custody without specifying which Parent must provide health coverage.

If both Parents have the same birthday, the Program that covered either of the Parents longer is the Primary Plan. However, if the other Program does not have this rule, but instead has a rule based on the gender of the Parent, and if, as a result, the Programs do not agree on the order of benefits, the rule in the other Program will determine the order of benefits.

Child Covered Under More than One Program – Custodial Parent

When the Lubrizol dental option and another Program cover the same child as the dependent of two or more Parents, if the Parents are not married, or are separated (whether or not they ever married), or are divorced, the Primary Program is:

- the Program of the custodial Parent; then
- the Program of the spouse of the custodial Parent; then
- the Program of the non-custodial Parent; and then
- the Program of the spouse of the non-custodial Parent.

Active or Inactive Employee

A Program that covers a person as an employee who is neither laid off nor retired is Primary to a Program that covers the person as a laid-off or retired employee (or as that person's dependent). If the other Program does not have this rule and, if as a result, the Programs do not agree on the order of benefits, this rule is ignored.

Continuation of Coverage

The Program that covers a person as an active employee, member or subscriber (or as that employee's dependent) is Primary to a Program that covers that person under a right of continuation pursuant to federal law (e.g., COBRA) or state law. If the Program that covers the person has not adopted this rule, and if, as a result, the Programs do not agree on the order of benefits, this rule shall not apply.

Longer/Shorter Time Covered

If none of the above rules determine which Program is Primary, the Program that has covered the person for the longer time shall be Primary to a Program that has covered the person for a shorter time.

No Rules Apply

If none of the above rules determine which Program is Primary, the Allowable Expenses shall be shared equally between all the Programs. In no event will the Lubrizol dental option pay more than it would if it were Primary.

Effect on Benefits of the Lubrizol Dental Benefit Option

If the Lubrizol dental option is Secondary, when the total Allowable Expenses incurred by a covered person in any Claim Determination Period are less than the sum of:

- the benefits that would be payable under your Lubrizol dental option without applying this Coordination of Benefits provision; and
- the benefits that would be payable under all other Programs without applying Coordination of Benefits or similar provisions;

Then the Lubrizol dental option will reduce the benefits that would otherwise be payable under the Lubrizol dental option. The sum of these reduced benefits, plus all benefits payable for such Allowable Expenses under all other Programs, will not exceed the total of the Allowable Expenses. Benefits payable under all other Programs include all benefits that would be payable if the proper claims had been made on time.

Right to Receive and Release Needed Information

The Claim Administrator needs certain information to apply the Coordination of Benefits rules. The claim administrator has the right to decide which facts the claim administrator needs. The claim administrator may get facts from or give them to any other organization or person. The claim administrator does not need to tell, or get the consent of, any person or organization to do this. To obtain all benefits available, a covered person who incurs Allowable Expenses should file a claim under each Program which covers the person. Each person claiming benefits under the Lubrizol dental option must give the claim administrator any facts the Lubrizol dental option needs to pay the claim.

Facility of Payment
A payment made under another Program may include an amount which should have been paid under your Lubrizol dental option. If it does, your Lubrizol dental option may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under your Lubrizol dental option. Your Lubrizol dental option will not have to pay that amount again. The term "payment made" includes benefits provided in the form of services, in which case the Lubrizol dental option may pay the reasonable cash value of the benefits provided in the form of services.

Right of Recovery
If the amount your Lubrizol dental option pays is more than the Lubrizol dental option should have paid under this Coordination of Benefits provision, the Lubrizol dental option may recover the excess from one or more of:

- the person the Lubrizol dental option has paid or for whom the Lubrizol dental option has paid;
- insurance companies; or
- other organizations.

The amount of the payment includes the reasonable cash value of any benefits provided in the form of services.

The Lubrizol Dental Options General Provisions
Upon receipt of a covered service, you may assign dental benefits to the dentist providing such service.

Dental Benefits: Who Your Lubrizol Dental Option Will Pay
If you assign payment of dental benefits to your or your dependent's dentist, the Lubrizol dental option will pay benefits directly to the dentist. Otherwise, your Lubrizol dental option will pay dental benefits to you.

Conformity with Law
If the terms and provisions of this Summary Plan Description do not conform to any applicable law, this Summary Plan Description shall be interpreted to so conform.

Overpayments
Recovery of Dental Benefit Overpayments
The Lubrizol dental option has the right to recover any amount that the claim administrator determines to be an overpayment, whether for services received by you or your dependents.

An overpayment occurs if the claim administrator determines that:

- the total amount paid by the Lubrizol dental option on a claim for dental benefits is more than the total of the benefits due to you under this Summary Plan Description; or
- payment this plan made should have been made by another group plan.

If such overpayment occurs, you have an obligation to reimburse your Lubrizol dental option.

How This Plan Recovers Overpayments
Your Lubrizol dental option will recover the overpayment from you by:

- stopping or reducing any future benefits payable for dental benefits;
- demanding an immediate refund of the overpayment from you; and
- taking legal action.

If the overpayment results from the Lubrizol dental option having made a payment to you that should have been made under another group plan, the Lubrizol dental option may recover such overpayment from one or more of the following:

- any other insurance company;
- any other organization; or
- any person to or for whom payment was made.

Lubrizol Dental Option Termination or Changes
This Plan sets forth those situations in which the Employer has the rights to end the Lubrizol dental option. The Employer reserves the right to change or terminate the Lubrizol dental option at any time. Therefore, there is no guarantee that you will be eligible for the coverage described herein for the duration of your employment. Any such action will be taken only after careful consideration.

Your consent or the consent of your beneficiary is not required to terminate, modify, amend, or change the Lubrizol dental option.

Claims Administrator
MetLife.

Contributions
You must make a contribution to the cost of dental benefits.

Qualified Domestic Relations Orders/Qualified Medical Child Support Orders
You and your beneficiaries can obtain, without charge from the plan administrator, a copy of any procedures governing Qualified Domestic Relations Orders (QDRO) and Qualified Medical Child Support Orders (QMCSO).

Claims Information
Procedures for Presenting Claims for Dental Benefits
To access a claim form contact your local benefits representative or visit the benefit's website at http://benefits.lubrizol.com. Dental claim forms can also be downloaded from www.metlife.com/dental.

Routine Questions
If there is any question about a claim payment, an explanation may be requested from MetLife by dialing 1-800-942-0854.

Claim Submission
For claims under your Lubrizol dental option, the claimant must complete the appropriate claim form and submit the required proof as described below:
Step 1: A claimant may request a claim form by calling MetLife at 1-800-942-0854.
Step 2: MetLife will send a claim form to the claimant and explain how to complete it. The claimant should receive the claim form within 15 days of requesting it.
Step 3: When the claimant receives the claim form the claimant should fill it out as instructed and return it with the required proof described in the claim form.
If the claimant does not receive a claim form within 15 days, proof may be sent using any form sufficient to provide the claim administrator with the required proof.
Step 4: The claimant must give MetLife proof no later than 90 days after the date of the loss.
If proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such proof is given as soon as is reasonably possible.

Initial Determination

After you submit a claim for dental benefits to the claim administrator, the claim administrator will review your claim and notify you of its decision to approve or deny your claim. Such notification will be provided to you within a 30 day period from the date you submitted your claim; except for situations requiring an extension of time of up to 15 days because of matters beyond the control of the Lubrizol dental option. If the claim administrator needs such an extension, the claim administrator will notify you prior to the expiration of the initial 30 day period, state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information or filed an incomplete claim, the time from the date of the claim administrator's notice requesting further information and an extension until the claim administrator receives the requested information does not count toward the time period the claim administrator is allowed to notify you as to its claim decision. You will have 45 days to provide the requested information from the date you receive the notice requesting further information from the claim administrator.

If the claim administrator denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific provision(s) on which the denial is based. If the claim is denied because the claim administrator did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. Further, if an internal rule, protocol, guideline or other criteria was relied upon in making the denial, the claims decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge.

Appealing the Initial Determination

If the Claim Administrator denies your claim, you may make two appeals of the initial determination. Upon your written request, the claim administrator will provide you free of charge with copies of documents, records and other information relevant to your claim. You must submit your appeal to the claim administrator at the address indicated on the claim form within 180 days of receiving the claim administrator's decision. Appeals must be in writing and must include at least the following information:

- Name of Employee
- Name of this Plan
- Reference to the initial decision
- Whether the appeal is the first or second appeal of the initial determination
- An explanation why you are appealing the initial determination

As part of each appeal, you may submit any written comments, documents, records, or other information relating to your claim.

After the claim administrator receives your written request appealing the initial determination or determination on the first appeal, the claim administrator will conduct a full and fair review of your claim. Deference will not be given to initial denials, and the claim administrator's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny your claim. If the initial denial is based in whole or in part on a medical judgment, the claim administrator will consult with a health care professional with appropriate training and experience in the field of dentistry involved in the judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

The claim administrator will notify you in writing of its final decision within 30 days after the claim administrator's receipt of your written request for review, except that under special circumstances the claim administrator may have up to an additional 30 days to provide written notification of the final decision. If such an extension is required, the claim administrator will notify you prior to the expiration of the initial 30 day period, state the reason(s) why such an extension is needed, and state when it will make its determination.

If the claim administrator denies the claim on appeal, the claim administrator will send you a final written decision that states the reason(s) why the claim you appealed is being denied and references any specific provision(s) on which the denial is based. If an internal rule, protocol, guideline or other criteria was relied upon in denying the claim on appeal, the final written decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge. Upon written request, the claim administrator will provide you free of charge with copies of documents, records and other information relevant to your claim.

When the claim has been processed, you will be notified of the benefits paid. If any benefits have been denied, you will receive a written explanation.

Urgent Care Claim Submission

A small number of claims for dental benefits may be urgent care claims. Urgent care claims for dental benefits are claims for reimbursement of dental expenses for services which a dentist familiar with the dental condition determines would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Of course any such claim may always be submitted in accordance with the normal claim procedures. However, your dentist may also submit such a claim to the claim administrator by telephoning the claim administrator and informing the claim administrator that the claim is an Urgent Care Claim. Urgent Care Claims are processed according to the procedures set out above, however once a claim for urgent care is submitted, the claim administrator will notify you of the determination on the claim as soon as possible, but no later than 72 hours after the claim was filed. If you or your covered dependent does not provide the claim administrator with enough information to decide the claim, the claim administrator will notify you within 24 hours after it receives the claim of the further information that is needed. You will have 48 hours to provide the information. If the needed information is provided, the claim administrator will then notify you of the claim decision within 48 hours after the claim administrator received the information. If the needed information is not provided, the claim administrator will notify you or your covered dependent of its decision within 120 hours after the claim was received.

If your urgent care claim is denied but you receive the care, you may appeal the denial using the normal claim procedures. If your urgent care claim is denied and you do not receive the care, you can request an expedited appeal of your claim denial by phone or in writing. The claim administrator will provide you any necessary information to assist you in your appeal. The claim administrator will then notify you of its decision within 72 hours of your request in writing. However, the claim administrator may notify you by phone within the time frames above and then mail you a written notice.

Discretionary Authority of Plan Administrator, Claim Administrator and Other Plan Fiduciaries

In carrying out their respective responsibilities under the Lubrizol dental option, the Plan administrator, claim administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Lubrizol dental option and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Lubrizol dental option. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Temporary Extended Coverage (COBRA)

Certain employment status changes and other events can result in a loss of coverage. If such coverage is lost, only expenses incurred prior to the termination date are eligible for reimbursement. However, under certain circumstances, you and/or your eligible dependents may be entitled to purchase temporary medical, prescription, dental, and vision coverage in which you or your covered dependents are enrolled for the time period shown below. In addition, if you are enrolled in a Health Care Reimbursement Account, you may elect to continue that coverage for the remainder of the calendar year.

Contributions for dependents who elect COBRA coverage are made on an after tax basis through the COBRA billing center at Conexis. If you leave the company (other than on account of your gross misconduct) and lose coverage, or if your hours are reduced and your premium is increased because of the reduction of hours, you and/or your dependents will be eligible to purchase extended medical, prescription, dental, and/or vision care coverage for up to 18 months. If either you or your dependent(s) were determined under Title II or XVI of the Social Security Act to have been disabled within 60 days from the time you left the company, you and your dependents will be eligible to purchase medical, prescription, dental, and/or vision care coverage for up to an additional 11 months (total 29 months), so long as you or your dependent provides the company with notice of the determination within 60 days of the determination but prior to the end of the original 18 months. If you leave the company (other than on account of your gross misconduct) within 18 months after you become entitled to Medicare and lose coverage, your dependents will be eligible to purchase medical, prescription, dental, and/or vision care coverage for up to 36 months from the date you became entitled to Medicare. If your dependent is no longer eligible for coverage under this plan because of divorce, your death, or ceasing to be a dependent child under the terms of the plan, the dependent may purchase medical, prescription, and/or dental care benefit coverage for up to 36 months. A dependent also may purchase coverage for the balance of the 36 month period if coverage was extended on account of the death of the employee (as previously described) and the coverage under that extension is subsequently lost.

Eligible employees or dependents are called “qualified beneficiaries” below. Circumstances that entitle a qualified beneficiary to extended coverage are called “qualifying events.”

Notification and Election Requirements

Employees and their dependents are responsible for notifying the appropriate parties within 60 days of the end of the month after a divorce or legal separation or when a child ceases to be eligible under the terms of the plan. Lubrizol will notify a qualified beneficiary of the right to continue coverage within 44 days of the employee’s termination of employment or death, or a dependent child’s 26th birthday.

Detailed information can be found on the Life Events quick link on the benefits website (http://benefits.lubrizol.com). Within 14 days of notification or loss of coverage, whichever is later, Lubrizol will notify all qualified beneficiaries of the right to continue medical, prescription drug, dental and/or vision care benefit coverage under the plan. Any notification to the spouse of an employee will be treated as notification to all other qualified beneficiaries residing with the spouse.

You and/or your dependent(s) must elect temporary extended coverage on a form provided by the Benefits Center within the period that begins on the later of the date coverage would otherwise terminate or the date notice of continuation rights has been mailed to the qualified beneficiary, and ends 60 days thereafter.

Length of Temporary Extended Coverage

In the case of termination of employment, coverage of the “qualified beneficiaries” may be continued for up to 18 months (29 months in certain cases of disability). For all other qualifying events, coverage for dependents may be continued for up to 36 months.

Coverage will stop before the end of the maximum period if any of the following occur:

1. Failure to pay premiums for coverage within 30 days of the date due.
2. The start of health, dental, or vision coverage for the qualified beneficiary under any other group plan that does not have a pre-existing condition clause that would affect the qualified beneficiary.
3. The qualified beneficiary's entitlement to Medicare benefits.
4. The termination of benefits under The Lubrizol Corporation Employee Benefits Plan.

Cost of Temporary Extended Coverage

The coverage offered is identical to the coverage available to employees. The premium charge is 102% of the total cost of the coverage (150% after the 18th month of COBRA continuation of coverage when a disability arises after COBRA began).

Notice Regarding Privacy of Protected Health Information

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

Federal regulations under the Health Insurance Portability and Accountability Act (HIPAA) require that the plan provide you with this Notice Regarding Privacy of Protected Health Information. This notice describes (1) how the plan may use and disclose your protected health information, (2) your rights to access and control your protected health information and (3) the plan's duties and contact information.

Protected Health Information

"Protected health information" is health information created or received by the plan that contains information that may be used to identify you, such as your name or address. It includes written or verbal health information that relates to your past, present or future physical or mental health; the provision of health care to you; and your past, present or future payment for health care.

The Use and Disclosure of Protected Health Information in Payment and Health Care Operations

Your protected health information may be used and disclosed by the plan in the course of providing payment for treatment and conducting medical, prescription, vision and dental claims operations. Any disclosures may be made in writing, electronically, by facsimile, or orally. The plan may also use or disclose your protected health information in other circumstances if you authorize the use or disclosure, or if state law or the HIPAA privacy regulations authorize the use or disclosure.

Treatment. The plan may use or disclose your protected health information in connection with your treatment, which includes the provision, coordination or management of health care and related services. For example, the plan may disclose information to a treating specialist the name of your regular doctor so that the specialist may request the transfer of your test results from your doctor.

Payment. The plan may use or disclose your protected health information to provide payment to you or your health care providers for services rendered to you by your health care providers. These uses or disclosures may include disclosures to your health care provider or to another group health care plan or insurer to obtain the information needed to process your claim for benefits.

Operations. The plan may use or disclose your protected health information when needed for the plan's medical, prescription, and dental claims operations for the purposes of management and administration of the plan. For example, the plan may use your information for claims operations including: utilization management; disease management program activities; administration of the plan's subrogation provisions; coordination of benefits; claims management; reviewing provider performance and plan performance; activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits; conducting or arranging for medical review, legal services, actuarial services and auditing functions, including fraud and abuse detection and compliance programs; business planning and development; systems maintenance; and management activities.

Other Uses and Disclosures. The plan may also use or disclose your protected health information to provide appointment reminders; to describe or recommend treatment alternatives or to provide information about other health-related benefits and services that may be of interest to you.

The plan may use or disclose protected health information for underwriting purposes as permitted by law, but the plan cannot use or disclose your genetic information for that purpose. Underwriting purposes include eligibility rules or determinations, including eligibility for enrollment or continued enrollment and for benefits under the plan; calculating premium or contribution amounts under the plan; applying pre-existing condition exclusions, if any; or activities related to creating, renewing or replacing any health insurance contract or health benefits. The plan may also disclose protected health information to The Lubrizol Corporation, the sponsor of the plan. Any disclosure to The Lubrizol Corporation will be in accordance with the HIPAA privacy regulations.

Additional Uses and Disclosures Permitted without Authorization or An Opportunity to Object

In addition to payment and health care operations, the plan may use or disclose your protected health information without your permission or authorization in certain circumstances, including:

When Legally Required. The plan will comply with any federal, state or local law that requires it to disclose your protected health information.

For Judicial and Administrative Proceedings. The plan may disclose your protected health information for any judicial or administrative proceeding if the disclosure is expressly authorized by an order of a court or administrative tribunal as expressly authorized by the order or a signed authorization is provided.

For Workers' Compensation. The plan may disclose your protected health information to comply with workers' compensation laws or similar Programs.

Uses and Disclosures Permitted with an Opportunity to Object

Subject to your objection, the plan may disclose your protected health information to a family member or close personal friend if the disclosure is directly relevant to the person's involvement in your care or payment related to your care. The plan will inform you orally or in writing of these uses and disclosures of your protected health information as well as provide you with an opportunity to object in advance. Your agreement or objection to the uses and disclosures can be oral or in writing. If you do not respond to these disclosures, the plan is able to infer from the circumstances that you do not object, or the plan determines that it is in your best interests for the plan to disclose information that is directly relevant to the person's involvement with your care, then the plan may disclose your protected health information. If you are incapacitated or in an emergency situation, the plan may determine if the disclosure is in your best interests and, if that determination is made, may only disclose information directly relevant to your health care.

Uses and Disclosures Authorized by You

Other than the circumstances described above, the plan will not disclose your health information unless you provide written authorization. In particular the plan will not, without your authorization, use or disclose your health information that consists of psychotherapy notes, except to defend itself in a legal action or other proceeding brought by you or as otherwise permitted by law. The plan must also obtain your authorization to use or disclose your information for most marketing purposes or to sell your information. You may revoke your authorization in writing at any time except to the extent that the plan has taken action in reliance upon the authorization.

Your Rights

You have certain rights regarding your protected health information under the HIPAA privacy regulations.

These rights include:

The right to inspect and copy your protected health information. For as long as the plan holds your protected health information, you may inspect and obtain a copy of the information included in a designated record set. A "designated record set" contains enrollment, payment, claims adjudication and case or medical management records systems maintained by or for the plan, as well as any other records the plan uses to make decisions regarding health care benefits provided to you. The plan may deny your request to inspect or copy your protected health information if the plan determines that the access requested is likely to endanger your life or safety or that of another person, or that it is likely to cause substantial harm to another person referred to in the information. You have the right to request a review of this decision.

In addition, you may not inspect or copy certain records by law, including:
(1) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and
(2) protected health information that is subject to a law that prohibits access to protected health information.
You have the right to make a decision to deny access reviewed in some situations. You must submit a written request to the plan's Privacy Officer to inspect and copy your health information. The plan may charge you a fee for the costs of copying, mailing, or other costs incurred by the plan in complying with your request. Please contact the Privacy Officer at the number given at the end of this notice if you have any questions about access to your medical information.

The right to request a restriction on uses and disclosures of your protected health information. You may request that the plan not use or disclose specific sections of your protected health information for the purposes of payment or health care operations. Additionally, you may request that the plan not disclose your health information to family members or friends who may be involved in your care or for notification purposes described in this notice. In your request, you must specify the scope of restriction requested as well as the individuals for whom you want the restriction to apply. Your request should be directed to the Privacy Officer. The plan may choose to deny your request for a restriction, in which case the plan will notify you of its decision. Once the plan agrees to the requested restriction, the plan may not violate that restriction unless use or disclosure of the relevant information is needed to provide emergency treatment. The plan may terminate the agreement to a restriction in some cases.

The right to request to receive confidential communications from the plan by alternative means or at an alternative location. You have the right to request to receive communications of protected health information from the plan through alternative means or at an alternative location if you clearly state that the disclosure of all or part of that information could endanger you. The plan will make every effort to comply with reasonable requests. However, the plan may condition its compliance by asking you for information regarding the procurement of payment or specific information regarding an alternative address or other method of contact. You are not required to provide an explanation for your request. Requests should be made in writing to the Privacy Officer.

The right to request an amendment of your protected health information. During the time that the plan holds your protected health information, you may request an amendment of your information in a designated record set. The plan may deny your request in some instances. However, should the plan deny your request for amendment, you have the right to file a statement of disagreement with the plan. In turn, the plan may develop a rebuttal to your statement. If it does so, the plan will provide you with a copy of the rebuttal. Requests for amendment must be submitted in writing to the Privacy Officer. Your written request must supply a reason to support the requested amendments.

The right to request an accounting of certain disclosures. You have the right to request an accounting of the plan's disclosures of your protected health information made for the purposes other than payment or health care operations as described in this notice. The plan is not required to account for disclosures (1) you requested, (2) you authorized by signing an authorization form, (3) to friends or family members involved in your care and (4) certain other disclosures the plan is permitted to make without your authorization. The request for an accounting must be made in writing to the Privacy Officer and should state the time period that you wish the accounting to include, up to a six year period. The plan is not required to provide an accounting for disclosures that took place prior to April 14, 2003. The plan will not charge you for the first accounting you request in any 12-month period. Subsequent accountings may require a fee based on the plan's reasonable costs for compliance of the request.

The right to receive a paper copy of this notice. The plan will provide a separate paper copy of this notice upon request even if you have already been given a copy of it or have agreed to review it electronically.

The Plan's Duties

The plan is required by law to ensure the privacy of your protected health information, to provide you with this notice of your rights and the plan's legal duties and privacy practices, and to notify you in the event of a breach of your unsecured protected health information. The plan must abide by the terms of this notice, as may be amended periodically. The plan reserves the right to change the terms of this notice and to make the new notice provisions effective for all protected health information that the plan collects and maintains. If the plan alters its notice, the plan will provide a copy of the revised notice through regular mail or in person.

Complaints

If you believe that your privacy rights have been violated, you have the right to relay complaints to the plan and to the Secretary of the Department of Health and Human Services. You may provide complaints to the plan verbally or in writing. These complaints should be directed to the Privacy Officer. The plan encourages you to relay any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Contact Person

The plan's contact person regarding the plan's duties and your rights under the HIPAA privacy regulations is the Privacy Officer. The Privacy Officer can provide information regarding issues related to this notice by request. Complaints to the plan should be directed to the Privacy Officer at the following address:

HIPAA Privacy Officer
The Lubrizol Corporation
29400 Lakeland Boulevard – 491A
Wickliffe, OH 44092

The Privacy Officer can be contacted by telephone at 440-347-5151.

The Lubrizol Vision Option

Lubrizol's vision option is self-insured and administered by EyeMed. The plan allows you to improve your health through a routine eye exam, while saving you money on your eye care purchases. The plan is available through thousands of provider locations participating on the EyeMed Access Network.

You can use this benefit at thousands of private practice and retail providers across the country. To learn more or locate providers near you, log on to www.eyemedvisioncare.com. You can also reach EyeMed's Customer Care Center seven days a week by calling **1-866-723-0513**.

Eye exams and refractions due to medical conditions are covered under your health plan.

Summary of Vision Benefits		
Vision Care Service	**Member Cost**	**Out-of-Network Reimbursement**
Exam with dilation as necessary	$0 co-pay	up to $35
Standard contact lens fit and follow-up	up to $55	N/A
Premium contact lens fit and follow-up	90% of retail price	N/A
Eyeglass frames (once every 24 months)	$0 copay, 80% of charge over150	up to $65
Standard plastic lenses: (once every 12 months instead of contact lenses) Single vision Bifocal Trifocal Standard progressive Premium progressive	 $15 copay $15 copay $15 copay $15 copay $15 copay, 80% of charge less $120 allowance	 up to $25 up to $40 up to $55 up to $55 up to $55
Lens options: (paid by member and added to the base price of the lenses) Tint (solid and gradient) UV Coating Standard scratch resistance Standard polycarbonate Standard polycarbonate (for children under 19) Standard anti-reflective Polarized Other add-ons and services	 $15 $0 $0 $0 $0 $45 80% of retail price 80% of retail price	 N/A up to $5 up to $5 up to $5 up to $5 N/A N/A N/A
Contact Lenses (materials only) Conventional Disposables Medically necessary*	 $0 copay, 85% of charge over $150 $0 copay, 100% of charge over $150 $0 copay, paid in full	 Up to $120 Up to $120 Up to $200
Lasik and PRK Vision Procedures	15% of retail price or 95% of promotional pricing	N/A

Frequency of services:

One exam every 12 months
Frames-once every 24 months
Standard plastic lenses or contact lenses-once every 12 months

*Contact lenses are defined as medically necessary if the participant is diagnosed with a specific medical condition where the patient's vision cannot be corrected using standard spectacle lenses. Contact EyeMed for additional information.

Definitions

Please note certain words used in this document have specific meanings. These terms will be capitalized throughout the document.

Benefit Frequency means the period of time in which a benefit is payable.

The Benefit Frequency begins on the later of the Insured Person's effective date or last date services were provided to the Insured Person. Each new Benefit Frequency begins at the expiration of the previous Benefit Frequency.

Co-payment means the designated amount, if any, shown in the Schedule of Benefits each Insured Person must pay to a Provider before benefits are payable for covered Vision Examination and Vision Materials per Benefit Frequency.

Comprehensive Eye Examination means a comprehensive ophthalmological service as defined in the Current Procedural Technology (CPT) and the Documentation Guidelines listed under "Eyes-examination items". Comprehensive ophthalmological service describes a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields and basic sensorimotor examination. It often includes, as indicated by examination, biomicroscopy, examination with cyclopegia or mydriasis and tonometry. It always includes initiation of diagnostic and treatment Programs.

In-Network Provider means a Provider who has signed a Preferred Provider Agreement with the PPO.

Medically Necessary Contact Lenses means:

1. Keratoconus where the Insured Person is not correctable to 20/30 in either or both eyes using standard spectacle lenses, or the Provider attests to the specified level of visual improvement;
2. High Ametropia exceeding -10D or +10D in spherical equivalent in either eye;
3. Anisometropia of 3D in spherical equivalent or more; or
4. Vision for an Insured Person can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle.

Out-of-Network Provider means a Provider, located within the PPO Service Area, who has not signed a Preferred Provider Agreement with the PPO.

PPO Service Area means the geographical area where the PPO is located.

Preferred Provider Agreement means an agreement between the PPO and a Provider that contains the rates and reimbursement methods for services and supplies provided by such Provider.

Preferred Provider Organization ("PPO") means a network of Providers and retail chain stores within the PPO Service Area that has signed a Preferred Provider Agreement.

Provider means a licensed physician or optometrist who is operating within the scope of his or her license or a dispensing optician.

Vision Examination means any eye or visual examination covered under the Policy and shown in the Schedule of Benefits.

Vision Materials means those materials shown in the Schedule of Benefits.

Benefits

Benefits are payable for you and your covered dependents as shown in the *Lubrizol Vision Option Summary of Benefits* for expenses incurred while the Lubrizol vision option is in force.

Comprehensive Eye Examination

You and your dependents are eligible for one Comprehensive Eye Examination in each Benefit Frequency.

In-Network Provider Benefits

You must pay any Co-payment or any cost above the allowance shown in the *Lubrizol Vision Option Summary of Benefits* at the time the covered service is provided. Benefits will be paid to the In-Network Provider who will file a claim with EyeMed.

Out-of-Network Provider Benefits

You must pay the Out-of-Network Provider the full cost at the time the covered service is provided and file a claim with EyeMed. EyeMed will reimburse you for the Out-of-Network Provider benefits up to the maximum dollar amount shown in the *Lubrizol Vision Option Summary of Benefits*.

Vision Materials

If a Vision Examination results in you or your dependents needing corrective Vision Materials for you or your dependents' visual health and welfare, those Vision Materials prescribed by the Provider will be supplied, subject to certain limitations and exclusions of the Policy, as follows:

- Lenses provided one time in each Benefit Frequency.
- Frame(s) provided one time in each Benefit Frequency.
- Contact Lenses provided one time in each Benefit Frequency in lieu of lenses.

Limitations

Fees charged by a Provider for services other than a covered benefit must be paid in full by you to the Provider. Such fees or materials are not covered under the Policy.

Benefit allowances provide no remaining balance for future use within the same Benefit Frequency.

Exclusions

No benefits will be paid for services or materials connected with or charges arising from:

1. orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
2. medical and/or surgical treatment of the eye, eyes or supporting structures;
3. any Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear;
4. services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or Program whether federal, state or subdivisions thereof;
5. plano (non-prescription) lenses;
6. non-prescription sunglasses;
7. two pairs of glasses in lieu of bifocals;
8. services or materials provided by any other group benefit plan providing vision care;
9. services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; and
10. lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

Claims & Claims Appeals

Time Frames for Processing Claims

Health Claim Processing Activity	Post Service Claims
Plan Initial Determination • Initial Review Decision • Extension Period, including extension for Missing Information	 30 calendar days 15 calendar days
Plan Notice of Incomplete Claim • Missing Information	 Included in Extension Time above
Claimant Time to Complete Claim • Provide Additional Information • Comply with Required Filing Procedure	 45 calendar days 45 calendar days

Time Frames for Responding to Appealed Claims

Activity	Time Frame
Claimant Appeal of Adverse Determination (Denial or Reduction)	180 calendar days
Plan Decision on Appeal	60 calendar days

EyeMed Vision Care has been determined to belong to the post service claims category. If a claim for benefits is denied, EyeMed will notify the member in writing of the specific reasons for the denial. The member may request a full review by EyeMed within 180 days of the date of a denial. The member's written letter of appeal should include the following:

- The applicable claim number or a copy of the EyeMed Vision Care denial information or Explanation of Benefits, if applicable.
- The item of your vision coverage that the member feels was misinterpreted or inaccurately applied.
- Additional information from the member's eye care provider that will assist EyeMed Vision Care in completing its review of the member's appeal, such as documents, records, questions or comments.

The appeal should be mailed or faxed to the following address:

EyeMed Vision Care, L.L.C.
Attn: Quality Assurance Dept.
4000 Luxottica Place
Mason, Ohio 45040
Fax: 1-513-492-4999

EyeMed will review your appeal for benefits and notify you in writing of its decision, the reasons for the decision, a reference to specific plan provisions, statement of any guideline, rule or protocol relied on, if appropriate, a statement of the specific medical determination used to make the decision and the specialization of any physician or other professional consulted, if appropriate, along with a description of the appeal process and timeframe.

Complaint Procedure

A complaint is any dissatisfaction expressed by a Member in writing to EyeMed regarding unresolved inquiries submitted in writing, dissatisfaction with quality of care, dissatisfaction with Provider services, materials or facility, or dissatisfaction with plan benefits or plan administration. If you are dissatisfied with an EyeMed Provider's quality of care, services, materials or facility and/or plan benefit or administration, you should file a formal complaint by writing to EyeMed at the address indicated above.

For informal resolution, you may contact EyeMed Vision Care's Customer Care Center at 1-877-754-7428 to relay your dissatisfaction informally about your plan benefits or claim administration. The Customer Care representative will attempt to reach resolution to the issues you raise during the telephone call. If you are not satisfied with the informal resolution from the Customer Care representative, or if the issue cannot be resolved during the telephone call, the representative will advise that you file a formal complaint to the Quality Assurance department to the address noted above.

If you choose to file a written formal complaint about your dissatisfaction, the EyeMed Vision Care Quality Assurance Department will log your complaint and send you a written acknowledgement within three (3) business days. The acknowledgement letter may also request additional information necessary to investigate the complaint. Quality Assurance will investigate the complaint with the EyeMed Provider and notify you in writing of its decision. The resolution response includes a statement of the decision, reason(s) for the decision, statement of any guideline, rule or protocol relied on, if appropriate, specific medical determination, clinical basis and/or contractual criteria used to make the decision and the specialization of any physician or other Provider consulted as applicable, along with a description of the complaint appeal process and timeframe.

If you remain dissatisfied with the complaint resolution, you may file a formal written complaint appeal to EyeMed Quality Assurance and submit any new information and a new independent review will occur. The reconsideration process is the same as the first complaint review and conducted by a review committee who's members were not involved in the original review. Your complaint appeal will be acknowledged in writing. EyeMed will review your complaint appeal and notify you in writing of its decision.

The resolution response includes a statement of the decision, reason(s) for the decision, statement of any guideline, rule or protocol relied on, if appropriate, specific medical determination, clinical basis and/or contractual criteria used to make the decision and the specialization of any physician or other Provider consulted as applicable, along with the contact information of your state Bureau of Insurance, as applicable.

You may have other voluntary complaint resolution through your state Bureau of Insurance or your local or state consumer advocacy group. The time frame to file a complaint with your state Bureau of Insurance from the day of occurrence varies by state as does the state's resolution time frame.

EyeMed Time Frames for Responding to Member Complaints

Activity	**Time Frame**
Occurrence of Dissatisfaction	180 calendar days
EyeMed Decision on Complaint	30 calendar days
Member Appeal of Complaint Resolution	30 calendar days
EyeMed Decision of Complaint Appeal	30 calendar days

Note: If you have any questions or concerns, please contact EyeMed Vision Care.

Temporary Extended Coverage (COBRA)

Certain employment status changes and other events can result in a loss of coverage. If such coverage is lost, only expenses incurred prior to the termination date are eligible for reimbursement. However, under certain circumstances, you and/or your eligible dependents may be entitled to purchase temporary medical, prescription, dental, and vision coverage in which you or your covered dependents are enrolled for the time period shown below. In addition, if you are enrolled in a Health Care Reimbursement Account, you may elect to continue that coverage for the remainder of the calendar year.

Contributions for dependents who elect COBRA coverage are made on an after tax basis through the COBRA billing center at Conexis. If you leave the company (other than on account of your gross misconduct) and lose coverage, or if your hours are reduced and your premium is increased because of the reduction of hours, you and/or your dependents will be eligible to purchase extended medical, prescription, dental, and/or vision care coverage for up to 18 months. If either you or your dependent(s) were determined under Title II or XVI of the Social Security Act to have been disabled within 60 days from the time you left the company, you and your dependents will be eligible to purchase medical, prescription, dental, and/or vision care coverage for up to an additional 11 months (total 29 months), so long as you or your dependent provides the company with notice of the determination within 60 days of the determination but prior to the end of the original 18 months. If you leave the company (other than on account of your gross misconduct) within 18 months after you become entitled to Medicare and lose coverage, your dependents will be eligible to purchase medical, prescription, dental, and/or vision care coverage for up to 36 months from the date you became entitled to Medicare. If your dependent is no longer eligible for coverage under this plan because of divorce, your death, or ceasing to be a dependent child under the terms of the plan, the dependent may purchase medical, prescription, and/or dental care benefit coverage for up to 36 months. A dependent also may purchase coverage for the balance of the 36 month period if coverage was extended on account of the death of the employee (as previously described) and the coverage under that extension is subsequently lost.

Eligible employees or dependents are called “qualified beneficiaries” below. Circumstances that entitle a qualified beneficiary to extended coverage are called “qualifying events.”

Notification and Election Requirements

Employees and their dependents are responsible for notifying the appropriate parties within 60 days of the end of the month after a divorce or legal separation or when a child ceases to be eligible under the terms of the plan. Lubrizol will notify a qualified beneficiary of the right to continue coverage within 44 days of the employee’s termination of employment or death, or a dependent child’s 26th birthday.

Detailed information can be found on the Life Events quick link on the benefits website (http://benefits.lubrizol.com). Within 14 days of notification or loss of coverage, whichever is later, Lubrizol will notify all qualified beneficiaries of the right to continue medical, prescription drug, dental and/or vision care benefit coverage under the plan. Any notification to the spouse of an employee will be treated as notification to all other qualified beneficiaries residing with the spouse.

You and/or your dependent(s) must elect temporary extended coverage on a form provided by the Benefits Center within the period that begins on the later of the date coverage would otherwise terminate or the date notice of continuation rights has been mailed to the qualified beneficiary, and ends 60 days thereafter.

Length of Temporary Extended Coverage

In the case of termination of employment, coverage of the “qualified beneficiaries” may be continued for up to 18 months (29 months in certain cases of disability). For all other qualifying events, coverage for dependents may be continued for up to 36 months.

Coverage will stop before the end of the maximum period if any of the following occur:

1. Failure to pay premiums for coverage within 30 days of the date due.
2. The start of health, dental, or vision coverage for the qualified beneficiary under any other group plan that does not have a pre-existing condition clause that would affect the qualified beneficiary.
3. The qualified beneficiary's entitlement to Medicare benefits.
4. The termination of benefits under The Lubrizol Corporation Employee Benefits Plan.

Cost of Temporary Extended Coverage

The coverage offered is identical to the coverage available to employees. The premium charge is 102% of the total cost of the coverage (150% after the 18th month of COBRA continuation of coverage when a disability arises after COBRA began).

Notice Regarding Privacy of Protected Health Information

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

Federal regulations under the Health Insurance Portability and Accountability Act (HIPAA) require that the plan provide you with this Notice Regarding Privacy of Protected Health Information. This notice describes (1) how the plan may use and disclose your protected health information, (2) your rights to access and control your protected health information and (3) the plan's duties and contact information.

Protected Health Information

"Protected health information" is health information created or received by the plan that contains information that may be used to identify you, such as your name or address. It includes written or verbal health information that relates to your past, present or future physical or mental health; the provision of health care to you; and your past, present or future payment for health care.

The Use and Disclosure of Protected Health Information in Payment and Health Care Operations

Your protected health information may be used and disclosed by the plan in the course of providing payment for treatment and conducting medical, prescription, vision and dental claims operations. Any disclosures may be made in writing, electronically, by facsimile, or orally. The plan may also use or disclose your protected health information in other circumstances if you authorize the use or disclosure, or if state law or the HIPAA privacy regulations authorize the use or disclosure.

Treatment. The plan may use or disclose your protected health information in connection with your treatment, which includes the provision, coordination or management of health care and related services. For example, the plan may disclose information to a treating specialist the name of your regular doctor so that the specialist may request the transfer of your test results from your doctor.

Payment. The plan may use or disclose your protected health information to provide payment to you or your health care providers for services rendered to you by your health care providers. These uses or disclosures may include disclosures to your health care provider or to another group health care plan or insurer to obtain the information needed to process your claim for benefits.

Operations. The plan may use or disclose your protected health information when needed for the plan's medical, prescription, and dental claims operations for the purposes of management and administration of the plan. For example, the plan may use your information for claims operations including: utilization management; disease management program activities; administration of the plan's subrogation provisions; coordination of benefits; claims management; reviewing provider performance and plan performance; activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits; conducting or arranging for medical review, legal services, actuarial services and auditing functions, including fraud and abuse detection and compliance programs; business planning and development; systems maintenance; and management activities.

Other Uses and Disclosures. The plan may also use or disclose your protected health information to provide appointment reminders; to describe or recommend treatment alternatives or to provide information about other health-related benefits and services that may be of interest to you.

The plan may use or disclose protected health information for underwriting purposes as permitted by law, but the plan cannot use or disclose your genetic information for that purpose. Underwriting purposes include eligibility rules or determinations, including eligibility for enrollment or continued enrollment and for benefits under the plan; calculating premium or contribution amounts under the plan; applying pre-existing condition exclusions, if any; or activities related to creating, renewing or replacing any health insurance contract or health benefits. The plan may also disclose protected health information to The Lubrizol Corporation, the sponsor of the plan. Any disclosure to The Lubrizol Corporation will be in accordance with the HIPAA privacy regulations.

Additional Uses and Disclosures Permitted without Authorization or An Opportunity to Object

In addition to payment and health care operations, the plan may use or disclose your protected health information without your permission or authorization in certain circumstances, including:

When Legally Required. The plan will comply with any federal, state or local law that requires it to disclose your protected health information.

For Judicial and Administrative Proceedings. The plan may disclose your protected health information for any judicial or administrative proceeding if the disclosure is expressly authorized by an order of a court or administrative tribunal as expressly authorized by the order or a signed authorization is provided.

For Workers' Compensation. The plan may disclose your protected health information to comply with workers' compensation laws or similar Programs.

Uses and Disclosures Permitted with an Opportunity to Object

Subject to your objection, the plan may disclose your protected health information to a family member or close personal friend if the disclosure is directly relevant to the person's involvement in your care or payment related to your care. The plan will inform you orally or in writing of these uses and disclosures of your protected health information as well as provide you with an opportunity to object in advance. Your agreement or objection to the uses and disclosures can be oral or in writing. If you do not respond to these disclosures, the plan is able to infer from the circumstances that you do not object, or the plan determines that it is in your best interests for the plan to disclose information that is directly relevant to the person's involvement with your care, then the plan may disclose your protected health information. If you are incapacitated or in an emergency situation, the plan may determine if the disclosure is in your best interests and, if that determination is made, may only disclose information directly relevant to your health care.

Uses and Disclosures Authorized by You

Other than the circumstances described above, the plan will not disclose your health information unless you provide written authorization. In particular the plan will not, without your authorization, use or disclose your health information that consists of psychotherapy notes, except to defend itself in a legal action or other proceeding brought by you or as otherwise permitted by law. The plan must also obtain your authorization to use or disclose your information for most marketing purposes or to sell your information. You may revoke your authorization in writing at any time except to the extent that the plan has taken action in reliance upon the authorization.

Your Rights

You have certain rights regarding your protected health information under the HIPAA privacy regulations. These rights include:

The right to inspect and copy your protected health information. For as long as the plan holds your protected health information, you may inspect and obtain a copy of the information included in a designated record set. A "designated record set" contains enrollment, payment, claims adjudication and case or medical management records systems maintained by or for the plan, as well as any other records the plan uses to make decisions regarding health care benefits provided to you. The plan may deny your request to inspect or copy your protected health information if the plan determines that the access requested is likely to endanger your life or safety or that of another person, or that it is likely to cause substantial harm to another person referred to in the information. You have the right to request a review of this decision.

In addition, you may not inspect or copy certain records by law, including:
(1) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and
(2) protected health information that is subject to a law that prohibits access to protected health information.
You have the right to make a decision to deny access reviewed in some situations. You must submit a written request to the plan's Privacy Officer to inspect and copy your health information. The plan may charge you a fee for the costs of copying, mailing, or other costs incurred by the plan in complying with your request. Please contact the Privacy Officer at the number given at the end of this notice if you have any questions about access to your medical information.

The right to request a restriction on uses and disclosures of your protected health information. You may request that the plan not use or disclose specific sections of your protected health information for the purposes of payment or health care operations. Additionally, you may request that the plan not disclose your health information to family members or friends who may be involved in your care or for notification purposes described in this notice. In your request, you must specify the scope of restriction requested as well as the individuals for whom you want the restriction to apply. Your request should be directed to the Privacy Officer. The plan may choose to deny your request for a restriction, in which case the plan will notify you of its decision. Once the plan agrees to the requested restriction, the plan may not violate that restriction unless use or disclosure of the relevant information is needed to provide emergency treatment. The plan may terminate the agreement to a restriction in some cases.

The right to request to receive confidential communications from the plan by alternative means or at an alternative location. You have the right to request to receive communications of protected health information from the plan through alternative means or at an alternative location if you clearly state that the disclosure of all or part of that information could endanger you. The plan will make every effort to comply with reasonable requests. However, the plan may condition its compliance by asking you for information regarding the procurement of payment or specific information regarding an alternative address or other method of contact. You are not required to provide an explanation for your request. Requests should be made in writing to the Privacy Officer.

The right to request an amendment of your protected health information. During the time that the plan holds your protected health information, you may request an amendment of your information in a designated record set. The plan may deny your request in some instances. However, should the plan deny your request for amendment, you have the right to file a statement of disagreement with the plan. In turn, the plan may develop a rebuttal to your statement. If it does so, the plan will provide you with a copy of the rebuttal. Requests for amendment must be submitted in writing to the Privacy Officer. Your written request must supply a reason to support the requested amendments.

The right to request an accounting of certain disclosures. You have the right to request an accounting of the plan's disclosures of your protected health information made for the purposes other than payment or health care operations as described in this notice. The plan is not required to account for disclosures (1) you requested, (2) you authorized by signing an authorization form, (3) to friends or family members involved in your care and (4) certain other disclosures the plan is permitted to make without your authorization. The request for an accounting must be made in writing to the Privacy Officer and should state the time period that you wish the accounting to include, up to a six year period. The plan is not required to provide an accounting for disclosures that took place prior to April 14, 2003. The plan will not charge you for the first accounting you request in any 12-month period. Subsequent accountings may require a fee based on the plan's reasonable costs for compliance of the request.

The right to receive a paper copy of this notice. The plan will provide a separate paper copy of this notice upon request even if you have already been given a copy of it or have agreed to review it electronically.

The Plan's Duties

The plan is required by law to ensure the privacy of your protected health information, to provide you with this notice of your rights and the plan's legal duties and privacy practices, and to notify you in the event of a breach of your unsecured protected health information. The plan must abide by the terms of this notice, as may be amended periodically. The plan reserves the right to change the terms of this notice and to make the new notice provisions effective for all protected health information that the plan collects and maintains. If the plan alters its notice, the plan will provide a copy of the revised notice through regular mail or in person.

Complaints

If you believe that your privacy rights have been violated, you have the right to relay complaints to the plan and to the Secretary of the Department of Health and Human Services. You may provide complaints to the plan verbally or in writing. These complaints should be directed to the Privacy Officer. The plan encourages you to relay any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Contact Person

The plan's contact person regarding the plan's duties and your rights under the HIPAA privacy regulations is the Privacy Officer. The Privacy Officer can provide information regarding issues related to this notice by request. Complaints to the plan should be directed to the Privacy Officer at the following address:

HIPAA Privacy Officer
The Lubrizol Corporation
29400 Lakeland Boulevard – 491A
Wickliffe, OH 44092

The Privacy Officer can be contacted by telephone at 440-347-5151.

Vacation Buy and Sell Program

Introduction and Enrollment

During annual enrollment, you will have the opportunity to enroll in the Vacation Buy and Sell Program. You may elect to buy additional vacation and the cost for the amount of vacation you purchase will automatically be deducted from each of your pays on a pre-tax basis. The cost deducted or added to your biweekly pay will change to reflect an increase or decrease in pay.

You also may elect to sell vacation time. The amount you receive when you sell time is added to each pay and is taxable income.

Elections for vacation buy and sell do not continue from year to year, so new elections are necessary each year to participate in the Program. Elections can only be made during annual enrollment. You may not change your election during the year, and cannot cancel it except at separation of employment or retirement.

New employees are not eligible for the Program until their first annual enrollment period.

Please Note: A "day" of vacation is defined as 8 hours.

Minimum and Maximum Vacation

Amount to Buy or Sell

You may buy or sell between one and five vacation days per calendar year. A "day" of vacation is defined as 8 hours and you must use your vacation days in 8 hour increments. When you choose to buy or sell vacation days, the benefit will be deducted from or added to your paycheck on a pre-tax basis. If you buy vacation time, you will be taxed on the benefit when the vacation days are taken. When you sell vacation, taxes will be deducted as the benefit is paid.

Minimum

There is no minimum.

Maximum

The most vacation you can take is six weeks per year.

Unused Elected Vacation Time

Any vacation time elected, but not used, during the year will be forfeited and does not carry over into the next year (unless required by the state in which you work).

If you terminate employment, state laws where you work will apply regarding any unused vacation.

Long Term Disability Plan

Table of Contents

General Information

This summary plan description (SPD) describes the main features of the Lubrizol long-term disability (LTD) plan. The SPD includes important details about eligibility and long-term disability benefits, as well as the requirements which you must satisfy to obtain the greatest possible benefit. Please read the entire SPD carefully to understand the benefits available under this plan. If there are any conflicts between this SPD and the long-term disability plan document, the plan document shall govern.

Lubrizol hopes to continue this long-term disability plan indefinitely, but, as with all benefits programs, the plan may be changed or discontinued at any time by written action of the Board of Directors or its designee. Lubrizol also reserves the right by action of its Board of Directors to terminate the plan as to any or all employers at any time. Federal law provides you with certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). A summary of these rights, along with specific information identifying each plan in the Lubrizol benefits program, is included in the "General" section of this Benefits Resource Guide.

The cost of the basic long-term disability plan coverage is paid entirely by your employer. The cost of the optional enhanced coverage option is paid entirely by you. If you elect the enhancement option, you must enroll and make the necessary contributions in order to be eligible for the additional coverage.

If you have any questions about the terms of the long-term disability plan or about the payment of benefits, you may obtain more information from any Lubrizol benefits representative.

Eligibility and Enrollment

You are automatically covered by this plan if you are a regular employee of Lubrizol or an affiliate of Lubrizol that has adopted the plan, who works at least an average of 20 hours per week or is participating in a phased-in retirement program. Your coverage becomes effective on the first day of active employment. If you are not actively at work on the date coverage would become effective, you will become covered on the first day you begin active employment.

If you wish to elect the enhanced coverage option, you must enroll and agree to contribute the specified amount for the coverage option. Coverage will be effective on your employment date when you complete and submit the enrollment form within 30 days of your employment. If you do not make an election within 30 days of your employment date you will have basic coverage for the remainder of the plan year.

See the section titled *Amount of Benefits* for a description of your coverage options.

Collective bargaining employees are eligible for this plan only if their collective bargaining agreement specifically provides for coverage under this plan.

Cost of Coverage

The 60% LTD option is provided at no cost to all eligible employees. The additional cost for the optional 70% LTD coverage is paid by employees. The premiums for the 70% coverage will be deducted from your pay on a pre-tax basis. This means that these deductions will be taken before federal and state income taxes and Social Security taxes are deducted. Since pre-tax contributions reduce your income for purposes of Social Security, your Social Security benefits may be affected. If you think the effect on your Social Security benefit will be a factor in your pre-tax contribution decisions, you should consult a tax advisor prior to making your elections.

When Benefits Begin

You will be eligible to begin receiving long-term disability benefits under this plan after you are considered to be totally disabled, have used 1,040 hours of salary continuation and apply for benefits. As part of the application process you must sign a consent form which authorizes third party investigations while you are receiving long-term disability benefits. Also, you must provide medical documentation to support your disability.

Total Disability Defined

To be considered totally disabled, you must be unable to perform the essential functions of your job or any other available job with your employer for which you are qualified and pays at least 60% of your basic earnings for more than 1,040 equivalent work hours (based on a 40 hour work week) due to injuries or illnesses, and you must be under the care of a legally qualified physician for such injuries or illnesses, and such injuries or illnesses occurred while you were actively at work or while receiving salary continuation pay pursuant to Lubrizol's salary continuation policy.

Separate periods of the same illness or injury will be added together for purposes of calculating the 1,040 equivalent work hours (based on a 40 hour work week) unless separated by 12 months during which you do not receive salary continuation for such injury or illness. If, while receiving salary continuation for an injury or illness, you incur an unrelated injury or illness, separate periods of these unrelated injuries or illnesses will be added together for purposes of calculating the 1,040 equivalent work hours (based on a 40 hour work week), unless separated by 12 months during which you do not receive salary continuation for such injuries or illnesses.

You will also be deemed totally disabled if after your benefits have been discontinued you are unable to perform the essential functions of your job any time within 12 months of such discontinuation of benefits, due to the same illness(es) or injury(ies) which led to the original disability.

After you incur a total of 18 months of total disability, you will be totally disabled only if you remain unable to perform the essential functions of any reasonable occupation for compensation or profit which equals at least 60% of your basic earnings. You will no longer be considered totally disabled once you receive a final (non-appealable) denial of Social Security disability benefits. A denial of Social Security disability benefits will be considered final if Lubrizol is advised by you or your attorney that you do not intend to appeal the denial of your claim for Social Security disability benefits; the period for filing an appeal of the denial has expired, with no appeal filed prior to the expiration of such period; or the internal Social Security Administration appeal process has been exhausted with respect to the denial (your ability to file a lawsuit in federal court with respect to the denial, and any subsequent remand by the court to the Social Security Administration, will not be considered a part of the internal Social Security Administration process). Any approval of Social Security disability benefits that approve a benefit for a finite period shall be treated as a final denial of Social Security benefits with respect to the period for which Social Security benefits were not granted. All applications for Social Security disability benefits and any appeals of denials therefore will be handled by an attorney designated and paid for by Lubrizol or its affiliate. If you fail to cooperate with the attorney, LTD benefits will cease. Any total disability must be certified by a physician.

Return to Work

If you recover from your medical condition and are able to return to work, your LTD benefits will cease. If there is a position available for which you are qualified, you may interview for the position. **However, receipt of LTD benefits does not guarantee a future position with the company.**

If you return to work for less than 12 consecutive months after being on long-term disability leave, and incur a work absence due to the same illness or injury, you will be returned to long-term disability leave.

How Long-Term Disability Benefits Continue

Benefits continue until the first of the following occur: 1) you are no longer totally disabled; 2) you receive a final (non-appealable) denial of Social Security Disability Income (SSDI) benefits, 3) you reach age 65 (or up to five years for employees who become disabled after age 60); 4) you die; 5) you separate from employment; 6) you fail to cooperate with case management or rehabilitative programs, if applicable; 7) the plan is terminated; or 8) you fail to cooperate with Allsup (the third party Lubrizol provides to help you apply for SSDI). You will be required to furnish periodic proof of the continuance of your total disability, and Lubrizol retains the right to require an examination by a physician designated and paid for by Lubrizol or its affiliate, whenever and as often as it may reasonably require. Failure to cooperate will result in the termination of your benefits.

Case Management and Rehabilitation

Case management is a systematic process in which a rehabilitation professional and/or the company's occupational nurses work with an employee with a total disability to assist him/her toward optimal independence.

Vocational rehabilitation services are designed to assist the employee in returning to work and may include vocational training for a new occupation. Rehabilitation counselors and/or the company's occupational nurses coordinate physical medicine services and consult with the employer, and if necessary other employers, regarding return to work planning. Additionally, the counselors may conduct job analyses, counsel with regard to reemployment strategies and provide job placement assistance. These programs may be recommended from time to time by your employer or case manager. Failure to cooperate with case management will result in the suspension of benefits and/or termination of employment.
If you reach a point in your recovery when it would be of benefit for you to start to work, you may be required to return to work under a rehabilitation plan approved in writing by Lubrizol or its designee. If you return to work up to one-half of your regular schedule with your employer as part of a vocational rehabilitation program you will receive 100% of your basic earnings for the time worked and your LTD pay under the plan for the time not worked.

Upon the successful completion of a program of case management and/or vocational rehabilitation you will:

1) return to your regular job, if possible;
2) return to a similar job; or
3) return to a job for which you are qualified, if available. If no appropriate job is available, you can receive outplacement assistance after which your employment and benefits under this plan will cease.

If your long-term disability leave qualifies, and has been designated by you, as a leave under the Family Care Leave Practice, you will not be required to return to less than full work for the duration of the Family Care Leave. In that case, your long term disability benefits will cease, and the long-term disability leave will be unpaid.

Amount of Benefits

If you become eligible for long-term disability benefits, you will receive a biweekly benefit that totals 60% of your basic earnings less any amounts described under Other Income Benefits. For purposes of determining the benefit payable under the Plan to a driver employed by LSP Transport, LLC ("LSPT"), the driver's annual basic earnings shall be $75,000.00. The enhanced coverage option is:

- 70% of your biweekly basic earnings

You are eligible to elect the enhanced option within 30 days of your employment date or during any annual enrollment period. The enhanced coverage will only take effect if you are actively at work and working a regular schedule on the first scheduled workday in December before the New Year. Vocational rehabilitation under this plan or a shortened schedule while on sick leave is not considered a regular schedule for this purpose. You will not be eligible for the enhanced level of coverage if you were out on long-term disability under the basic level of coverage and returned to work, then made a new coverage level election for the next year during annual enrollment, and went back out on long-term disability before you had been back for 12 months. Your long-term disability benefits would be paid at the same level as during your previous long-term disability leave. Drivers employed by LSPT are not eligible to purchase this enhanced option.

Definition of Biweekly Basic Earnings

Biweekly basic earnings is defined as biweekly base salary, on a biweekly basis (excluding any bonuses, overtime pay or any other compensation) in effect on the day you become eligible for long-term disability benefits.

Example:

Total biweekly basic earnings		$1,376
	x	60%
LTD biweekly benefit amount		**$825.60**

Other Income Benefits

Income from the sources listed below will reduce the benefits payable to you from the plan, dollar for dollar. You should promptly report receipt of income benefits from any other source to Lubrizol, as Lubrizol or its affiliate has the right to recover any overpayment of long-term disability benefits either directly from you or by deduction from your future biweekly income benefit payments.

1. Wages or salary from Lubrizol, another employer or through self-employment (except as provided under an approved rehabilitation plan);
2. Disability, retirement or unemployment benefits provided for under any law of a government, Workers' Compensation, Unemployment Compensation, and wage replacement benefits, including any retroactive lump sum awards and Social Security Disability Income (including family benefits). In many instances, part or all of any cost of living increases in these governmental benefits which occur during a period of total disability will not be included as other income benefits;
3. Disability or unemployment benefits provided under any other group arrangement or coverage (whether on an insured or uninsured basis) unless provided by Lubrizol or its affiliate;
4. Pension benefits and any applicable settlements, including any retroactive lump sum applicable settlements. Retroactive lump sum settlements will reduce the number of future Benefit payments equal to the number of months covered by the retroactive settlement. Non-retroactive lump sum payments of any kind will be amortized and will reduce future Benefits over 60 months.

The plan does not count any disability income benefits payable under individual disability policy or any other individual policy which provides income benefits which you have purchased. For participants who purchase the 70% LTD coverage, the extra 10% is not affected by other benefit offsets (e.g., other wages, Social Security benefits, etc.)

For the purposes of this plan, other income benefits will be deducted from your plan benefit and will be allocated as follows:

1. Any periodic payments will be allocated to biweekly periods;
2. Any single sum payment including any periodic payments which you or your spouse, children, or other dependents could have elected to receive in a single sum, will be allocated to biweekly pays over a specific period of time;
3. Any periodic or single sum payments received as a retroactive award may be allocated retroactively.

The amount of the benefit payable under this plan will be reduced by the amount of earnings and benefits from other sources, including, for example, benefits paid by Social Security or Workers' Compensation. You must apply for any other benefits to which you may be entitled (such as social security) in order to receive the full benefit.

An example of how benefits would be reduced by Social Security is shown below, assuming that biweekly basic earnings are $1,376 at the time disability began and you are covered by the 60% benefit:

If you are eligible for other income, for example a disability income of $400 per month ($4,800 per year) from Social Security, the plan will add enough to this other income to make up the 60% benefit as follows:

Benefit: 60% of $1,376	$825.60 (biweekly benefit)
Less: other income (Social Security)	-$184.62 (biweekly equivalent of yearly benefit)
Total paid by the plan	**$640.98**

Effect on Other Lubrizol Benefits

If you become disabled to the extent that you are eligible to receive benefits from this long-term disability plan, you will be placed on a long-term disability leave of absence. You may continue to participate in other Lubrizol plans according to the terms below:

1. You will continue to be covered by the health care, prescription, vision and dental options and health care flexible reimbursement account, provided you continue to make any required contributions.
2. If you are a participant in The Lubrizol Corporation Pension Plan, you will continue to accrue pension credits under the pension plan, based on the basic (60%) disability pay (without offsets for other income benefits).
3. You will continue as an inactive participant in The Lubrizol Corporation Employees' Profit Sharing and Savings Plan; any loans will continue to be repaid, but you will not be eligible for any new loans. You may withdraw from your savings portion of The Lubrizol Corporation Employees' Profit Sharing and Savings Plan before age 59½ only as provided by that plan.
4. If you are a participant in The Lubrizol Corporation Age-Weighted Defined Contribution Plan, you will continue to participate in that plan.

You may voluntarily elect to terminate your employment and apply for a distribution from the pension and/or age-weighted defined contribution plan, as applicable, and profit sharing and savings plan. If you terminate your employment, you will no longer be eligible for long-term disability benefits.

Limitations

No benefits will be paid for any period during which you:

- Are not under the regular care of a physician;
- Are engaged in any Reasonable Employer Occupation or any Reasonable Occupation (other than may be required as vocational rehabilitation); or
- Are on leave that qualifies as and has been designated by you as unpaid Family and Medical Leave.

No benefits will be paid for total disability which results from:

- active duty with the US Armed forces, the Army National Guard, the Air National Guard or the commissioned corps of the Public Health Service, war or any act of war in a recognized war zone, whether declared or undeclared.
- encouraging, promoting or taking part in an unlawful assembly, civil commotion, disorderly conduct and all other forms of disturbance of the public peace by three or more persons assembled together, whether by signs, gestures, words or by distinctive devices which identify the person with such disturbance;
- intentionally self-inflicted injuries;
- commission or attempted commission of a criminal offense; or
- an event occurring after the first 90 days of an unpaid leave of absence

Plan Administration

The company is the administrator of the plan. However, the day-to-day administration of the plan, such as receiving and approving applications for benefits, is handled by the Disability Committee. Benefits under this plan will be paid only if the plan administrator decides in its discretion that you are entitled to them. The plan administrator has the authority to interpret the terms of the plan, to make factual determinations, to determine the adequacy of submitted proofs of disability and to determine all questions arising from the plan.

How to Apply for Benefits

You must submit written proof of your claim, with a statement from a physician giving proof of the nature and extent of your disability. You should file your claim no later than 30 days after the end of the qualifying period. Your claim may be filed prior to the end of the qualifying period so that benefits will start as soon as you are eligible.

If, through no fault of your own, you are unable to meet the 30-day deadline, your claim will still be accepted if you file as soon as reasonably possible, but no later than one year after the deadline, unless you are legally incapacitated. Otherwise, late claims will not be covered.

It is to your advantage to submit the claim promptly. Claim forms are available from your benefits representative.

Notification of Benefit Determinations

You will be notified of the benefit determination within 45 days after receipt of your claim. This period may be extended for an additional 30 days if more time is needed due to matters beyond the control of the Plan. You will be notified prior to the end of the first 45 days if more time is needed. This notice will tell you how much more time is needed and why it is needed. If prior to the end of the 30-day extension, the plan administrator determines that due to matters beyond the control of the Plan an additional 30 days is necessary, you will be notified of the additional extension of time and why it is needed. For any notice of an extension you will be notified of the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision and the additional information needed to resolve those issues. You will then have at least 45 days within which to provide the additional information.

If your Claim is Denied

If your claim is denied in whole or in part, you will receive a notice explaining the reason for the denial including specific plan provisions on which the decision was made. You will be given a description of any additional information needed to complete the claim and why the information is necessary. You will also be given a description of the Plan's review procedures and time limits, including a statement of your right to bring suit.

Claims Review Procedure

You may request a review of the denial. The request should be submitted to the Employee Benefits Administrative Committee in writing, within 180 days after the claim for benefits was first denied or reduced, and should include your reason for requesting the review. Your request for review may include written comments, documents, records and other information relating to your claim. During the review, you may represent yourself or appoint a representative, and will have the right to inspect all documents and information that was relevant to your claim. If no request is received within the time limit, the denial or reduction of benefits will be final. If you make a timely appeal, you will remain an employee on an unpaid leave of absence for the duration of the appeal process.

Within 45 days, the committee will render its decision unless special circumstances require an extension of not more than an additional 45 days. You will be notified prior to the end of the first 45 days if more time is needed. The review of the denial of your claim will take into account all comments, documents and information you submit. Any medical or vocational experts whose advice was obtained during the review of the denial of your claim will be identified. All decisions of the committee will be in writing and will include specific reasons for the action taken as well as indicate the specific plan provisions on which the decision is based. The written notification will include a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim. If no decision is made within 90 days, you may consider the claim denied.

Disabilities Not Covered

Certain disabilities are beyond the scope of this long-term disability plan. You are not insured against loss of your earnings if your disability is the result of:

1. Injuries which are intentionally self-inflicted.
2. Commission of, or attempt to commit, a criminal offense.
3. For employees on active duty with the U.S. Armed Forces, the Army or Air National Guard, or the commissioned corps of the Public Health Service, war or any act of war in a recognized war zone, whether declared or undeclared.
4. Encouraging, promoting or taking part in a riot or civil commotion.
5. An event occurring after the first 90 days of an unpaid leave of absence.
6. Disabilities not approved for Social Security Disability Income (SSDI) after an employee receives a final (non-appealable) denial.

Suspension of Benefits

Employees who are eligible for benefits must comply with the following:

1. You must comply with the agreed upon treatment plan prescribed by your treating physician within a reasonable period of time after it has been prescribed. The treatment plan may include participation in a disease self-management program, which is paid for by Lubrizol or its affiliate. If you have two physicians which disagree upon a treatment plan, Lubrizol may request that you obtain a third opinion by a physician who is chosen and paid for by the Plan, and you must comply with the opinion.
2. You must actively participate in any program of case management or vocational rehabilitation recommended by Lubrizol, including cooperation with and compliance with the requests of your case manager and Lubrizol's medical department.
3. Within 30 days of your receipt of a retroactive Social Security award, which applies to a period of time during which the Plan has paid to you unreduced Benefits, you must remit to Lubrizol an amount equal to the amount of the Social Security award that would have been used to reduced Benefit payments, had you been receiving Social Security award payments during the period of time covered by the retroactive award.
4. Annually, you must provide to Lubrizol a physician's certification as to your continued disability.
5. Annually, you must respond within 30 days after the request of Lubrizol as to your receipt or non-receipt of wages for the calendar year just ended by providing a copy of your Federal Income Tax return, and such other information as Lubrizol may reasonably request. If you do not provide Lubrizol with a copy of your Federal Income Tax return and any other requested information within 30 days of the date specified in the request, your employment will be terminated and Benefits hereunder will cease at the expiration of such 30-day period.
6. Within 30 days of your receipt of a retroactive applicable settlement, which applies to a period of time during which the Plan has paid you unreduced Benefits, you must remit to Lubrizol an amount equal to the amount of such retroactive applicable settlement that applies to such period of time.

If you fail to cooperate or comply with the requirements listed above, LTD benefits will be suspended until you comply. If LTD benefits are suspended for 90 days, your benefits and employment will cease. If LTD benefits are reinstated prior to 90 days, no benefits will be payable for the period of noncompliance. If LTD benefits are suspended for any reason, back pay will not be reinstated.

Annually, Employees must respond within 30 days after the request of the Company as to their receipt or non-receipt of wages for the calendar year just ended by providing a copy of their Federal Income Tax Return, and such other information as the Company may reasonably request.

When Coverage Ends

Your long-term disability coverage will end when the earliest of the following events occurs:

1. Your employment terminates.
2. The plan is terminated.
3. You are no longer eligible for coverage under this plan.
4. You fail to receive Social Security Disability Income (SSDI) after your final appeal has been denied.

If you are temporarily laid off or are granted an unpaid leave of absence (military or otherwise) longer than 90 days, your long-term disability coverage will be suspended during the period of layoff or after the 90th day of an approved leave, and will be reinstated if you return to active employment without incurring a break in service.

Rights to Recover Overpayment

You shall have no entitlement to unjust enrichment by the Plan. Accordingly, Lubrizol shall have the right to recover from you (or if applicable, your estate) and you (or, if applicable, your estate's estate) shall, upon demand from Lubrizol, repay within 45 days of such demand, any and all benefits paid under the Plan which Lubrizol determines were wrongly paid to you as a result of fraud, misstatement or misrepresentation, or error, whether intentional or unintentional. No prior forbearance by Lubrizol in exercising its right of recovery shall otherwise be construed as a waiver, or serve to limit, Lubrizol's right of recovery under this section.

Life and Travel Accident Insurance Plans

Table of Contents

General Information

The Lubrizol Corporation Travel Accident Plan provides insurance protection for your beneficiary (ies) if you are an employee and you are seriously injured or die while traveling on company business. The Lubrizol Corporation Group Life Insurance Plan provides insurance protection for your beneficiary (ies) if you die while an employee.

This summary plan description (SPD) describes the main features of the Lubrizol life and accident insurance program, which is underwritten by Aetna under the group policy number 866275, and of the Lubrizol travel accident insurance program, which is underwritten by Chubb under the group policy number 64821680. Complete descriptions of the terms of these plans are contained in the group contracts issued by Aetna and Chubb, and the terms of those contracts will govern.

Although Lubrizol expects to maintain each benefit plan as a permanent program, the company reserves the right to amend and/or terminate any plan or practice at any time. Neither this SPD, nor the plans, or the insurance contracts described herein constitute a contract of employment or a promise of continuing employment.

Federal law provides you with certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). A summary of these rights, along with specific information identifying each plan in the Lubrizol benefits program, is included in the "General" section of this Benefits Resource Guide.

The cost of your major and/or basic coverage as an employee or retiree under these plans is paid entirely by Lubrizol, and you are not required to make any contributions with respect to your coverage for this life insurance program. However, the cost of the premium paid by Lubrizol for your life insurance coverage in excess of $50,000 is taxable income to you each year you are covered.

If you have any questions about the terms of these plans or about the payment of benefits, you may obtain more information from your benefits representative.

Group Life Insurance Plan

Who is Eligible for Employee Coverage Under This Plan

If you are a regular employee of Lubrizol or its participating subsidiaries or affiliates who works an average of at least 20 hours per week or is participating in a phased-in retirement program, you are eligible to participate in the Plan.

Coverage is effective on the day you begin employment. You are not required to request coverage. Enrollment is automatic and there is no cost for coverage. If you are eligible for an increase in coverage and if you happen to be both disabled and away from work on the date your increase would become effective, the increase will not go into effect until you return to regular active work.

If you are employed by more than one employer, you are not eligible to receive multiple coverages under this plan.

Please see Exclusions from Coverage for All Plans in the General Section of this Benefits Resource Guide for a list of persons who are excluded from coverage (unless otherwise provided).

Amount of Life Insurance Coverage

Definition of Basic Earnings

Basic earnings are defined as: weekly or bi-weekly base salary. For purposes of determining the major term life insurance benefit for a driver employed by LSP Transport, LLC ("LSPT"), the driver's annual basic earnings shall be $75,000.00.

Life Insurance Benefits

Your major term life insurance is the greater of $50,000 or 2 times your eligible pay, up to $1,000,000 annual basic earnings. You can view your current benefit amount on lubrizol.benefitsnow.com.

Lubrizol pays the full cost of basic life insurance for you. If your eligible pay I smore than $25,000, the premiums Lubrizol pays for your coverage in excess of $50,000 are treated as taxable income to you. During annual enrollment you have the option to limit your coverage to $50,000 to avoid this tax. If your eligible pay is $25,000 or less, taxes do not appl to any portion of the Lubrizol-paid premiums.

For any person who is receiving long term disability benefits from Aetna and who does not pay employee withholding taxes on imputed income for coverage over $50,000, coverage will be limited to $50,000.

If you change employment status among full-time, part-time, or reduced hours schedule , your life insurance benefit will be adjusted immediately. A reduced hours schedule is less than 40, but more than 30 hours per week. However, if you are participating in a phased-in retirement program, your life insurance benefit will not be reduced from your full-time coverage.

Beneficiaries

When you become eligible for insurance as an employee, you will be asked to designate a beneficiary or beneficiaries to whom the insurance proceeds would be paid upon your death. You may name anyone you wish and may change your beneficiary at any time.

If, at the time of your death, there is no beneficiary designation on file, or if your named beneficiary is no longer living, the insurance proceeds will be paid as follows:

1. Up to $500 of your life insurance to any party that Aetna deems is entitled because of their payment of your burial expense and/or
2. the executors or administrators of your estate or
3. to the first of the following living at the time of your death: your spouse, your children, your parents.

It is important to you and your family to keep your beneficiary designation current. You can elect your beneficiaries, or make changes to your current beneficiaries, at **Lubrizol.BenefitsNow.com.**

Assignments

Life insurance may be assigned only with the insurer's written consent and only if you assign all ownership as a gift. If you wish to do this, an assignment form must be completed by you and three copies sent to the insurer's home office for approval. See your benefits representative for details. Neither Lubrizol nor the insurer guarantees or assumes any obligation concerning any assignment.

How to File a Claim

Upon notification of your death, a benefits representative will contact the beneficiary and arrange for completion of all forms required to make payment of the insurance proceeds.

If Your Claim is Denied

The insurance company makes all determinations of entitlement to benefits under this plan. If your claim is denied, in whole or in part, you will receive a notice explaining the reason for the denial. You may request a review of the denial. The request for review should be submitted, in writing, within 60 days after you receive

the denial notice, and should include your reasons for requesting the review. Your request should be submitted directly to the insurance company.

How Benefits are Paid

Payment will be made in one sum unless you have elected an optional method of settlement by written agreement with the insurer. If you do not select an optional method of settlement by written agreement with the insurer prior to your death, your beneficiary may elect an optional method of settlement by written agreement with the insurer. Optional methods of payment are not available under dependent life insurance.

When Insurance Coverage Ends

Your coverage as an employee under this plan will end when the earliest of the following events occurs:

1. Your employment terminates.
2. Coverage is discontinued under the group contract.
3. You are no longer eligible for coverage under this plan.
4. Supplemental and/or dependent coverage terminates if you discontinue paying premiums due.

Any continuation of coverage during your absence from work will be subject to the terms of the group contracts.

Continuation Provisions

If you are absent from work because of disease, injury, or FMLA, insurance coverage under this plan will continue for the duration of the leave subject to the terms of the group contract. Coverage during other leaves of absence such as military, personal or unpaid leaves will continue for a maximum of one year.

If you become permanently and totally disabled while insured, and if you furnish all information, notices and proofs when required, part of your insurance coverage under this plan will be continued during the disability until you retire. You must qualify for long-term disability benefits and remain on long-term disability leave to be eligible for this extension. Any total disability should be reported immediately to your supervisor and human resources for help in determining whether you qualify for this valuable extended insurance.

Portable Coverage

If your life insurance ceases because you leave or are no longer eligible for the insurance, you may elect portable coverage for yourself. The portable coverage will be your current employer-provided coverage and amount that you are insured for at the time you lose coverage as an employee.

If you wish to elect portable coverage, you should immediately contact your benefits representative for further details. You will have 31 days from the date your insurance ceases to make written application to the insurance company and pay the first premium. The portable coverage will become effective at the end of the 31 day period.

You are not eligible for portable coverage if you have an injury or sickness which has a material affect on life expectancy, the policy which offers the portable coverage is cancelled, or you fail to pay the premiums.

If you are not eligible for portable coverage or portable coverage ends, then you may qualify for conversion coverage.

Conversion Provision

If your life insurance ceases because you leave or are no longer eligible for the insurance, you may convert all or a portion of your insurance to an individual policy without providing evidence of insurability. The converted policy may be any kind of individual policy available from the insurance company in the amount being converted and for your age (nearest birthday) on the date it will be issued, except for a term policy or one with disability or other supplementary benefits.

If your life insurance ceases because any part of the group contract discontinues as to your employee class, and if insurance on your life has been in force under the group contract for at least five consecutive years prior to the discontinuance, you may convert to an individual policy the amount that ceases less the amount of any group life insurance for which you become eligible within 31 days of discontinuance. However, the maximum amount that can be converted by each individual is $2,000.

If you wish to convert to an individual policy, you should immediately contact your benefits representative for further details. You will have 31 days from the date your insurance ceases under the group contract to make written application to the insurance company and pay the first premium. A converted policy will become effective at the end of the 31 day period.

Accelerated Death Benefit Provision

If you become terminally ill while you are insured by the plan, Aetna can pay you a portion of your life insurance prior to your death. The payment will be based on 80% of your life insurance amount. However, the one-time benefit paid will not be greater than $500,000. If you have any questions regarding the accelerated death provisions, you should contact your benefits representative for further details.

Additional Plan Information Provided by Aetna

This SPD describes the principal provisions of the Lubrizol Group Life Insurance Plan. The complete terms of the insurance coverage are set forth in the insurance contract issued by Aetna. The terms of the plan apply only if you are eligible for the coverage, become covered, and remain covered in accordance with the terms of the group contract.

No legal action can be brought to recover under any accidental death and dismemberment benefit after three years from the deadline for filing a claim.

Aetna retains the right and opportunity, at its own expense, to examine the person of an individual who is the basis of any claim at all reasonable times while that claim is pending.

Life insurance and accidental death and dismemberment coverage benefits are exempt from legal or equitable process for your debts or those of your beneficiary, insofar as possible under applicable law.

In the event of a misstatement of any fact affecting your coverage under this plan, the true facts will be used to determine the coverage in force.

Supplemental and Dependent Coverage

You may be able to purchase additional life insurance coverage for yourself or dependent life insurance for your spouse and children through the Group Universal Life program. If you are an active employee, you may pay for the cost of this coverage through payroll deductions. These are optional coverages and are in addition to your life insurance coverage described above. The supplemental and dependent life insurance coverages are not covered by ERISA. See the separate brochure available from your benefits representative for more information.

Business Travel and Accident Insurance Plan

Who is Eligible

All directors and employees of The Lubrizol Corporation (including its participating affiliates), including their accompanying partner and/or child(ren) and including those on an expatriate assignment, are covered under the policy. Non-employees traveling on behalf of Lubrizol or its participating affiliates are also covered under the policy.

When Benefits are Payable

This insurance provides coverage while on an insured business trip on behalf of Lubrizol or its participating affiliate, including a personal vacation when the trip occurs outside the country of permanent residence/expatriate assignment of the insured person; or within the country of permanent residence of the insured person provided that such a business trip includes an airplane flight or overnight stay or involves either a trip by railroad or sea, excluding commuting between residence and usual place of employment.

Coverage commences from the time the employee (or covered non-employee) leaves his residence or usual place of employment (whichever occurs last) and continues until the employee (or covered non-employee) arrives back at his residence or usual place of employment (whichever occurs first).

Exclusions

The insurer will not pay benefits for any loss or injury that is caused by, or results from any of the following, or occurs with respect to the following:

- War within your country of permanent residence
- Committing or attempting to commit suicide or intentionally inflicting self injury
- Anyone 80 years of age or older
- Flying an airplane
- Medical expenses within your country of permanent residence/expatriate assignment
- Dental or optical expenses unless incurred as the result of an emergency
- Repatriation expenses incurred without the prior approval of ISOS Assistance
- Travelling against the advice of a Qualified Medical Practitioner or travelling for the purposes of receiving medical treatment
- More than $3,172/£3,000 worth of cash
- Any item of personal property that exceeds $3,172/£3,000 in value
- Travel to Afghanistan and Iraq without prior notification to and acceptance by Chubb
- Travel to Cuba or Iran
- Any trip over 6 months in duration
- Any cover or claim that would directly or indirectly be breach of any applicable economic/trade sanction that applies to Chubb or its parent company

International SOS (ISOS)

This program provides a range of Medical and Travel Assistance services, supported by a 24-Hour Emergency Helpline. International SOS Assistance is your first point of contact for travel emergencies especially those involving the need for medical care (Chubb is fully integrated with ISOS). Always carry your ISOS card with you while traveling. If you need an ISOS card, contact Shari Gonzalez (shari.gonzalez@lubrizol.com).

Services Provided

Services include help with medical advice, repatriation, medical referral, emergency medical supplies, direct billing, lost documents or medications, translator services, emergency medical transmission, inoculation and visa requirement information, lost luggage assistance, and embassy and legal referral.

ISOS Contact Information

In the event that you require assistance, the Emergency Helpline can be contacted by:

Telephone
Philadelphia Assistance Center: +00 1 215 942 8226 Beijing Assistance Center: +86 (0) 10 6462 9100 London Assistance Center: +44 (0) 20 8762 8008 Singapore Assistance Center: +65 6338 7800 New Delhi Assistance Center: +91 11 4189 8800 Seoul Assistance Center: +82 (2) 3140 1700
E-mail
Philadelphia Assistance Center: phlopsmed@internationalsos.com Beijing Assistance Center: 1bjsopsmedical@internatioanlsos.com London Assistance Center: 1lonops@internationalsos.com Singapore Assistance Center: sin.medical@internatioanlsos.com New Delhi Assistance Center: 1delops@internationalsos.com Seoul Assistance Center: selopsmedical@internationalsos.com

Amount of Coverage**

Chubb Sums of Insurance:	All Directors and Employees	Accompanying Partner and/or Child(ren)
Accidental Death	4 times annual salary to $2,496,000	$117,000
Accidental Dismemberment	Up to 4 times annual salary to $2,496,000; coverage amount dependent upon loss	Up to $117,000; coverage amount dependent upon loss
Medical Expenses	Unlimited	
Repatriation Expenses	Included in Medical Expenses	
Personal Property	£10,000/$10,573	
Business Equipment	£3,000/$3,172	
Delayed Personal Property	£2,000/$2,114	
Loss of Travel Documents	£2,000/$2,114	
Money	£10,000/$10,573	
Cancellation, Disruption, or Replacement Expenses	£10,000/$10,573	
Government Advice	£50,000/$52,867	
Rental Vehicle Excess	£25,000/$26,433	
Legal Expenses	£50,000/$52,876	
Personal Liability	£5,000,000/$5,286,749	

**USD conversion as of 2/14/2017; currency conversion will be based on the date the claim is paid.

Beneficiaries

Unless you designate otherwise, the death benefit from this policy will be paid to the same beneficiary as designated to receive the proceeds of your group life insurance.

How to File a Claim

In the event of any circumstances which could give rise to a claim, you should give notice to Chubb as soon as reasonably possible by contacting Chubb via the information below:

For personal accident claims:
Chubb U.S. Policy # 99074853
Crawford and Company
P.O. Box 4090
Atlanta, GA 30302
U.S.A

Overnight Delivery:
Chubb U.S. Policy # 99074853
Crawford and Company
100 Glenridge Point Parkway, Ste. 300
Atlanta, GA 30342
U.S.A.

For all other claims:
Chubb Master Policy # 64821680
Chubb Insurance Company of Europe SE
106 Fenchurch Street
London EC3M 5NB
England

How Benefits are Paid

Any benefits due will be paid when the Insurer receives written (or authorized electronic or telephonic) proof of loss.

When Insurance Coverage Ends

An Insured's coverage will end on the earliest of the date:

1. The Policy terminates;
2. The Insured is no longer eligible; or
3. The period ends for which premium is paid.

A Dependent's coverage will end on the earliest of the date:

1. He or she is no longer a Dependent;
2. The Insured's coverage ends; or
3. The period ends for which premium is paid.

Volunteer Firefighters' Insurance

Who is Eligible
All active Employees who are designated as Firefighters by Lubrizol.

When Benefits are Payable
This insurance provides coverage in the event of an accident while working as a volunteer firefighter at Lubrizol or one of its participating subsidiaries. The Covered Accident must take place:

1. While on duty or an emergency call; and either at a fire or emergency call, traveling to or returning from a fire or emergency call; at a fire drill, parade test or trial of any firefighting or emergency apparatus; or
2. While riding in or on an organization apparatus while traveling to or returning from a fire drill, a parade, a test or trail of any fire-fighting or emergency apparatus.

Definitions
"Covered Accident" means an accident that occurs while coverage is in force for a Covered Person and results directly and independently of all other causes in a loss or Injury covered by the Policy for which benefits are payable.

"Covered Person" means any eligible person, including Dependents if eligible for coverage under the Policy, for whom the required premium is paid.

"Doctor" means a licensed health care provider acting within the scope of his or her license and rendering care or treatment to a Covered Person that is appropriate for the conditions and locality. It will not include a Covered Person or a member of the Covered Person's Immediate Family or household.

"Immediate Family Member" means a Covered Person's parent, grandparent, spouse, child, brother, sister, or in-laws.

"Injury" means accidental bodily harm sustained by a Covered Person that results directly and independently from all other causes from a Covered Accident. The Injury must be caused solely through external, violent, and accidental means. All injuries sustained by one person in any one Covered Accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury.

"Sickness" means an illness, disease or condition of the Covered Person that causes a loss for which a Covered Person incurs medical expenses while covered under this Policy. All related conditions and recurrent symptoms of the same or similar condition will be considered one Sickness.

Exclusions
The insurer will not pay benefits for any loss or Injury that is caused by, or results from:

- Intentionally self-inflicted Injury.
- Suicide or attempted suicide.
- War or any act of war, whether declared or not.
- A Covered Accident that occurs while on active duty service in the military, naval or air force of any country or international organization.
- Sickness, disease, bodily or mental infirmity, bacterial or viral infection, or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food.
- Piloting or serving as a crewmember in any aircraft (except as provided by the Policy).
- The Covered Person being legally intoxicated as determined according to the laws of the jurisdiction in which the Injury occurred.
- Injury or loss contributed to the use of drugs, unless administered by a Doctor.

In Addition to the General Exclusions, the insurer will not pay Accident Medical Expense Benefits for any loss, treatment or services resulting from or contributed by:

- Treatment by persons employed or retained by Lubrizol, or by any Immediate Family or member of the Covered Person's household.
- Treatment of Sickness, disease or infections except pyogenic infections or bacterial infections that result from the accidental ingestion of contaminated substances.
- Treatment of hernia, Osgood-Schlatter's Disease, osteochondritis, appendicitis, osteomyelitis, cardiac disease or conditions, pathological fractures, congenital weakness, detached retina unless caused by an Injury, or mental disorder or psychological or psychiatric care or treatment (except as provided in the Policy), whether or not caused by a Covered Accident.
- Pregnancy, childbirth, miscarriage, abortion or any complications of any of these conditions.
- Mental and nervous disorders (except as provided in the Policy).
- Damage to or loss of dentures or bridges, or damage to existing orthodontic equipment (except as specifically covered by the Policy).
- Expenses incurred for treatment of temporomandibular or craniomandibular joint dysfunction and associated myofacial pain (except as provided by the Policy).
- Injury covered by Workers' Compensation, Employer's Liability Laws or similar occupational benefits or while engaging in activity for monetary gain from sources other than the Lubrizol Corporation.
- Injury or loss contributed to by the use of drugs unless administered by a Doctor.
- Cosmetic surgery, except for reconstructive surgery needed as the result of an Injury.
- Any elective treatment, surgery, health treatment, or examination, including any service, treatment or supplies that: (a) are deemed by the insurer to be experimental; and (b) are not recognized and generally accepted medical practices in the United States.
- Eyeglasses, contact lenses, hearing aids, examinations or prescriptions for them, or repair or replacement of existing artificial limbs, orthopedic braces, or orthotic devices.
- Expenses payable by any automobile insurance Policy without regard to fault. (This exclusion does not apply in any state where prohibited).
- Conditions that are not caused by a Covered Accident.
- Participation in any activity or hazard not specifically covered by the Policy.
- Any treatment, service or supply not specifically covered by the Policy.

Amount of Coverage

The principal sum is as follows:

Accident medical expense benefits:	Covered up to $50,000; $0 Deductible
Total disability due to a Covered Accident:	$100 per week; maximum benefit period: 26 weeks
Total disability due to contagious and infectious disease:	$100 per week; maximum benefit period: 104 weeks
Partial disability due to a Covered Accident:	Covered up to $1,000
Influenza, La Grippe, and Pneumonia benefit:	Covered up to $25,000
Contagious and infectious disease benefit:	Covered up to $25,000
HIV Positive benefit:	Covered up to $25,000
Heart or circulatory malfunction benefit:	Covered up to $25,000
Cosmetic disfigurement from burns benefit:	Covered up to $25,000

This page left blank intentionally

Pension Plan

(applicable to employees hired before January 1, 2010)

Table of Contents

General Information

The Lubrizol Corporation Pension Plan was first established by The Lubrizol Corporation ("Lubrizol" or "the company") on December 11, 1944, to provide employees with a portion of their retirement income. It works together with The Lubrizol Corporation Employees' Profit Sharing and Savings Plan to provide an income base, along with Social Security and your own retirement savings.

This summary plan description (SPD) describes the main features of The Lubrizol Corporation Pension Plan. A complete description of the terms of this plan is contained in the plan document and trust agreement, and the terms of that document will govern.

Although it is Lubrizol's expectation that the plan will be a permanent program, the company has the right to terminate or amend the plan in whole or in part by action of its Board of Directors. However, no amendment may reduce a participant's benefit earned to the time the amendment is made. Neither this SPD, nor the plan or the trust described herein constitutes a contract of employment or a promise of continuing employment.

The plan is financed entirely by company contributions to the trust fund. The amount of each contribution is determined by an actuary to be at least sufficient to meet the minimum funding standards required by the Internal Revenue Code. Under current law, none of the funds held in trust for the plan can be used for any purpose other than payment of benefits until full payment of all benefits under the plan has been provided.

Federal law provides you with certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). A summary of these rights, along with specific information identifying each plan in the Lubrizol benefits program, is included in the "General" section of this Benefits Resource Guide.

The cost of the plan is paid entirely by Lubrizol, and you are neither required nor permitted to make any contributions toward your benefits under this pension plan. If you have any questions about the terms of the plan or about the payment of benefits, you may obtain more information from any Lubrizol benefits representative.

The plan is closed to anyone hired or rehired by, or transferred to, Lubrizol or an adopting subsidiary after December 31, 2009.

Who is Eligible

As a regular employee of Lubrizol or a Lubrizol subsidiary which adopted the plan, and who was hired on or before December 31, 2009, you automatically became an active participant in this plan beginning on your date of employment. If you were a temporary employee of Lubrizol or a Lubrizol subsidiary which adopted the plan and you worked at least 1,000 hours in any 12 month period, you participated beginning the following January 1 or July 1. You will continue to be eligible for and participate in the plan if you directly transfer employment from Lubrizol or a U.S. Lubrizol subsidiary that has adopted the plan to another U.S. Lubrizol subsidiary or to Lubrizol Specialty Products, Inc. (LSPI) or an LSPI subsidiary, do not have a change in employment status that would otherwise affect your ability to participate in the plan, and immediately prior to such transfer were actively accruing a benefit under the plan.

There is no cost to you for participation; the entire cost of the plan is paid by the company. An employee hired on or after January 1, 2010 will not be eligible to participate in the plan. Please see Exclusions from Coverage for All Plans in the General Section of this Benefits Resource Guide for a list of persons who are excluded from coverage (unless otherwise provided).

When You Can Retire

If you terminate Lubrizol employment before you reach age 55, but after you have completed five years of service, you will become 100% vested in your pension benefit. You may begin distribution of your benefit immediately as either a lump sum payment or an annuity if you satisfy one of the following conditions:

- You were hired by Lubrizol before February 1, 1984.
- Your benefit commencement date occurs after December 31, 2015.

In either case, if payments begin before you reach age 65, the amount will be reduced for the extra years you are expected to benefit from the payment(s). If you terminate employment prior to age 55, actuarial factors are used to determine your pension benefit rather than the subsidized reduction factors used for terminations after age 55.

If you leave employment prior to age 70½ and choose to defer your retirement benefit distributions or make no election to receive your benefits when you separate employment or retire, your benefit distributions will begin at the earlier of your distribution request or the April 1 of the calendar year following the year in which you reach age 70½. The form of benefit will depend upon your marital status at the time of distribution.

You may not receive any benefit from this plan before you terminate employment with Lubrizol or a related company. If you continue to work past age 65, your service after age 65 will be used in the calculation of your benefit, but other than described in the next paragraph, your benefit will not be increased for the amount of monthly benefits that you would have received had you retired at age 65 and commenced distribution of your benefit.

If you do not work past age 65 and you do not commence your benefit by age 65, you benefits will be actuarially increased for the time period after you reach age 65 until you commence your benefit.

If you retire after age 70½, benefit distribution will automatically begin on the April 1 of the calendar year following the year in which you retire. Benefits will be actuarially increased for the time period after you reach age 70½ until you retire.

Retirement Income

When you retire from Lubrizol or related company employment, your income may be available from at least four sources: this pension plan, The Lubrizol Corporation Employees' Profit Sharing and Savings Plan, Social Security, and your own savings. The amount of retirement income you will receive from the pension plan is based on your compensation and length of service.

Your pension benefit is the larger of the amounts calculated under two formulas: the career pay formula, which is based on your career earnings and length of service, and the final pay formula, which is based on your final average earnings and length of service, and takes into account that you will receive benefits from Social Security.

Your service and compensation for the formulas are determined as follows:

Credited Benefit Service: The period of service from your last hire date to the date you retire or otherwise terminate employment. Benefit service will not include any time you are on a leave of absence, other than military leave, jury duty or long-term disability leave, for more than one year.

For employees of participating subsidiaries who already had a pension benefit in a plan that was merged into Lubrizol's pension plan, credited service is the same as described above. For all other employees of participating subsidiaries, credited benefit service is the period of service from the later of the date your employer adopted Lubrizol's pension plan or your hire date to the date you retire or otherwise terminate employment.

Basic Compensation: Your base biweekly salary (including military pay for up to six biweekly periods and workers' compensation payments), overtime, shift premiums, vacation and holiday pay, bonuses and gain sharing (excluding long term incentives), and commissions paid during a plan year, as applicable. Any amount of your salary which you defer to before-tax 401(k) savings under The Lubrizol Corporation Employees' Profit Sharing and Savings Plan or before-tax contributions to the flexible reimbursement program is included, as are basic (60%) long-term disability benefits which you receive while you are on long-term disability leave. Noncash or special allowances, extraordinary compensation, and separation pay are not included. Bonuses, commissions, and shift premiums were not included in basic compensation before 1981, and overtime was not included before 1977. If you are on military leave, your monthly rate of compensation used to determine basic compensation will be the monthly rate in effect when your leave begins. You will not receive credit for compensation if you are on an unpaid leave of absence other than military or long-term disability leave. Under current law, the amount of basic compensation that can be used to determine your benefits under the plan is limited to **$270,000** for compensation earned in 2017. This amount may be adjusted by the Internal Revenue Service periodically for increases in the cost of living in $5,000 increments.

Covered Compensation: An average of the annual wage bases over a 35-year period determined by Social Security. The covered compensation level increases each year as a new Social Security annual wage replaces an old wage to keep a current 35-year average.

The Career Pay Formula

The plan's career pay formula is based on your basic compensation during your participation in the plan and provides a monthly benefit payable at least for your life, beginning at age 65. Your **credited average compensation** is the average of your monthly basic compensation in effect on each January 1, during your participation in the plan.

If you became a participant before January 1, 1981, your credited average compensation will include a monthly rate of basic compensation for each January 1 during the period you were not yet a participant in the plan, but not more than four years. This rate will be the same rate as your basic compensation rate on the date you became a participant.

When you retire at age 65, your normal monthly benefit from the plan under this formula will be:

1.35% of credited average compensation x credited benefit service (no maximum)

For example, if your credited average compensation is $1,800 and you have 30 years of credited benefit service at age 65, your monthly benefit under this formula would be:

Credited average compensation		$1,800.00
Times 1.35%	x	.0135
		$24.30
Times credited benefit service	x	30
Monthly pension		**$729.00**

The Final Pay Formula

The plan's final pay formula is based on your basic compensation during your highest consecutive 5 years out of your last 10 years with Lubrizol or other covered employer and provides a monthly benefit payable at least for your life, beginning at age 65. Your **final average pay**, used in figuring your benefit under this formula, is the average of your monthly basic compensation in effect on January 1 for your highest consecutive 5 years out of your last 10 years of covered employment. If your total service is less than 30 years, your age 65 benefit amount is reduced proportionately. Your monthly pension benefit under this formula will be:

(28.5% of your final average pay + 15% of your final average pay in excess of the Social Security covered compensation level) x credited benefit service (up to 30) ÷ 30

For example, if your final average pay is $2,600, your Social Security covered compensation level is $2,026 and you have 30 years of credited benefit service at age 65, your monthly benefit under the final average pay formula would be:

Final Average Pay (FAP)	$2600	x 28.5%	**$741.00**
Minus covered compensation	- $2026		
FAP above covered compensation	$574	x 15%	+ 86.10
			$827.10
Times credited benefit service ÷ 30			x 30/30
Monthly pension			$827.10

NOTE: In these two examples, your benefit calculated under the final pay formula would be larger than under the career pay formula and, therefore, you would receive the benefit calculated under the final pay formula.

Early Retirement

If you are an active employee and retire after you reach age 55, but before you reach age 65, your early retirement benefit is figured under the final pay and career pay benefit formulas, using your credited benefit service, final average pay, credited average compensation and your Social Security covered compensation level in effect as of your retirement date. You may choose to receive the full monthly amount starting at age 65, or a permanently-reduced pension beginning any time after you reach age 55. In either case, your monthly pension benefits will continue at least as long as you live.

The table below does not apply to participants who terminate employment prior to age 55. If and when you terminate employment prior to age 55, actuarial factors are used to determine your pension benefit rather than the subsidized benefit that active employees receive.

If you choose to begin payments before you reach age 65, the amount of reduction will depend on your age at the time payments begin. The younger you are, the more payments you can expect to receive over your lifetime and therefore, the greater the reduction in the amount you will receive each month. You will receive a percentage of your full early retirement benefit as follows:

If your payments start at age:	The percentage you will receive is:
65	100%
64	100%
63	100%
62	100%
61	97%
60	94%
59	91%
58	88%
57	85%
56	82%
55	79%

Methods of Payment

Automatic Forms of Payment - Monthly Annuity

If you are **unmarried** when your pension benefit payments begin, you will receive your benefit in the form of a monthly ten year certain and life annuity for as long as you live. Under this form of payment, if you should die before receiving payments for ten years (120 monthly payments), the plan will continue to pay the same monthly benefit amount to your designated beneficiary for the rest of the ten-year period.

If you are **married** on the date your pension benefit payments begin, you will receive your pension in the form of a joint and 50% survivor annuity. Benefit payments during your lifetime will be reduced in order to provide a survivor benefit to your spouse. After your death, your spouse will receive a monthly benefit equal to 50% of the monthly amount you received during your lifetime; these payments will continue for the balance of your spouse's life. Your reduced benefit amount is based on the length of time you and your spouse can expect to receive monthly benefits, which depends on your age and your spouse's age at the time benefit payments begin.

If the present (commuted) value of any benefit payable under the plan is less than $1,000, the benefit will be paid to you in one lump sum regardless of any election of alternate form of payment or of when participation began. This lump sum will then be your only benefit payable under this plan.

Optional Forms of Payment

You also may choose to have your benefit paid in any one of the forms described below. If you are married at the time benefit payments begin, your spouse must give written, notarized agreement to your choice of one of these optional forms of payment. You must notify the committee of your choice before the date benefit payments are to begin, except as otherwise noted.

Ten Year Certain and Life Benefit

If you are married, you may choose to have your benefit paid in the same unreduced form as the automatic benefit payable to unmarried participants (described above).

Joint and Survivor Benefit

You may choose to have a reduced benefit amount paid to you for your lifetime, with either 100%, 75% or 50% of the reduced amount, continued after your death to your designated beneficiary (who may or may not be your spouse). The amount by which your benefit is reduced is determined by your age and the age of your designated beneficiary at the time payments begin; certain restrictions may apply.

Commuted Benefit

You have the ability to elect the form of distribution for your plan benefit. In addition to the monthly annuity forms, the plan offers a commuted benefit (lump sum form), which is available to you as an optional form of distribution as long as you satisfy one of the following conditions:

- You were hired by Lubrizol before February 1, 1984.
- You terminated on or after January 1, 2005 with a benefit having a present value of $5,000 or less.
- Your benefit commencement date occurs after December 31, 2015.

The lump sum form of distribution provides the actuarial present value of your monthly annuity (10 year certain and life or in the case of a survivor benefit, the survivor annuity). To calculate the amount of the lump sum, the plan utilizes a "lump sum factor," which is prepared using mortality tables and interest rates prescribed by the Internal Revenue Code, as amended by the Pension Protection Act of 2006.
The plan uses a single lookback month of August of the prior calendar year to determine the applicable interest rate to be used to develop the lump sum factors for a plan year.

Straight Life Annuity

You may choose to have a monthly annuity paid to you for your lifetime. After you die, the payments stop.

Tax Implications

A lump sum distribution will be subject to ordinary income tax unless rolled over to another qualified plan or an IRA. Lump sum distributions will also be subject to a penalty tax equal to 10% of the untaxed amount unless:

- You are at least age 59½ when the distribution is made;
- The distribution is made after you separate from service if you will be at least age 55 in the year of the separation ; or
- The distribution is made because of your death.

A lump sum distribution that is paid directly to you will be subject to an automatic 20% federal income tax withholding requirement. There may be additional tax consequences if you do not roll over the entire taxable amount of your lump sum distribution (including the 20% withheld) to an IRA or a new employer's qualified retirement plan within 60 days of your receipt of the distribution (such as the 10% penalty tax described above).

To avoid the 20% withholding requirement and additional tax consequences, you may elect instead to have your lump sum distribution directly transferred to an IRA or a new employer's qualified retirement plan.

Monthly annuity distributions are subject to ordinary income tax, but are not subject to this 20% withholding rule or the 10% penalty tax.

Other Plan Benefits

Death Benefits

If you die before benefit payments begin at a time when you are 100% vested in your benefit, a benefit may be payable to your spouse or other designated beneficiary only under the following circumstances:

If you have been **married** at least one year and you are actively employed by Lubrizol or a participating subsidiary at the time of your death, your spouse will receive a lifetime monthly benefit. If you die after you reach your "earliest retirement date," the amount of the survivor benefit will be equal to 50% of your pension benefit figured as if you had left employment on the day before the date of your death based on your years of benefit service and the formula in effect on the date of your death. If you die prior to your "earliest retirement age," the amount of the survivor benefit will be equal to 50% of your pension, figured as if you had left employment on the date of your death and lived until the earliest date you could have started to receive monthly benefits, and then reduced for a joint and 50% survivor annuity (see Methods of Payment). If you have reached your "earliest retirement age" at the time of your death, payments to your surviving spouse will begin the month after your death. If you have not yet reached your "earliest retirement age" at the time of your death, payments to your surviving spouse will begin the month after you would have reached your "earliest retirement age". The term "earliest retirement age" if you were hired by Lubrizol before March 1, 1984, is the date you die. For everyone else, it means age 55.

Your spouse may elect to defer the commencement of payments until the date you would have reached the age of 70½. Effective January 1, 2016, a surviving spouse will be able to elect to receive, in lieu of the monthly survivor benefit, the actuarial equivalent of the monthly survivor benefit paid as an immediate lump sum, provided that the surviving spouse had not already started to receive the survivor benefit as a monthly annuity.

If you have been **married** at least one year, you are not actively employed by Lubrizol at the time of your death and you have not yet begun to receive benefits, your spouse will receive the surviving spouse benefit described above. If you were hired before March 1, 1996, and you terminate employment, you and your spouse may waive the surviving spouse benefit and elect instead for your spouse to receive an amount equivalent to your monthly pension benefit figured at the date of your death, which may be received as a lump sum or in annual installments over a period of time not to exceed the greater of five years or life expectancy, or as a life annuity, as chosen by your spouse. Or, you may elect for a designated beneficiary other than your spouse to receive this benefit in a lump sum or in annual or monthly installments over a period of time of up to five years. The surviving spouse benefit described above may be waived only with your spouse's written, notarized consent. This waiver may be revoked at any time before your death.

If you were hired before March 1, 1996, and you are **unmarried** at the time of your death, a death benefit is payable to your designated beneficiary only if you have retired or terminated employment at the time of your death, and you are entitled to but have not yet started to receive benefits from this plan. Your beneficiary will receive an amount equivalent to your monthly pension benefit figured at the date of your death, and may choose to receive it as a lump sum, or in annual or monthly installments over a period of time up to a maximum of five years.

If you die **after** benefits payments have begun, the only death benefits payable will be those provided by the method of payment you have chosen.

Designation of Beneficiary

It is important that you file a designation of beneficiary when:

- You have ended your Lubrizol employment but have not yet started to receive a pension benefit, or
- You have started to receive a benefit in the 10 year certain and life form of payment.

Your designation of beneficiary must be made in writing. You may designate a beneficiary or change your designation by filing the required form with your benefits representative. If you are married, your spouse is automatically your beneficiary, even if you designate another, unless your spouse provides written, notarized agreement to your designation.

Termination of Employment before Age 55

If you terminate Lubrizol employment before you reach age 55, but after you have completed five years of service, you will become 100% vested in your pension benefit. If you were hired by Lubrizol before February 1, 1984 or your benefit commencement date occurs after December 31, 2015,you may receive a commuted lump sum benefit immediately (see section titled Optional Forms of Payment-Commuted Benefit) or you may begin to receive an annuity. If payments begin before you reach age 65, the amount will be reduced actuarially for the extra years you are expected to benefit from the payment(s). If you terminate employment prior to age 55, actuarial factors are used to determine your pension benefit rather than the subsidized benefit that active employees receive. See the section titled *Methods of Payment*.

Re-employment

If you are re-employed by Lubrizol or a related company, any benefit payments which you are receiving will cease. If you are re-employed as a regular employee by Lubrizol or a covered U.S. subsidiary after December 31, 2009, you will become a participant in The Lubrizol Corporation Age-Weighted Defined Contribution Plan.

Transfer of Employment

You will continue to be eligible for and participate in the plan if you directly transfer employment from Lubrizol or a U.S. Lubrizol subsidiary that has adopted the plan to another U.S. Lubrizol subsidiary, LSPI or an LSPI subsidiary, do not have a change in employment status that would otherwise affect your ability to participate in the plan, and immediately prior to such transfer were actively accruing a benefit under the plan.

Your transfer may cause you to be ineligible to continue to participate in the plan – for example, because you transfer to a site that is covered by a collective bargaining agreement or you become an employee of a non-U.S. subsidiary. In that case, your service in a non-covered position will be counted in determining your vested percentage at the time you finally retire or terminate employment. If you transferred to a covered position from a non-covered position prior to January 1, 2010, you will receive credited benefit service and service for vesting purposes under this plan for such non-covered employment. Your benefit under this plan will be the greater of the following:

1. An amount under this plan based on your total covered and non-covered service, offset by any benefit you receive from the non-covered service company plan; or
2. An amount under this plan based on only your covered service without any offsets for other benefits.

Disability

If you become disabled and qualify for benefits under The Lubrizol Corporation Long Term Disability Plan, you will be placed on a long-term disability leave so long as you are eligible for those benefits. While you are on long-term disability leave, you will continue to earn credited benefit service. For purposes of the pension plan, your basic compensation during your leave will be the gross amount of your basic (60%) long-term disability benefit (before deductions). If your long-term disability benefits terminate because you recover and return to covered employment, you will continue as an active participant in the pension plan. If you recover and do not return to covered employment, or if your long-term disability benefits end for any other reason (including by your own choice), your long-term disability leave and your covered employment will end.

You will then be eligible for retirement benefits, if you either 1) were hired prior to February 1, 1984 or 2) have reached age 55. If you were hired on or after February 1, 1984 and are not yet 55, you will be eligible for benefits as a terminated employee (see the section titled *Termination of Employment before Age 55*.)

How to Apply for Benefits

To become eligible to receive any benefit under this plan, you must apply for it on a form provided by the administrator. If you wish payment to begin before the automatic starting date, you must apply no later than 30 days before the date you wish payments to begin, but you may not apply for a distribution earlier than 180 days before your benefit commencement date.

Who Administers the Plan

Lubrizol is the administrator of this plan. Day-to-day administration, such as receiving and approving applications for benefits and directing the trustee to pay benefits, is handled by the Employee Benefits Administrative Committee ("the committee"). Benefits under this plan will be paid only if the plan administrator decides in its discretion that the applicant is entitled to them. The administrator has the sole right to interpret and construe the plan, to make factual determinations and to determine any disputes under the plan.

Notification of Benefit Determination

You will be notified of the benefit determination within 90 days after receipt of your claim. This period may be extended for an additional 90 days if more time is needed due to special circumstances. You will be notified prior to the end of the first 90 days if more time is needed. This notice will tell you how much more time is needed and why it is needed.

If Your Claim is Denied

If your claim is denied, you will receive a notice explaining the reason for the denial, including specific plan provisions on why the decision was made. You will be given a description of any additional information needed to complete the claim and why the information is necessary. You will also be given a description of the Plan's review procedure and time limits, including a statement of your rights to bring suit.

Claims Review Procedure

If you disagree with a decision made by the committee regarding a claim under the plan, you have the right to ask for a review of the decision. You should contact the Employee Benefits Administrative Committee, in writing, within 60 days of the date on which you receive notice of denial of the claim. Your request for review must include the date on which your request is filed; the specific part of the claim you want reviewed; the reasons you think the decision should be revised; and any written material that you think is pertinent to your claim. You will have the right to review and get copies of any information relevant to your claim. The review of the decision will take into account all comments, documents, records and other information you submit. Within 60 days of the date your request is filed, the committee will review the denial of the claim and notify you in writing of its decision, unless special circumstances require an extension of not more than an additional 60 days. You will be notified prior to the end of the first 60 days if more time is needed. The notice will tell you how much more time is needed and why it is needed. You will receive a written notification of the committee's decision, which will include the specific reasons for the action taken as well as indicate the specific plan provisions on which the decision is based. The written notification will include a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim.

If an error is made in calculating your benefit, upon discovery of the error, the amount of your benefit will be adjusted to the correct amount.

Lawsuits Against the Plan

You must exhaust the plan's claims procedure before you can bring a lawsuit against the plan. The lawsuit must be filed within 18 months of the earlier of the date of the committee's decision following the review of your claim, or the date the review period described above expires. Any lawsuit must be filed in the U.S. District Court for the Southern District of Texas. In the unlikely event that the United States District Court for the Southern District of Texas lacks jurisdiction over a particular lawsuit, the lawsuit must be brought in the United States District Court for the Northern District of Ohio, or if such court lacks jurisdiction, then the lawsuit may be brought in any United States federal or state court that does have jurisdiction.

Other Plan Information

Vesting service will include up to one year following termination of employment, but only if you return to covered employment before that year ends. If your absence is for maternity or paternity reasons, you may return within two years and receive credit for benefit and vesting service. However, the second year of such a period will not be included as service for benefit calculations. Re-employment during or after this period will be subject to company policies and procedures.

Any amount payable to a person who is found to be mentally or physically incapable of attending to his/her own financial affairs may be paid to a qualified guardian or other legal representative. If there is no such guardian or representative, at the discretion of the committee the benefits may be paid to another person for the use and benefit of the person found to be incapable, or benefits may be paid in satisfaction of legal obligations incurred by or on behalf of that person.

Vesting and Forfeitures

You become 100% vested in your pension benefit on the earlier of your fifth anniversary of employment or age 55. If you have not reached age 55 and your employment terminates before you have completed five years of service with Lubrizol or a related company, you will have no vested rights under this plan and you will forfeit your benefit.

Missing Participants

If you leave employment and fail to file an application for benefits within 120 days after attainment of your Normal Retirement Date, the plan administrator shall treat the accrued portion as forfeited if the plan administrator is unable to locate you after a diligent search. The accrued portion shall be reinstated upon the subsequent filing of a completed application with the plan administrator. The benefit shall commence within 90 days following the plan administrator's receipt of a valid application for benefits, adjusted as required for delay of payment.

If the plan is ever classified as top-heavy, participants will vest at the rate of 20% for each year of service after the first anniversary date. The plan is considered top-heavy if the value of the benefits of certain highly-compensated officers and shareholders is more than 60% of the value of the benefits of all participants.
If the plan is ever terminated, you may lose that portion of your vested interest which is not insured by the PBGC.

You may not alienate, pledge, or encumber your benefits under this plan. You may not cause your benefits to be paid to anyone other than yourself, or, in the event of your death, to your spouse or other designated beneficiary, except as provided by a qualified domestic relations order in the event of your divorce or separation.

Plan Termination Insurance

Your pension benefits under this plan are insured by the Pension Benefit Guaranty Corporation (PBGC), a federal insurance agency. If the plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under their plan, but some people may lose certain benefits.

The PBGC guarantee generally covers:

1. normal and early retirement benefits; and
2. certain benefits for your survivors.

The PBGC guarantee generally does not cover:

1. benefits greater than the maximum guaranteed amount set by law for the year in which the plan terminates;
2. some or all of benefit increases and new benefits based on plan provisions that have been in place for fewer than 5 years at the time the plan terminates;
3. benefits that are not vested because you have not worked long enough for the company;
4. benefits for which you have not met all of the requirements at the time the plan terminates;
5. certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the Plan's normal retirement age; and
6. non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay.

Even if certain types of your benefits are not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money your plan has and on how much the PBGC collects from employers.

For more information about the PBGC and the benefits it guarantees, ask your plan administrator or contact the PBGC's Technical Assistance Division, 1200 K Street N.W., Suite 930, Washington, D.C. 20005-4026 or call 202-326-4000 (not a toll-free number). TTY/TDD users may call the federal relay service toll-free at 1-800-877-8339 and ask to be connected to 202-326-4000. Additional information about the PBGC's pension insurance program is available through the PBGC's website on the Internet at http://www.pbgc.gov.

Qualified Domestic Relations Orders

Participants and beneficiaries can obtain, without charge, a copy of the plan's procedures governing Qualified Domestic Relations Orders from the plan administrator.

Vested Noveon Plan Participants

If you participated in the Noveon, Inc. Pension Plan for Salaried Employees, your benefit will be determined under the Noveon formulae through February 28, 2006. Starting March 1, 2006, your benefits will be determined using the Lubrizol formulae described above. However, your accrued benefit will never be less than the benefit you accrued using the Noveon formulae as of February 28, 2006.

Change of Address

It is your responsibility to notify Lubrizol of a change in your mailing address.

If you are an active employee you must complete a Personnel Action Request (PAR) – Address and Phone Number Change form. The form can be completed online or by submitting a hard copy. For the online and hard copy versions of the form visit the Channel.

If you are a retiree receiving monthly payments or a deferred vested participant, you must notify Lubrizol of your address change in writing. Correspondence should be sent to the following address:

The Lubrizol Corporation
c/o The Employee Benefits Administrative Committee
29400 Lakeland Blvd.
Wickliffe, Ohio 44092

Or via email to: **lzretirementplans@Lubrizol.com**

This page left blank intentionally

Employees' Profit Sharing and Savings Plan

The part of this Benefits Resource Guide under the caption "Employees' Profit Sharing and Savings Plan" constitutes part of a prospectus covering securities that have been registered under the Securities Act of 1933.

Neither the Securities and Exchange Commission nor any state securities commission has approved or disapproved of these securities or passed upon the accuracy or adequacy of this prospectus. Any representation to the contrary is a criminal offense.

The date of this Summary Plan Description/Prospectus is August 1, 2017.

Table of Contents

General Information

This document constitutes part of a prospectus covering employer securities that have been registered under the Securities Act of 1933.

The Lubrizol Corporation Employees' Profit-Sharing Plan, established on December 11, 1944, and The Lubrizol Corporation Employees' Stock Purchase and Savings Plan, established in 1986, were merged effective January 1, 1995 and renamed The Lubrizol Corporation Employees' Profit Sharing and Savings Plan. The plan provides employees of Lubrizol and its participating subsidiaries and affiliates with retirement benefits funded by a portion of the company's profits and by voluntary employee savings. It works together with The Lubrizol Corporation Pension Plan (for those employees hired prior to January 1, 2010), The Age-Weighted Defined Contribution Plan (for those eligible employees hired or transferred on or after January 1, 2010) and The Lubrizol Corporation Wage Employees' Pension Plan to provide a retirement income base, along with Social Security and your own retirement savings outside the plan.

This summary plan description (SPD) describes the main features of The Lubrizol Corporation Employees' Profit Sharing and Savings Plan. A complete description of the terms of the plan is contained in the plan document and trust agreement, and the terms of those documents will govern.

Although it is Lubrizol's expectation that the plan will be a permanent program, the company has the right to terminate or amend the plan in whole or in part by written action of its Board of Directors or its designee. However, no amendment may reduce a participant's vested interest in his/her account balance at the time the amendment is made. Neither this SPD, nor the plan document or trust agreement described herein, constitutes a contract of employment or a promise of continuing employment.

The plan is financed by your voluntary before-tax, after-tax and Roth 401(k) contributions and employer matching contributions which are based on your before-tax, after-tax and Roth 401(k) contributions, and by participating employers' discretionary profit sharing contributions to the trust fund. Under current law, none of the funds held in trust for the plan can be used for any purpose other than the provision of benefits under the plan, until full payment of all benefits under the plan has been provided.

Federal law provides you with certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). A summary of these rights is included in the "General Information Section – Your Rights Under ERISA" at the beginning of this Benefits Resource Guide, which is incorporated by reference herein. If you have any questions about the terms of the plan or about the payment of benefits, you may obtain more information from any benefits or human resources representative.

Quarterly statements regarding your account balance, performance and transactions are available through Voya, the plan's recordkeeper. You may also view your account online anytime through the Voya Participant website at https://lzs401k.voya.com.

Who is Eligible

As a regular employee of Lubrizol, a Lubrizol subsidiary or an affiliate which adopts the plan, you automatically become an active participant in this plan beginning on your date of employment. If you are a temporary employee of Lubrizol, a Lubrizol subsidiary or an affiliate which adopts the plan and who works at least 1,000 hours in any 12 month period, you will participate beginning the following January 1 or July 1.

Please see Exclusions from Coverage for All Plans in the General Section of this Benefits Resource Guide for a list of persons who are excluded from coverage (unless otherwise provided).

Auto Enrollment

As a participant in the plan you are eligible to enroll in the 401(k) portion of the plan. Newly eligible employees, both new hires and rehires, are subject to automatic enrollment. You will be automatically enrolled in the plan at a before-tax contribution rate of 3% if you take no action on your own to enroll.

There is a 30-day opt-out period during which you may change your before-tax contribution rate or elect not to contribute ("opt-out"). If you do not make a positive election or opt-out, your contributions will begin to be withheld from your paycheck as soon as administratively possible following the end of the 30 day period. Your before-tax contributions and company match contributions will be invested in the appropriate State StreetTarget Retirement Fund. Once enrolled, you may choose to change your election percentage or stop contributing at any time. You can also change how your contributions will be invested at any time.

Auto Escalation

If you were hired on or before January 1 of the current year with plan contribution rates between 0% and 5% of eligible compensation (whether those contributions are pre-tax, Roth, after-tax, or any combination) as of July 1 of the current year, your pre-tax contribution rate will automatically increase to the next higher full percent starting the first full pay period after July 1 of the current year (or as soon thereafter as administratively practicable). Auto escalation will continue the first full pay period after July 1 of each year until you are contributing 6%.

If you are hired after January 1 of any year, auto escalation will work as described above, except that the first automatic escalation will not occur until July 1 of the year following the year you were hired.

Keep in mind that, depending on the timing of July payroll dates year-to-year, your new auto escalated payroll deduction might vary between the first and second pay date of the month.

Any additional contributions made to your plan account as a result of auto escalation will be invested in the plan's core investment funds in accordance with your election on file. If you have no election on file, then those amounts will be invested in the State Street Target Retirement Fund that most closely matches your expected retirement date based on age 65.

Opting Out of Auto Escalation

You have the right to opt out of your scheduled auto escalation before it would otherwise take effect. To opt out online, log on to your account at https://lzs401k.voya.com and select Account> Contributions> Rate Escalator, then select "Discontinue your Rate Escalator on file." Or, you can call the Information Line at 1-866-597-4015 and speak with a Customer Service Associate. Each year the window in which you can opt out of auto escalation will be communicated.

Your opt out election affects only the 12-month period for which the election is made. If you do not want to be auto escalated on the following July 1, you will need to go into your account again next year before July 1 and discontinue the scheduled rate escalator.

If you did not opt out of auto escalation in a given year, and you wish to discontinue it for the remainder of the 12-month period, you can always do so by logging into your account online or by calling the Information Line and speaking with a Customer Service Associate, and changing your pre-tax contribution percentage to your desired pre-tax contribution level (including 0%, if you do not want to make any pre-tax contributions to your account).

Transfer of Employment

If you should transfer to employment with a Lubrizol subsidiary or affiliate not covered by this plan, you will become an inactive participant. No additional contributions will be made on your behalf, unless you are entitled to a "true-up" matching contribution for the plan year in which your transfer occurs (see the "Employer Matching Contributions" section under "401(k) Savings Contributions to the Plan" below). The amounts in your accounts will continue to appreciate/depreciate with the value of the investment funds during the time you are an inactive participant. If you should later return to employment covered by this plan, you will immediately become an active participant again and future contributions will be credited to your account as provided by the plan. Any service you have with a related employer will be counted in determining your eligibility for employer matching contributions and your vested percentage when you finally retire or terminate employment.

Re-employment

If you terminate employment and become re-employed by Lubrizol or a participating subsidiary or affiliate, any benefit payments which you are receiving will cease and you will once more become a participant in the plan, and earn further service and benefits as provided by the plan. If you originally left covered employment before you were fully vested and received a distribution of your vested portion, or if you were not vested, you forfeited the unvested portion of your account. These forfeitures may be reinstated under certain conditions if you return to covered employment within 60 months, and repay any lump sum benefits already received.

401(k) Savings Contributions to the Plan

Your Before-Tax Contributions

This type of contribution is taken from your earnings before deductions for federal and, as a general matter, state income taxes are made. (However, your before-tax contributions are still subject to FICA tax.) That means your taxable income will be lower and your take-home pay will be higher than if you made these contributions on an after-tax basis. You may elect to have from 1% to 75% of your eligible compensation contributed to the plan as before-tax contributions in whole percentage increments subject to the limits described below. Your eligible compensation is your wages, salaries, fees for professional services, and other amounts received for services actually rendered in the course of employment, to the extent that the amounts are includible in gross income. Your eligible compensation also includes salary reduction amounts that you contributed to an employer-sponsored cafeteria plan or 401(k) plan. Your eligible compensation does not include, however, long-term incentive compensation payments if you are considered a "highly compensated employee" under applicable IRS rules, severance pay, deferred compensation, reimbursements and allowances, moving expenses, and fringe benefits.

Your After-Tax Contributions

This type of contribution is deducted from your earnings after the deduction for income taxes. You may elect to have from 1% to 75% of your eligible compensation (same as defined for before-tax contributions above) contributed to the plan as after-tax contributions in whole percentage increments, subject to the limits described below.

Your Roth 401(k) Contributions

This type of contribution is deducted from your earnings after the deduction for income taxes. You may elect to have from 1% to 75% of your eligible compensation (same as defined for before-tax contributions above) contributed to the plan as Roth 401(k) contributions in whole percentage increments, subject to the limits described below.

Once a day, you may change the percentage of your future before-tax, after-tax, and Roth 401(k) contributions or stop and resume contributions. To do so, contact Voya by visiting the Participant website at https://lzs401k.voya.com or calling the Information Line at 1-866-597-4015. The change will take effect with the next available payroll date.

Limits on your Contributions

Under current law, your before-tax and Roth 401(k) contributions cannot be greater than $18,000 in 2017. Also under current law, the amount of eligible compensation that may be used to determine your contributions under the plan is limited to **$270,000** in 2017. These limits may be adjusted periodically by the Internal Revenue Service for increases in the cost of living.

In addition to the above limits, your total before-tax, after-tax and Roth 401(k) contributions cannot be greater than 75% of eligible compensation for the year.

Finally, the Internal Revenue Service limits contributions that may be made in a year to defined contribution plans. These contributions are sometimes called "total annual additions," and the year for which the total annual additions are made is called the "limitation year." The limit on total annual additions is **$54,000** in 2017. This **$54,000** includes a combination of contributions you and your employer make to The Lubrizol Corporation Employees' Profit Sharing and Savings Plan (any catch-up contributions you make are not included in the limit) plus employer contributions made to The Lubrizol Corporation Age-Weighted Defined Contribution Plan." This limit also may be adjusted periodically by the Internal Revenue Service. If the Plan Administrator determines that the "total annual additions" to be credited to a participant for a limitation year under all defined contribution plans of the Company will exceed the $54,000 limit, the first contribution to be reduced will be the profit sharing contribution under The Lubrizol Corporation Employees' Profit Sharing and Savings Plan, and, the next contribution to be reduced, if necessary, is the profit sharing contribution under the Age-Weighted Defined Contribution Plan. In the event that those reductions do not eliminate the excess annual addition amount, the Plan Administrator will then have the discretion to determine the order in which other contributions will be reduced.

Catch Up Contributions

If you will turn at least age 50 during the year, you may elect to make additional before-tax and/or Roth 401(k) contributions of up to $6,000 (in 2017). You may contribute this amount only if you meet one of the following conditions:

- You elect for the full plan year to make combined before-tax and Roth 401(k) contributions at 75% of your eligible compensation; or
- You contribute $18,000 for the 2017 plan year.

Employer Matching Contributions

You are eligible for employer matching contributions upon enrollment in the 401(k) portion of the plan. Your employer contributes an amount equal to 100% of your before-tax, after-tax, and Roth 401(k) contributions up to 6% of your eligible compensation. This means, for example, that your employer will contribute $1.00 for every $1.00 that you have contributed as before-tax, after-tax, or Roth 401(k) contributions to the 401(k) portion of the plan (on the first 6% of your eligible compensation).

For example: if your annual eligible compensation is $40,000, and you elect to contribute 10% of your eligible compensation to the 401(k) portion of the plan (5% as before-tax contributions, 3% as after-tax contributions, and 2% as Roth 401(k) contributions), your total annual 401(k) contributions would be as follows:

Before-tax contributions	(5% of $40,000)	$2,000
After-tax contributions	(3% of $40,000)	$1,200
Roth 401(k) contributions	(2% of $40,000)	$800
Employer matching contributions	100% of (6% of $40,000)	$2,400

Since your before-tax contributions would be made before taxes are taken out, your taxable pay would be $38,000 ($40,000 - $2,000).

In the event you stop contributing or change the amount you are contributing during the plan year, you will receive the full match (100% of your contributions, up to the 6% of eligible compensation limit). Once year end payroll processing is complete, Voya and Lubrizol will annualize the matching contributions. Once such amounts are calculated, Lubrizol will deposit the difference (or **true-up** the match amount) into participants' accounts as soon as administratively possible in the following year.

Because the Internal Revenue Service currently limits the amount of base salary that may be used to determine contributions to **$270,000**, employer matching contributions are limited to $16,200 (**$270,000** x 6%) in 2017. This limit may be adjusted periodically by the Internal Revenue Service for increases in the cost of living.

Profit Sharing Contributions to the Plan

Determination of Contribution

The plan allows a participating employer to make a discretionary profit sharing contribution the plan. The amount of the profit sharing contribution, if any, for a plan year is determined on or before the following March 15th.

Amount of your Profit Sharing Portion

If your employer determines to make a discretionary profit sharing contribution to the plan for a plan year, you will receive a portion of the profit sharing contribution if you are an active participant in the plan on the last day of the plan year, or if you transferred to a non-participating subsidiary or affiliate of the company during the year and were employed by them on the last day of the plan year, or were an active participant during the year and on an approved leave of absence on the last day of that plan year.

Your portion of your employer's profit sharing contribution is based on a percentage of your **basic compensation**. Your basic compensation is your base biweekly salary as applicable (including military pay up to twelve weekly or six biweekly pay periods), overtime, shift premiums, vacation and holiday pay, bonuses (excluding long term incentives) and commissions paid during the plan year, as applicable. Any portion of your salary which you defer as before-tax contributions under the 401(k) portion of this plan is included as are any before-tax contributions made to the flexible reimbursement program and health savings accounts. Noncash or special allowances, extraordinary compensation, and long-term disability benefits are not included.

For example, if your basic compensation for the year is $40,000 and the profit sharing percentage approved by your employer for that year is 2.25% your share would be $900. Calculated as follows:

$40,000 x 2.25% = $900

Under current law the amount of basic compensation that may be used to determine your portion of the profit sharing contribution is limited to **$270,000** for 2017. This limit may be adjusted by the Internal Revenue Service periodically for increases in the cost of living.

Rollover Contributions

If you have worked for another employer and receive, or are eligible to receive, a lump-sum distribution or installment payments (for less than 10 years) from certain types of retirement plans, you may roll over or transfer the distribution payment into the 401(k) portion of the plan. By making a rollover, you can postpone paying taxes on the rollover. Rollover contributions may be made by depositing the allowable cash payment within 60 days of receipt. You may postpone paying taxes on your entire distribution payment by arranging for a direct transfer from the other plan or a previously-established rollover IRA to this plan. You may not transfer monies from a Roth 401(k) plan, Roth IRA or personal IRA to the plan. Contact the Information Line, 1-866-597-4015, for more details.

Investment of 401(k) and Profit Sharing Contributions

All contributions made to the 401(k) and/or profit sharing portions of the plan are held by the plan trustee, and allocated to individual accounts established in the name of each participant. These separate accounts reflect the type of contributions (profit sharing, before-tax, after-tax, Roth 401(k), employer match, rollover, or transferred) as well as the participant's investment choice.

The plan trustee invests your employee, employer matching and profit sharing contributions according to the investment choices you have elected. **If you do not have an investment election on file with Voya, your employee, employer matching and profit sharing contributions will be invested in the Target Retirement Fund which most closely matches your expected retirement date based on age 65.**

The Investment Funds

Your profit sharing, before-tax, after-tax, Roth 401(k), rollover and transferred contributions and your employer matching contributions may be invested in any one, or combination of, the following funds, according to your election. **If you do not have an investment election on file with Voya, your contributions will be invested in the Target Retirement Fund that most closely matches your expected retirement date based on age 65. These descriptions are intended as a general overview of the investment choices offered. Participants are encouraged to call Voya to obtain and read both the prospectus and the fund fact sheet for each fund to better understand its investment policy, composition, operating guidelines, historical performance, potential risks and applicable expenses. Additional fund information from mutual fund rating services such as Morningstar and Value Line may also be available at your public library. Be sure to carefully consider your options and your investment objectives before making any election. None of the investment options are guaranteed, and your account balance may decline due to investment loss.**

Except as described below, there are no restrictions on your ability to transfer between any of the investment funds available under the plan. However, there may be certain restrictions on your ability to withdraw from the investment funds before you reach age 59½. Refer to the discussion under "Withdrawals and Distributions" for further information.

The **Stable Value Fund** investment objective is to provide a stable rate of return while seeking to preserve principal value. Goldman Sachs Asset Management serves as the investment manager of the Fund. The Fund invests in stable value investment contracts issued by banks, insurance companies, and other financial institutions and a diversified portfolio of fixed income instruments including U.S. government and agency securities, mortgage-backed securities, asset backed securities, corporate bonds, and interest rate futures and options. Up to 100% of the Fund may be invested in any of these types of fixed income investments. All income received by the Fund is automatically reinvested in the Fund. While the value of the underlying securities in the Fund will change, it is the intention of the Fund to maintain a $1 net asset value (NAV). Fund performance is measured against the return of the Barclays Intermediate Government/Credit Bond Index. Any assets of the Fund not invested in fixed income instruments may also be invested by the Trustee or fund manager on a temporary basis in a money market fund maintained as part of a collective trust fund. The principal value of the fund is insured by several different insurance companies through wrap contracts negotiated by the manager (Goldman Sachs) in order to help protect the principal value of the fund; however, it is not backed by the FDIC or any government agency. Participants who wish to transfer account balances from the Fund into their self-directed brokerage account must first transfer those account balances from the Fund into any of the other investment options. The transferred account balances must remain invested in investment options (excluding the Fund) for 90 days before they can be transferred into the self-directed brokerage account.

The **Core Fixed Income Fund** investment objective is to maximize total return by investing for both current income and capital appreciation, consistent with preservation of capital and prudent investment management. The Fund invests in an actively managed mutual fund, the Baird Aggregate Bond Fund (Institutional Class) (tracking fund reference ticker symbol: BAGIX), which invests in fixed income securities and can include U.S. government and corporate bond securities, mortgage and other asset-backed securities, U.S. dollar and non-U.S. dollar denominated securities of non-U.S. issuers. The fund focuses on intermediate maturity, fixed income securities and maintains an average duration ranging between three and seven years. All income received by the Fund is automatically reinvested in the Fund. The value of this Fund varies depending on the performance of the securities in the underlying actively managed fund. Fund performance is measured against the return of the BBgBarc US Aggregate Bond Index. Assets of the Fund may also be invested by the Trustee or fund manager on a short-term basis in a money market fund maintained as part of a mutual fund.

The **Retirement Ready Target Retirement Income Fund** investment objective is to allocate its assets across multiple asset classes in a conservative manner. The fund is designed for those in or near retirement or those who wish to have a more conservative investment structure. The Fund seeks to provide a balanced fund with current income from fixed income securities while maintaining a moderate exposure to global equity, real estate, and commodity investments for capital appreciation. The Fund is managed by State Street Global Advisors, an affiliate of the Trustee, and has a current target asset allocation of 65% fixed income, and 35% in equities, real estate, and commodities. Fund performance is measured against the return of a similarly weighted composite benchmark. The Fund also seeks to maintain a level of volatility which approximates that of the composite benchmark.

The **Retirement Ready Target Retirement 2020 Fund** investment objective is to allocate its assets across multiple asset classes in a manner which becomes increasingly conservative over time, while seeking to achieve the appropriate level of risk given a participant's anticipated retirement date on or within a few years of 2020. The Fund seeks to provide a balanced fund with current income from fixed income securities while maintaining a larger exposure to global equity, real estate, and commodity investments for capital appreciation. The Fund is managed by State Street Global Advisors, an affiliate of the Trustee, and has a current target asset allocation of 45% fixed income, and 55% in equities, real estate, and commodities. Fund performance is measured against the return of a similarly weighted composite benchmark. The Fund also seeks to maintain a level of volatility which approximates that of the composite benchmark.

The **Retirement Ready Target Retirement 2030 Fund** investment objective is to allocate its assets across multiple asset classes in a manner which becomes increasingly conservative over time, while seeking to achieve the appropriate level of risk given a participant's anticipated retirement date on or within a few years of 2030. The Fund seeks to provide a balanced fund with some current income from fixed income securities while mainly maintaining an exposure to global equity and some commodity investments for capital appreciation. The Fund is managed by State Street Global Advisors, an affiliate of the Trustee, and has a current target asset allocation of 26% fixed income, and 74% equities and commodities. Fund performance is measured against the return of a similarly weighted composite benchmark. The Fund also seeks to maintain a level of volatility which approximates that of the composite benchmark.

The **Retirement Ready Target Retirement 2040 Fund** investment objective is to allocate its assets across multiple asset classes in a manner which becomes increasingly conservative over time, while seeking to achieve the appropriate level of risk given a participant's anticipated retirement date on or within a few years of 2040. The Fund seeks to provide a balanced fund with a large exposure to global equity and some commodity investments for capital appreciation and some current income from fixed income securities. The Fund is managed by State Street Global Advisors, an affiliate of the Trustee, has a current target asset allocation of 14% fixed income, and 86% equities and commodities. Fund performance is measured against the return of a similarly weighted composite benchmark. The Fund also seeks to maintain a level of volatility which approximates that of the composite benchmark.

The **Retirement Ready Target Retirement 2050 Fund** investment objective is to allocate its assets across multiple asset classes in a manner which becomes increasingly conservative over time, while seeking to achieve the appropriate level of risk given a participant's anticipated retirement date on or within a few years of 2050. The Fund seeks to provide a balanced fund with a large exposure to global equity and some commodity investments for capital appreciation and some current income from fixed income securities. The Fund is actively managed by State Street Global Advisors, an affiliate of the Trustee, and has a current target asset allocation of 10% fixed income, and 90% equities and commodities. Fund performance is measured against the return of a similarly weighted composite benchmark. The Fund also seeks to maintain a level of volatility which approximates that of the composite benchmark.

The **Retirement Ready Target Retirement 2060 Fund** investment objective is to allocate its assets across multiple asset classes in a manner which becomes increasingly conservative over time, while seeking to achieve the appropriate level of risk given a participant's anticipated retirement date on or within a few years of 2060. The Fund seeks to provide a balanced fund with a large exposure to global equity and some commodity investments for capital appreciation and some current income from fixed income securities. The Fund is actively managed by State Street Global Advisors, an affiliate of the Trustee, and has a current target asset allocation of 10% fixed income, and 90% equities and commodities. Fund performance is measured against the return of a similarly weighted composite benchmark. The Fund also seeks to maintain a level of volatility which approximates that of the composite benchmark.

The **Large Cap Core Equity Passive Fund** investment objective is to provide investment results which closely replicate the overall performance of the common stocks included in the Standard & Poor's 500 Composite Stock Price Index ("S&P 500 Index"). The S&P 500 Index is a composite stock price index of 500 large capitalization common stocks, selected by Standard & Poor's Corporation, which is intended to furnish a measure of the composite price patterns of domestic, publicly-traded common stocks, weighted by capitalization, and represent a cross section of industry sectors and companies within each industry. The Fund invests in an index fund, the SSgA S&P 500 Index Fund, maintained by State Street Global Advisors, an affiliate of the Trustee, as part of a collective trust fund which invests in the common stocks included in the S&P 500 Index, futures contracts and other derivative securities. This fund does not purchase or sell any individual stock in the Index on the basis of any independent consideration relating to economic or financial conditions or market timing or analysis. All dividends and other income received by the Fund are automatically reinvested in the Fund. The value of this Fund varies depending on the performance of the securities in the underlying index fund. Fund performance is measured against the return of the S&P 500 Index. Assets of the Fund may also be invested by the Trustee or fund manager on a short-term basis in a money market fund maintained as part of a collective trust fund.

The **Large Cap Value Equity Passive Fund** investment objective is to provide investment results which closely replicate the overall performance of the common stocks included in the FTSE Russell 1000 Value Index ("Russell 1000 Value Index"). The Russell 1000 Value Index measures the performance of the large-cap value segment of the U.S. equity universe. It includes those Russell 1000 companies with lower price-to-book ratios and lower expected growth values. The Russell 1000 Value Index is constructed to provide a comprehensive and unbiased barometer for the large-cap value segment. The Index is completely reconstituted annually to ensure new and growing equities are included and that the represented companies continue to reflect value characteristics. The Fund invests in an index fund, the SSgA Russell Large Cap Value Index Fund, maintained by State Street Global Advisors, an affiliate of the Trustee, as part of a collective trust fund which invests in the common stocks included in the Russell 1000 Value Index, futures contracts and other derivative securities. This fund does not purchase or sell any individual stock in the Index on the basis of any independent consideration relating to economic or financial conditions or market timing or analysis. All dividends and other income received by the Fund are automatically reinvested in the Fund. The value of this Fund varies depending on the performance of the securities in the underlying index fund. Fund performance is measured against the return of the Russell 1000 Value Index. Assets of the Fund may also be invested by the Trustee or fund manager on a short-term basis in a money market fund maintained as part of a collective trust fund.

The **Large Cap Growth Equity Passive Fund** investment objective is to provide investment results which closely replicate the overall performance of the common stocks included in the FTSE Russell 1000 Growth Index ("Russell 1000 Growth Index"). The Russell 1000 Growth Index measures the performance of the large-cap growth segment of the U.S. equity universe. It includes those Russell 1000 companies with higher price-to-book ratios and higher forecasted growth values. The Russell 1000 Growth Index is constructed to provide a comprehensive and unbiased barometer for the large-cap growth segment. The Index is completely reconstituted annually to ensure new and growing equities are included and that the represented companies continue to reflect growth characteristics. The Fund invests in an index fund, the SSgA Russell Large Cap Growth Index Fund, maintained by State Street Global Advisors, an affiliate of the Trustee, as part of a collective trust fund which invests in the common stocks included in the Russell 1000 Growth Index, futures contracts and other derivative securities. This fund does not purchase or sell any individual stock in the Index on the basis of any independent consideration relating to economic or financial conditions or market timing or analysis. All dividends and other income received by the Fund are automatically reinvested in the Fund. The value of this Fund varies depending on the performance of the securities in the underlying index fund. Fund performance is measured against the return of the Russell 1000 Growth Index. Assets of the Fund may also be invested by the Trustee or fund manager on a short-term basis in a money market fund maintained as part of a collective trust fund.

The **Mid Cap Value Equity Fund** investment objective is to seek long-term capital appreciation and income from mid-capitalization stocks. The Fund invests in an actively managed mutual fund, the Vanguard Selected Value fund (ticker symbol: VASVX), which invests in equity securities which are believed to be undervalued. The fund is currently sub-advised by three investment managers with complementary investment processes. Vanguard oversees the allocations to the sub-advisors, and the resulting portfolio typically has 100-160 stocks. All dividends and other income received by the Fund are automatically reinvested in the Fund. The value of this Fund varies depending on the performance of the securities in the underlying actively managed fund. Fund performance is measured against the return of the Russell Mid Cap Value Index. Assets of the Fund may also be invested by the Trustee or fund manager on a short-term basis in a money market fund maintained as part of a collective trust fund. The Vanguard Selected Value Fund has a short-term trading restriction to protect investors from the cost impact of short-term trading. Participants who transfer/reallocate money out of this fund will be prohibited from transferring/reallocating money back into this fund for 60 calendar days.

The **Mid Cap Growth Equity Fund** investment objective is to seek long-term capital growth. The Fund invests in an actively managed mutual fund, the MassMutual Select Mid Cap Growth Equity Fund II Class I (ticker symbol: MEFZX), which invests primarily in securities of companies which are expected to grow at a faster rate than the average company. The fund is currently sub-advised by two investment managers with complementary investment processes. MassMutual oversees the allocations to the sub-advisors, and the resulting portfolio typically has 150-250 stocks. All dividends and other income received by the Fund are automatically reinvested in the Fund. The value of this Fund varies depending on the performance of the securities in the underlying actively managed fund. Fund performance is measured against the return of the Russell Mid Cap Growth Index. Assets of the Fund may also be invested by the Trustee or fund manager on a short-term basis in a money market fund maintained as part of a collective trust fund.

The **Small Cap Value Equity Fund** investment objective is to seek long-term growth through capital appreciation and income. The Fund invests in an actively managed mutual fund, the DFA US Small Cap Value fund (ticker symbol: DFSVX), which invests primarily in a portfolio of common stocks of small capitalization companies which are believed to be undervalued versus their peer group. DFA utilizes a quantitative investment approach, and the fund is broadly diversified across industries and typically holds over 1,000 different stocks. Under normal market conditions, at least 80% of the fund will be invested in securities of companies with a market value capitalization consistent with equities in the Russell 2000 Value Index. All dividends and other income received by the Fund are automatically reinvested in the Fund. The value of this Fund varies depending on the performance of the securities in the underlying actively managed fund. Fund performance is measured against the return of the Russell 2000 Value Index. Assets of the Fund may also be invested by the Trustee or fund manager on a short-term basis in a money market fund maintained as part of a collective trust fund.

The **Small Cap Growth Equity Fund** investment objective is to seek long-term capital appreciation. The Fund invests in an actively managed mutual fund, the Hartford Small Cap Growth HLS fund (ticker symbol: HISCX), which invests primarily in a portfolio of common stocks of small market capitalization companies which are believed to have superior growth potential. The fund is sub-advised by Wellington Management, and employs both a quantitative and fundamental investment process. The fund is broadly diversified across industries and typically holds 300-400 stocks. All dividends and other income received by the Fund are automatically reinvested in the Fund. The value of this Fund varies depending on the performance of the securities in the underlying actively managed fund. Fund performance is measured against the return of the Russell 2000 Growth Index. Assets of the Fund may also be invested by the Trustee or fund manager on a short-term basis in a money market fund maintained as part of a collective trust fund.

The **International Core Equity Fund** investment objective is to achieve long-term capital growth by investing in securities of issuers domiciled outside the United States. The Fund invests in an actively managed mutual fund, the Fidelity Advisors Diversified International Fund Z (ticker symbol: FZABX), which invests in a diversified portfolio of common stocks and other equity-like securities of companies based outside the United States. The assets of this fund may be invested with geographic diversity; however, there is no limitation on the percentage of assets which may be attributable to any one country, nor will all countries be represented. In addition to investing directly in common stocks, investments may also be maintained in securities convertible into common stocks, preferred stocks and warrants. All dividends and other income received by the Fund are automatically reinvested in the Fund. The value of this Fund varies depending on the performance of the securities in the underlying actively managed fund. Fund performance is measured against the return of the MSCI EAFE Index. Assets of the Fund may also be invested by the Trustee or fund manager on a short-term basis in a money market fund maintained as part of a collective trust fund. To help offset the negative impact of short-term trading, this Fund has added redemption fees. Charged as a percentage of the money withdrawn, the redemption fee only applies if you sell your shares before the end of the required holding period. There is a 1% redemption fee for shares sold before the required holding period of 30 days has elapsed.

The **International Small Cap Equity Fund** investment objective is to achieve long-term capital growth by investing in securities of issuers domiciled outside the United States. The Fund invests in an actively managed mutual fund, the Vanguard International Explorer Fund (ticker symbol: VINEX), which invests primarily in the equity securities of small-capitalization companies located outside the United States that the advisors believe offer the potential for capital appreciation. The fund is currently sub-advised by two investment managers with complementary investment processes. Vanguard oversees the allocations to the sub-advisors, and the resulting portfolio typically has approximately 300 holdings. Under normal market conditions, at least 80% of the assets will be invested in securities of international small capitalization companies. All dividends and other income received by the Fund are automatically reinvested in the Fund. The value of this Fund varies depending on the performance of the securities in the underlying actively managed fund. Fund performance is measured against the return of the MSCI ACWI ex US Small Cap Index. Assets of the Fund may also be invested by the Trustee or fund manager on a short-term basis in a money market fund maintained as part of a collective trust fund. The Vanguard International Explorer Fund has a short-term trading restriction to protect investors from the cost impact of short-term trading. Participants who transfer/reallocate money out of this fund will be prohibited from transferring/reallocating money back into this fund for 30 calendar days.

The **Emerging Markets Equity Fund** investment objective is to achieve long-term capital growth by investing in securities of issuers domiciled in the Emerging Markets. The Fund invests in an actively managed mutual fund, the DFA Emerging Markets Core Equity fund (ticker symbol: DFCEX), which invests in a diversified portfolio of equity securities that are traded principally in the Emerging Markets. DFA utilizes a quantitative investment approach, and the fund is broadly diversified across countries and typically holds approximately 3,000 different stocks. Under normal market conditions, at least 80% of the assets will be invested in securities of Emerging Markets companies. All dividends and other income received by the Fund are automatically reinvested in the Fund. The value of this Fund varies depending on the performance of the securities in the underlying actively managed fund. Fund performance is measured against the return of the MSCI Emerging Markets Index. Assets of the Fund may also be invested by the Trustee or fund manager on a short-term basis in a money market fund maintained as part of a collective trust fund.

The **Berkshire Hathaway Class B Stock Fund** investment objective is to provide long-term growth of capital by investing solely in shares of Class B Common Stock of Berkshire Hathaway Inc. (ticker symbol: BRK-B). The shares of Berkshire Hathaway Class B Common Stock held by the Fund are purchased at the then-current market price on the open market. All income received by the Fund automatically is reinvested in the Fund. The value of investments in this Fund varies depending on the market price of Berkshire's Class B Common Stock. Any assets of this Fund not invested in Class B Common Stock may also be invested by the Trustee on a short-term basis in a money market fund maintained by the Trustee as part of a collective trust fund. Because the Fund typically holds a small amount of cash in order to provide liquidity to participants, the performance of the Fund may deviate slightly from the actual Berkshire Hathaway stock. This Fund is part of an employee stock ownership plan (ESOP) contained in the plan. Note that, effective July 1, 2015, certain limitations with respect to the Berkshire Hathaway Class B Stock Fund went into effect:

- You may not make a transfer into the Berkshire Hathaway Class B Stock Fund if the percentage of your account balance invested in the Berkshire Hathaway Class B Stock Fund exceeds 50%, or to the extent that the transfer would cause your account balance invested in the Berkshire Hathaway Class B Stock Fund to exceed 50%.
- You may not make a reallocation election or a rebalancing election for the Berkshire Hathaway Class B Stock Fund that exceeds 50%.
- You may not make a rollover election into the Berkshire Hathaway Class B Stock Fund that exceeds 50%.
- You may not make an election to invest more than 50% of your future contributions in the Berkshire Hathaway Class B Stock Fund.
- On the last day of the quarter, if 50% or more of your account balance is invested in the Berkshire Hathaway Class B Stock Fund, any election you have on file to invest future contributions into the Berkshire Hathaway Class B Stock Fund will automatically be reduced to 0%. In that event, however, you will not be restricted from restoring your prior election for the Berkshire Hathaway Class B Stock Fund or electing another percentage for the Berkshire Hathaway Class B Stock Fund, as long as your election does not exceed 50%.
- If you attempt to make a transaction or election online that does not comply with the limits on the Berkshire Hathaway Class B Stock Fund, the transaction or election will not be processed, and you will receive a message prompting you to revise your transaction or election to comply with the limit. If your rollover election form shows an election for the Berkshire Hathaway Class B Stock Fund that exceeds 50%, your election for the Berkshire Hathaway Class B Stock Fund will automatically be reduced to 50%, and the excess percentage will be invested in the SSgA Target Date Retirement Fund that most closely corresponds to your age.

Annual Returns of Plan Investment Options						
	Annual Returns (%)					
Periods Ending 12/31	**2016**	**2015**	**2014**	**2013**	**2012**	**2011**
Stable Value Fund	2.04	2.01	2.02	1.99	1.96	2.37
Core Fixed Income Fund	3.52	0.55	6.89	-1.25	7.92	7.85
Retirement Ready Target Retirement Income Fund	5.82	-1.37	3.69	5.14	9.73	4.68
Retirement Ready Target Retirement 2020 Fund	7.60	-1.88	6.00	13.29	13.85	5.94
Retirement Ready Target Retirement 2030 Fund	8.42	-2.02	6.49	18.24	15.02	3.56
Retirement Ready Target Retirement 2040 Fund	9.12	-2.32	6.31	21.38	16.09	0.10
Retirement Ready Target Retirement 2050 Fund	9.48	-2.43	6.27	21.51	16.08	0.12
Retirement Ready Target Retirement 2060 Fund	9.49	N/A	N/A	N/A	N/A	N/A
Large Cap Core Equity Passive Fund	11.96	1.36	13.63	32.34	15.97	2.09
Large Cap Equity Value Passive Fund	17.29	-3.70	13.37	32.44	17.52	0.38
Large Cap Equity Growth Passive Fund	7.09	5.65	13.02	33.44	15.27	2.56
Mid Cap Value Equity Fund	16.34	-3.80	6.36	42.04	15.25	0.82
Mid Cap Growth Equity Fund	6.19	5.95	13.00	36.31	14.71	-1.74
Small Cap Value Equity Fund	28.26	-7.81	3.48	42.38	21.72	-7.55
Small Cap Growth Equity Fund	12.37	-0.55	5.83	44.87	17.40	1.42
International Core Equity Fund	-2.52	4.30	-3.02	26.42	20.49	-13.41
International Small Cap Equity Fund	-1.77	8.60	-2.88	30.24	17.93	19.74
Emerging Markets Equity Fund	12.35	-14.86	-0.91	-2.64	20.49	-20.65
Berkshire Hathaway Class B Stock Fund	22.77	-11.92	25.80	30.86	N/A	N/A

Newly Hired Employees

If a newly hired or rehired employee does not make an investment election with Voya, his/her contributions, company matching contributions and profit sharing contributions will be defaulted to the appropriate Target Retirement Fund with the date that most closely matches a retirement age of 65.

Valuation of the Funds

The value of each separate account is determined daily (based on the most recent valuation of the fund(s) and the best available information). It reflects increases or decreases in the value of the assets of each investment fund due to contributions, withdrawals, investment gains and losses, as well as income earned. There are limited circumstances where the value of an investment fund reflects the most currently available information. The value of each separate account will be a proportionate amount of the total value of the fund in which it is invested.

Allocation and Transfer of your Investments

When you begin to participate in the plan, you will indicate your investment choices for your contributions in multiples of 1%.

Once a day, you may change the manner in which your future contributions are to be invested through Voya. The change will take effect on the next available payroll date.

Once a day, you may transfer the balance in each of your separate accounts to any of the investment funds in 1% increments, subject to the limitations described below. This change may be made through Voya. These changes will occur at the end of the first available business day (i.e., 4:00 p.m. Eastern Time on the first available day the New York Stock Exchange is open). Your account will reflect these changes on the next available business day.

Vesting

You are always entitled to (or "vested in") 100% of the value of your contributions and earnings, including before-tax contributions, after-tax contributions, Roth 401(k) contributions, rollover contributions and transferred contributions. You are immediately vested in 100% of Lubrizol's matching contributions to your account.

If your employment ends after December 31, 2014, you will be 100% vested in the employer matching contributions and profit sharing contributions made to your account. You (or your beneficiary) will also be 100% vested in your employer matching contributions and profit sharing contributions if your participation in the plan ends because of your retirement at or after age 55, because you become totally and permanently disabled and are placed on long-term disability leave, or because of your death.

If your employment ended on or before December 31, 2014 except on account of retirement, disability, or death as described above, you are vested in the value of the employer matching and profit sharing contributions made on your behalf based on your years of service with the company and related companies.

If you have completed at least:	**The percentage of employer matching and profit sharing contributions in which you are vested:**
1 year of service	33
2 years of service	66
3 years of service	100%

TD Ameritrade Self-Directed Brokerage Account

The self-directed brokerage account is a brokerage account offered in the plan and provided through TD Ameritrade. It gives you access to more than 13,000 mutual funds (of which more than 2,100 are no-load, no-transaction-fee (NTF) mutual funds). However, unlike the plan's current investment options, transaction fees and operating expense fees generally apply to the mutual funds available through the self-directed brokerage account.

You may invest up to 50% of your total vested plan account balance through the self-directed brokerage account. Your minimum initial transfer into your self-directed brokerage account must be $1,000 per account, and you will have to establish separate accounts (each with a $1,000 minimum and subject to the fees described below) for amounts transferred from your before-tax contributions and your Roth 401(k) contributions. The mutual fund you select may also require a minimum investment. An investment in the self-directed brokerage account must come from your current plan balance through a funds transfer; you cannot elect to directly invest future contributions, including loan repayments, into the self-directed brokerage account.

Fees

Transaction fees and operating expense fees may apply to the mutual funds available within the plan's self-directed brokerage account. Once you open a self-directed brokerage account, there is a $50.00 annual fee (billed quarterly in $12.50 installments) to maintain the self-directed brokerage account. In addition, any investment you purchase or sell through the self-directed brokerage account may carry with it additional fees. Please read the TD Ameritrade Fee Schedule, which can be found on the TD Ameritrade website at www.tdameritraderetirement.com. In addition, be sure to ask TD Ameritrade about any fees, including any undisclosed fees, that may be charged in connection with the purchase or sale of any investment in the self-directed brokerage account, including a redemption fee of $49.99 for almost any mutual fund investment that you do not hold for at least 90 days.

Loans, Withdrawals, Distributions and Qualified Domestic Relations Orders
If you are eligible to take a loan or withdrawal from the plan, you cannot borrow or withdraw directly from your investments in the self-directed brokerage account. If you need to access the money you have invested in the self-directed brokerage account for a loan or withdrawal under the plan, you first need to sell some or all of your mutual fund investment(s) in the self-directed brokerage account and transfer the assets back to the plan's core investment funds. However, your total plan account balance, including your balance in the self-directed brokerage account, will be used to calculate the maximum loan amount you may take from the plan.

You cannot take a distribution directly from your investments in the self-directed brokerage account. If a distribution is to be made from your plan account that cannot otherwise be funded from your account balances outside the self-directed brokerage account, you must first transfer money from the self-directed brokerage account back into any of the plan's core investment funds. Once this has been completed, you can request the distribution from the plan according to plan rules.

Similar rules apply in the case of a qualified domestic relations order, where a separate interest in your plan account is established for your former spouse or other dependent. If the separate interest cannot be established entirely from money in your plan accounts not invested in the self-directed brokerage account, you will be asked to transfer money out of the self-directed brokerage account and into any of the plan's core investment options, so that the separate interest may be established entirely from your plan balances held outside the self-directed brokerage account.

Dividends and Interest
Any dividends and/or interest on your investments in the self-directed brokerage account will be reinvested in the mutual fund that paid the dividend and/or interest.

Required Minimum Distributions
If your plan account balance outside of the self-directed brokerage account is not sufficient to satisfy the required minimum distribution amount after you attain age 70½, you must transfer sufficient funds from your investments in the self-directed brokerage account back to the core investment funds available under the plan to make up for the shortfall and meet the required minimum distribution rules. If you do not make the required transfer, the plan administrator may cause investments in your self-directed brokerage account to be liquidated sufficient to fund the required minimum distribution.

Statements
You will receive a monthly statement regarding your self-directed brokerage account, unless there has been no activity in your account, in which case you will receive a quarterly statement. You will also receive trade confirmations made through your self-directed brokerage account.

Other Terms and Conditions
The self-directed brokerage account feature is subject to any additional terms and conditions which the plan administrator may adopt from time to time.

Customer Service Support
If you have questions about making a trade on the TD Ameritrade website, or about any account alerts or notifications you may receive if you request a trade, call a TD Ameritrade representative at 1-866-766-4015. Representatives are available between 8:00 a.m. and 7:00 p.m. Eastern Time on weekdays, except New York Stock Exchange holidays.

Withdrawals and Distributions

Withdrawals While Employed

Because The Lubrizol Corporation Employees' Profit Sharing and Savings Plan is designed as a long-term investment vehicle to provide you with retirement income, there are certain restrictions on withdrawals before you reach age 59½. These generally include an IRS penalty tax of 10% of any amount not previously subject to income tax (earnings, before-tax contributions and earnings on Roth 401(k) contributions), in addition to regular income tax on these amounts.

Withdrawals from your after-tax and rollover contribution accounts may be made at any time and must be at least $1,000 or, if smaller, the entire balance of your account. When a withdrawal is made, the money is taken proportionately from each investment fund. Any withdrawal of after-tax contributions will be taken first from contributions you made to the plan before January 1, 1987. Withdrawal of any after-tax contributions which you made after January 1, 1987 will include a portion of previously untaxed earnings on those contributions. These earnings will be subject to income tax and the 10% penalty tax. You must withdraw your entire after-tax contribution account before you withdraw your rollover contributions. If you receive an after-tax withdrawal, you may not make another after-tax withdrawal for six months. Similarly, you may not take a withdrawal of rollover amounts for six months after receiving a rollover withdrawal.

You may take a withdrawal from your matching contributions any time after you reach age 59 ½. If you had matching contributions that were made to the plan prior to January 1, 2015, you may withdraw those matching contributions any time after you reach age 55.

Your profit sharing account balance cannot be distributed until separation from employment or you meet the Plan's definition of Disability.

You may take a withdrawal at any time from your 401(k) account balance, once you have reached age 59½. Otherwise, you may not take a withdrawal from your 401(k) account balance unless you meet the requirements for a hardship withdrawal. A hardship is an immediate and heavy financial need that cannot be met from other sources (including withdrawals of after-tax and rollover contributions and plan loans).

You may request a hardship withdrawal for the following reasons:

- Purchase of a principal residence for you, excluding mortgage payments (but only after your offer has been accepted by the seller);
- Prevention of your eviction from or mortgage foreclosure on your principal residence (but only after you have received an eviction or foreclosure notice);
- Payment of tuition and related expenses for you, your spouse, your dependents or your designated beneficiary for the next 12 months of post-secondary education;
- Medical care expenses previously incurred by you, your spouse, your dependents or your designated beneficiary, and expenses that are necessary for you, your spouse, your dependents or your designated beneficiary to obtain medical care (i.e., distribution prior to actual incurring of the expense);
- Payment for burial or funeral expenses for your deceased parent, spouse, children, dependents or your designated beneficiary; or
- Payment for expenses for the repair of damage to your principal residence that would qualify as a casualty deduction under Section 165 of the Internal Revenue Code.

If you qualify for a hardship withdrawal, you may withdraw only the amount necessary to meet the immediate need which may include amounts necessary to cover federal, state or local income taxes or resulting penalties. However, you may not withdraw more than your before-tax contribution account balance and your Roth 401(k) contributions (Roth earnings are not eligible to be withdrawn due to a hardship). A hardship withdrawal requires separate application and approval of the committee. Any withdrawal from your before-tax contribution account is subject to ordinary income tax and is generally subject to the 10% penalty tax.

If you want to take a hardship withdrawal, you must first withdraw your after-tax and rollover contributions, and you must obtain all available plan loans. Withdrawals of contributions will be made proportionately from your investment funds. You may not take another hardship withdrawal for six months after receiving a hardship withdrawal.

If you receive a hardship withdrawal, your before-tax, after-tax and Roth 401(k) contributions will be suspended for six months. You may then resume contributions through Voya.

Profit sharing contributions may not be withdrawn prior to your eligibility for a full distribution.

Full Distributions

Distributions of your total vested interest in the plan may be made if you terminate employment through retirement, death or otherwise. Additionally, you may receive a distribution of your total vested interest in the plan if you become totally and permanently disabled as defined by the Internal Revenue Service and you are placed on long-term disability leave. Distributions will include both your profit sharing and 401(k) portions of the plan.

Other than described below, distribution will be made only with your written consent.

If you leave employment prior to age 70½ and choose to defer your benefit distribution or if you make no election to receive your benefits when you terminate or retire, your benefit distribution will begin at the earlier of your distribution request or the April 1 of the calendar year following the year in which you reach age 70½. If you retire after age 70½, benefit distribution will automatically begin on the April 1 of the calendar year following the year in which you retire.

If you have a termination of employment and your account balance is $1,000 or less, your account balance will be distributed to you in a lump sum payment.

If you are not yet age 59½ at the time a distribution is made, certain tax penalties may apply (see Tax Implications).

Methods of Payment

Your vested 401(k) and profit sharing account balances may be paid in a single lump sum, partial payments, or monthly, quarterly or annual installments over a fixed period of time not to exceed your life expectancy or the joint life expectancy of you and your designated beneficiary, whichever you elect. Participants who have a transferred balance from the Vesta Intermediate Funding, Inc. Profit Sharing Plan may also receive their distribution as an annuity.

The lump-sum distribution is the normal form of benefit under the plan. All distributions from the Berkshire Hathaway Class B Stock Fund are made in shares of Berkshire Class B Common Stock, except that cash is paid in place of a fractional share. You have the right, however, to choose cash in place of the shares of Class B Common Stock which you would otherwise receive. You may make this election by submitting a written form to Voya. Distributions from the rest of the investment funds are made in cash.

Death Benefits

If you die before benefit payments begin, a benefit may be payable to your spouse or other designated beneficiary as follows:

If you are married at the time of your death, your spouse will receive the full amount of your account balance in one lump sum. This benefit is provided whether or not you are actively employed by Lubrizol at the time of your death (provided you have not yet begun to receive benefits under the plan), and may be waived only with your spouse's written, notarized agreement.

If you are unmarried at the time of your death, or if you have waived the surviving spouse benefit described above, your entire account balance will be paid to your designated beneficiary in one lump sum.

Designation of Beneficiary

Your beneficiary designation must be in writing and comply with any procedures established by the plan administrator. You may designate a beneficiary or change your designation at any time through the Participant website (https://lzs401k.voya.com) or by calling Voya to obtain a Designation of Beneficiary form. The form must be returned to Voya to the address provided on the form. Voya is the official recordkeeper of the beneficiary elections. If you are married, your spouse is automatically your beneficiary, even if you designate another, unless your spouse provides written, notarized agreement to your designation. If you are not married and you die with no surviving designated beneficiary, your account balance will be paid to your estate.

Tax Implications

Because the plan is a tax-qualified plan under Section 401(a) of the Internal Revenue Code, under current law there are special tax advantages for participants:

- Before-tax contributions are made before federal income taxes are withheld. Your before-tax contributions, profit sharing contributions, employer matching contributions and earnings or gains are not subject to federal income tax until they are distributed or withdrawn.
- After-tax contributions have already been taxed at the time they are made. However, any earnings or gains on after-tax contributions are not subject to tax until they are withdrawn or distributed.
- Roth 401(k) contributions are after-tax contributions that have already been taxed at the time they are made. Earnings or gains on such contributions are not taxable upon a qualified distribution if your account is held for at least 5 years.
- Rollover and transferred contributions are untaxed contributions rolled over or transferred from other qualified plans or rollover IRAs. These contributions and their earnings or gains are not subject to tax until they are withdrawn or distributed.

Any distribution or withdrawal of contributions or earnings which have not already been taxed will be subject to ordinary income tax unless rolled over to another qualified plan or to an IRA. Roth 401(k) contributions and earnings are eligible to be rolled over to a Roth IRA with no tax or penalties. Previously untaxed amounts will also be subject to a penalty tax equal to 10% of the untaxed amount unless:

- You are at least age 59½ when the withdrawal or distribution is made;
- The distribution is made after you reach age 55 and is due to retirement;
- The distribution is made because of your death or total disability; or
- The withdrawal is used to pay a deductible medical expense.

The taxable portion of any distribution or withdrawal that is paid directly to you will be subject to an automatic 20% federal income tax withholding requirement. There may be additional tax consequences if you do not roll over the entire taxable amount of your distribution (including the 20% withheld) to an IRA or a new employer's qualified retirement plan within 60 days of your receipt of the distribution.

To avoid the 20% withholding requirement and additional tax consequences, you may elect instead to have the taxable amount of your distribution or withdrawal directly transferred to an IRA or a new employer's qualified retirement plan.

Hardship withdrawals are not subject to this 20% withholding rule. However, hardship withdrawals are subject to the 10% penalty tax except as described above.

Because tax laws are complex and frequently change, this information is intended only as a general outline. Before you withdraw or receive any distribution from the plan, you should consult a tax advisor.

How to Apply for Withdrawal or Distribution

Applications for withdrawals and distributions may be obtained through the Participant website at https://lzs401k.voya.com or by calling the Information Line at 1-866-597-4015. Applications must be properly filled out, signed and sent to Voya for processing. A separate application is required for distributions involving Roth 401(k) contributions and earnings.

Withdrawals of your matching, after-tax or rollover contributions while you are employed may be made by calling the Information Line at 1-866-597-4015.

Withdrawals from your 401(k) account balance before you reach age 59½ may only be made for immediate and heavy financial need (see the section titled Withdrawals and Distributions). Call the Information Line at 1-866-597-4015 for withdrawal forms and information.

A completed written application for distribution of your 401(k) account balance due to permanent and total disability or for distribution of your entire 401(k) and profit sharing account balances upon separation of employment must be sent to Voya at the following address:

Mail
Voya
Attention: Lubrizol Plan Administration
P.O. Box 24747
Jacksonville, FL 32241-4747

Overnight Delivery
Voya
U.S. Retirement Services
Attention: Lubrizol Plan Administration
30 Braintree Hill
Braintree, MA 02184

Plan Loans

You may be eligible to borrow money from your 401(k) account balance while you are still employed. Your profit sharing balance is not eligible for plan loans. You repay your loan plus interest through payroll deductions. Upon repayment of the loan, the principal and interest on the loan are deposited into the investment funds based on your current elections. A loan will not be considered a withdrawal subject to income taxes if you pay back your loan within the payment period. The payment period may not be more than five years, except for loans issued to purchase your principal residence, which may be repaid within 15 years.

You may also pay off your total outstanding loan balance via certified check, cashier's check or money order made payable to "Voya Institutional Trust Company" at any time prior to the original payoff date. Partial payoffs are not allowed. Loan payoffs must be sent to Voya at the following address:

Mail
Voya
Attention: Lubrizol Plan Administration
P.O. Box 24747
Jacksonville, FL 32241-4747

Overnight Delivery
Voya
U.S. Retirement Services
Attention: Lubrizol Plan Administration
30 Braintree Hill
Braintree, MA 02184

The loan number and your Social Security Number are required on the check or money order.

You may apply for a loan by calling the Information Line at 1-866-597-4015 or visiting the Participant website at https://lzs401k.voya.com. Residential loans (purchase of a principal residence) require paper processing accompanied by a Truth in Lending Agreement. A $75 fee will be charged for each new loan application. The fee will be deducted from your account balance.

You may borrow a minimum of $1,000. The maximum amount you may borrow is the lesser of:

- 50% of the value of your vested plan account balance or, if less, 100% of the value of your accounts attributable to before-tax, Roth, catch-up contributions, company stock dividends, matching contributions, other company contributions (special contributions made to employees of a specific business unit or business subsidiary) and rollover contributions or
- $50,000 less the highest outstanding loan balance in the last twelve months.

The loan will be made proportionately from your 401(k) source balances. You are limited to three outstanding loans at any one time. Your loan will be secured by up to 50% of your vested 401(k) balance.

The loan interest rate will equal the prime interest rate +1%, as printed in the Wall Street Journal for the last business day of the prior month, unless the plan administrator has established a different interest rate for plan loans. The interest rate will be fixed for the life of the loan. The loan application will be approved only if all of the following conditions are met:

- the applicant is an active employee;
- the applicant is not on long term disability;
- the employee's net biweekly pay will cover the loan repayment amount;
- there are no legal restraints on the employee's account (such as a pending qualified domestic relations order or a temporary restraining order);
- the employee has less than 3 outstanding loans; and
- none of the employee's outstanding loans are in default.

Expedited Mailing

You may request expedited mailing from Voya. A fee of $50.00 for each mailing for which you request expedited delivery will be deducted from your account.

Other Plan Information

Who Administers the Plan

Lubrizol (also referred to in this SPD as "the company") is the administrator of this plan. Day-to-day administration, such as receiving and approving applications for benefits and directing the trustee to pay benefits, is handled by the Employee Benefits Administrative Committee ("the committee"). Contact information for the committee is as follows: Employee Benefits Administrative Committee, c/o Human Resources Director – Employee Benefits, The Lubrizol Corporation, 29400 Lakeland Boulevard, Wickliffe, Ohio 44092, (440) 943-4200. Benefits under this plan will be paid only if the plan administrator decides in its discretion that the applicant is entitled to them. The administrator has the sole right to interpret and construe the plan, to make factual determinations and to determine any disputes under the plan.

Notification of Benefit Determination

You will be notified of any benefit determination within 90 days after receipt of your claim. This period may be extended for an additional 90 days if more time is needed due to special circumstances. You will be notified prior to the end of the first 90 days if more time is needed. This notice will tell you how much more time is needed and why it is needed.

If Your Claim is Denied

If your claim is denied, you will receive a notice explaining the reason for the denial, including specific plan provisions on which the decision was made. You will be given a description of any additional information needed to complete the claim and why the information is necessary. You will also be given a description of the plan's review procedure and time limits, including a statement of your rights to bring suit.

Claims Review Procedure

If you disagree with a decision made by the committee regarding a claim under the plan, you have the right to ask for a review of the decision. You should contact the Employee Benefits Administrative Committee, in writing, within 60 days of the date on which you receive notice of denial of the claim. Your request for review must include the date on which your request is filed; the specific part of the claim you want reviewed; the reasons you think the decision should be revised; and any written material that you think is pertinent to your claim. You will have the right to review and get copies of any information relevant to your claim. The review of the decision will take into account all comments, documents, records and other information you submit. Within 60 days of the date your request is filed, the committee will review the denial of the claim and notify you in writing of its decision, unless special circumstances require an extension of not more than an additional 60 days. You will be notified prior to the end of the first 60 days if more time is needed. The notice will tell you how much more time is needed and why it is needed. You will receive a written notification of the committee's decision, which will include the specific reasons for the action taken as well as indicate the specific plan provisions on which the decision is based. The written notification will include a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim.

Lawsuits Against the Plan

You must exhaust the plan's claims procedure before you can bring a lawsuit against the plan. The lawsuit must be filed within 18 months of the earlier of the date of the committee's decision following the review of your claim, or the date the review period described above expires. Any lawsuit must be filed in the U.S. District Court for the Southern District of Texas. In the unlikely event that the United States District Court for the Southern District of Texas lacks jurisdiction over a particular lawsuit, the lawsuit must be brought in the United States District Court for the Northern District of Ohio, or if such court lacks jurisdiction, then the lawsuit may be brought in any United States federal or state court that does have jurisdiction.

Voting Berkshire Class B Common Stock

As a participant in The Lubrizol Corporation Employees' Profit Sharing and Savings Plan, you are considered a "named fiduciary" with respect to the voting of the Berkshire Hathaway Class B common stock credited to your separate accounts in the Berkshire Hathaway Class B Stock Fund.

As the named fiduciary, you have the right to give the trustee voting instructions for the Berkshire Hathaway Class B common stock held in your accounts. You also have the right to direct the trustee to vote Berkshire Hathaway Class B common stock for which the trustee does not receive voting instructions. In this case, your instructions to the trustee will be to vote the portion of unvoted shares of Berkshire Hathaway Class B common stock which reflects the ratio of your shares in the plan to the total number of shares in the plan for which instructions have been received.

Your exercise of voting and tender rights with respect to the common stock held in the Berkshire Hathaway Class B Common Stock Fund is kept confidential. To ensure confidentiality of participant voting or tender instructions, you will be provided with a form on which you can give confidential instructions to the trustee by mail or telephone on how to vote or tender the number of shares of common stock allocated to your account. All such instructions are held in strict confidence and are not divulged to any person associated with Lubrizol or Berkshire Hathaway Inc., including the Employee Benefits Administrative Committee, and employees, officers and directors of Lubrizol or Berkshire Hathaway Inc. or their affiliates.

Disability

If you become disabled and qualify for benefits under The Lubrizol Corporation Long Term Disability Plan, you will be placed and remain on a long-term disability leave so long as you are eligible for those benefits. While you are on long-term disability leave, you will continue to be credited with earnings and any changes in the investment values in your accounts. However, no additional contributions will be added to your account. If you are totally and permanently disabled you may elect a distribution of your 401(k) account balances.

If your long-term disability benefits terminate because you recover and return to covered employment, you will continue as an active participant in the plan and again be eligible to receive a share of any discretionary profit sharing contribution. If you recover and do not return to covered employment, or if your long-term disability benefits end for any other reason (including by your own choice), your long-term disability leave and your employment will end. You will then be eligible for benefits under this plan (see the section titled Full Distributions).

Forfeitures

If you terminate employment prior to December 31, 2014, other than by retirement, disability, or death, before you have completed three years of service with Lubrizol, you will forfeit the non-vested portion of your interest in the profit sharing portion of the plan and in the employer matching contributions of the 401(k) portion of the plan made on your behalf. These forfeitures may be reinstated under certain conditions if you return to covered employment within 60 months. Forfeitures are used to reduce future employer matching contributions to the plan. The plan administrator may use forfeitures to pay administrative expenses of the plan. If you terminate employment during the course of a plan year, whether by retirement, death or otherwise, you will not be entitled to share in the profit sharing contribution which is made for that plan year.

You may not assign, alienate, pledge, or encumber your benefits under this plan. You may not cause your benefits to be paid to anyone other than yourself, or, in the event of your death, to your spouse or other designated beneficiary, except as provided by a qualified domestic relations order in the event of your divorce or separation.

Missing Participants

A participant who does not apply for benefits within 120 days of attaining age 55 will have his/her balances forfeited if the plan administrator is unable to locate the participant. If the participant later applies for distribution, the amounts will be reinstated and distributed to the Participant.

VOYA

Voya provides the Participant Account Information System which gives you access to your account information from a touch tone phone or through the Internet. You may call Voya at any time by calling the Information Line at 1-866-597-4015 or you may visit the Participant website at https://lzs401k.voya.com. You can also speak with a Customer Service Associate at Voya for more information. They are available from 8:00 a.m. to 8:00 p.m. Eastern Time, Monday through Friday (except on stock market holidays).

Investment Advice

Independent investment advice is available through VoyaRetirement Advisors, LLC, powered by Financial Engines. This service provides personalized advice on your retirement account and is accessible through the phone or website. Through the Information Line you can speak to a licensed and trained Financial Advisor. Financial Advisors are available from 8:00 a.m. to 8:00 p.m. Eastern Time, Monday through Friday (except on stock market holidays).

Professional financial management of your account is available for a fee of 0.75% of your account balance per year. Discounts would apply to accounts with balances in excess of $50,000. A team of professionals will manage your investments by selecting your funds, handling all of your account transactions and keeping you informed with a quarterly progress report.

Qualified Domestic Relations Orders

Participants and beneficiaries can obtain, without charge, a copy of the plan's procedures governing Qualified Domestic Relations Orders from the plan administrator.

Miscellaneous

The value of your accounts may fluctuate due to increases or decreases in the value of the investments.

At the current time, there are no fees charged to participants for plan administrative and operating expenses. Currently, plan administrative and operating expenses incurred are either paid by Lubrizol or are offset by revenue sharing payments received by the plan trustee and record keeper from investment fund managers for providing administrative, recordkeeping and other plan services for which the fund managers may have otherwise had to provide. Such payments made by investment fund managers to the plan service providers are made from the total expense charges paid by participants investing in the funds offered under the plan. Lubrizol monitors the payments received by the plan service providers to ensure that these are properly used for qualifying plan administrative and operating expenses. Lubrizol also reserves the right to initiate charges to participants for plan administrative and operating costs in future periods if offsetting revenue sharing payments are not sufficient to cover such costs.

Service for vesting purposes will include up to one year following termination of employment, but only if you return to covered employment before that year ends. If your absence is for maternity or paternity reasons, you may return within two years and receive some credit for vesting service. However, the second year of such a period will not be included as service for vesting purposes. Re-employment during or after that period will be subject to company policies and practices.

Any amount payable to a person who is found to be mentally or physically incapable of attending to his/her own financial affairs may be paid to a qualified guardian or other legal representative. If there is no such guardian or representative, at the discretion of the committee the benefits may be paid to another person for the use and benefit of the person found to be incapable, or benefits may be paid in satisfaction of legal obligations incurred by or on behalf of that person. Because the plan funds are held in separate accounts in the name of each participant, and because the amount in these accounts is never less than the total benefits payable to participants, insurance of benefits by the Pension Benefit Guaranty Corporation is neither necessary nor available.

Lubrizol intends for this plan to comply with the optional provisions of ERISA § 404(c) and Title 29 of the Code of Federal Regulations, Section 2550.404c-1, on participant-directed investments. To the extent that investments for your account are made as you have directed, the plan fiduciaries (the company, the committee and the trustee) may not be held responsible for the investment performance of your account.

Berkshire Hathaway Inc., the parent company of Lubrizol, is subject to the information requirements of the Securities Exchange Act of 1934. In accordance with those requirements, Berkshire Hathaway files reports and other information with the Securities and Exchange Commission. These documents are incorporated by reference into the registration statement relating to the plan. Lubrizol will provide without charge to each participant, upon written or oral request, a copy of any or all of the information that has been incorporated by reference into the registration statement for the plan. Lubrizol will also provide without charge to each participant a copy of any reports, proxy statements and other communications that Berkshire Hathaway distributes to its security holders generally. Requests for copies of any of these materials may be made orally or in writing and should be directed to The Lubrizol Corporation, 29400 Lakeland Boulevard, Wickliffe, Ohio 44092-2298, telephone 440/943-4200, attention: Anthony M. Smits.

Change of Address

It is your responsibility to notify Lubrizol of a change in your mailing address.

If you are an active employee you must complete a Personnel Action Request (PAR) – Address and Phone Number Change form. The form can be completed online or by submitting a hard copy. For the online and hard copy versions of the form visit the Channel at ***Corporate Services > Human Resources>U.S. Payroll***.

If you are a retired or terminated participant with a balance in your account, you must notify Lubrizol of your address change in writing. Correspondence should be sent to the following address:

The Lubrizol Corporation
c/o The Employee Benefits Administrative Committee
29400 Lakeland Blvd.
Wickliffe, Ohio 44092

Or via email to: **lzretirementplans@Lubrizol.com**

This page left blank intentionally

Age-Weighted Defined Contribution Plan

(applicable to employees hired on or after January 1, 2010)

The part of this Benefits Resource Guide under the caption "Age-Weighted Defined Contribution Plan" constitutes part of a prospectus covering securities that have been registered under the Securities Act of 1933.

Neither the Securities and Exchange Commission nor any state securities commission has approved or disapproved of these securities or passed upon the accuracy or adequacy of this prospectus. Any representation to the contrary is a criminal offense.

The date of this Summary Plan Description/Prospectus is August 1, 2017.

Table of Contents

General Information

The Lubrizol Corporation Age-Weighted Defined Contribution Plan was established January 1, 2010. The plan provides employees of Lubrizol and its participating subsidiaries and affiliates with retirement benefits funded by participating employers' annual contributions. It works together with The Lubrizol Corporation Employees' Profit Sharing and Savings Plan to provide a retirement income base, along with Social Security and your own retirement savings outside the plan.

This summary plan description (SPD) describes the main features of The Lubrizol Corporation Age-Weighted Defined Contribution Plan. A complete description of the terms of the plan is contained in the plan document and trust agreement, and the terms of that document will govern.

Although it is Lubrizol's expectation that the plan will be a permanent program, the company has the right to terminate or amend the plan in whole or in part by written action of its Board of Directors or its designee. However, no amendment may reduce a participant's vested interest in his/her account balance at the time the amendment is made. Neither this SPD, nor the plan or trust described herein constitutes a contract of employment or a promise of continuing employment.

The plan is financed by participating employers' annual contributions to the trust fund in accordance with the plan document. Under current law, none of the funds held in trust for the plan can be used for any purpose other than the provision of benefits under the plan, until full payment of all benefits under the plan has been provided.

Federal law provides you with certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). A summary of these rights, along with specific information identifying each plan in the Lubrizol benefits program, is included in the "General" section of this Benefits Resource Guide. If you have any questions about the terms of the plan or about the payment of benefits, you may obtain more information from any benefits or human resources representative.

Quarterly statements regarding your account balance, performance and transactions are available through Voya, the plan's recordkeeper. You may also view your account online anytime through the Voya Participant at https://lzs401k.voya.com

Who is Eligible

As a non-bargained employee of Lubrizol, a Lubrizol subsidiary or an affiliate which adopts the plan, if you are hired, transferred, re-hired or transferred into non-bargained status on or after January 1, 2010 and, in the case of transferred employees on or after January 1, 2013, were not otherwise actively accruing a benefit under The Lubrizol Corporation Pension Plan immediately prior to your transfer, you automatically become an active participant in this plan beginning on your date of employment. If you are a temporary employee of Lubrizol, a Lubrizol subsidiary or an affiliate which adopts the plan and who works at least 1,000 hours in any 12 month period, you will participate beginning the following January 1.

In order to be credited with an annual contribution for a given plan year, you must be an active participant on the last day of the plan year, must be transferred to a non-participating subsidiary or affiliate during the year and employed by them on the last day of the plan year, or were an active participant during the year and on an approved leave of absence on the last day of that plan year. Employees who terminate, retire or die mid-year are not eligible for an annual contribution for the plan year in which they terminate, retire or die.

Employees covered by a collective bargaining agreement are eligible for this plan only if their collective bargaining agreement specifically provides for participation in this plan or the plan specifically provides for their participation.

Please see Exclusions from Coverage for All Plans in the General Section of this Benefits Resource Guide for a list of persons who are excluded from coverage (unless otherwise provided).

Transfer of Employment

If you should transfer to employment with a Lubrizol subsidiary or affiliate not covered by this plan, you will become an inactive participant, and no additional contributions will be made on your behalf, other than for the year of transfer (please see Amount of Your Contribution, below). The amounts in your accounts will continue to appreciate/depreciate with the value of the investment funds during the time you are an inactive participant. If you should later return to employment covered by this plan, you will immediately become an active participant again and future contributions will be credited to your account as provided by the plan. Any service you have with a related employer will be counted in determining your eligibility and your years of vested service when you finally retire or terminate employment.

Re-employment

If you terminate employment and become re-employed by Lubrizol or a participating subsidiary or affiliate, any benefit payments which you are receiving will cease and you will once more become a participant in the plan, and earn further service and benefits as provided by the plan. If you originally left covered employment before you were fully vested and received a distribution of your vested portion, or if you were not vested, you forfeited the unvested portion of your account. These forfeitures may be reinstated under certain conditions if you return to covered employment within 60 months, and repay any lump sum benefits already received.

Employer Contributions to the Plan

Determination of Employer Contribution

Each year a contribution to the plan is made by your employer. The amount will be determined based on the table and rules contained in this SPD. The company reserves the right to change the basis for contribution in whole or in part by written action of its Board of Directors or its designee.

Amount of Your Contribution

You will receive a portion of your employer's contribution if you are an active participant in the plan on the last day of the plan year, or if you transferred to a non-participating subsidiary or affiliate of the company during the year and were employed by them on the last day of the plan year, or were an active participant during the year and on an approved leave of absence on the last day of that plan year. Employees who terminate, retire or die mid-year are not eligible for their employer's contribution for the plan year in which they terminate, retire or die.

If on the last day of the plan year you are an employee of The Lubrizol Corporation or a participating subsidiary or affiliate excluding Chemtool Inc.: Your portion of your employer's contribution is based on your age as of the last day of the plan year The chart below shows the percentage of your basic compensation (as described below) your employer will contribute to your account, based on your age.

Participant's age on last day of plan year	**Contribution percentage**
Under Age 36	3.00%
36 – 40	3.75%
41 – 45	4.50%
46 – 50	5.25%
51 – 55	6.00%
56 - 60	6.75%
Age 61 and Older	7.50%

The amount of your contribution for any given year will be equal to the following:

Your basic compensation	x	Your employer's contribution % as determined by your age on the last day of the plan year

For example, if you are 40 years old on December 31 and your basic compensation is $40,000, your contribution from your employer would be calculated as follows:

$40,000 x 3.75% = $1,500

The following year when you turn 41 years old, you move into the next age bracket and your percentage increases to 4.50%. You will remain at this contribution level until the year in which you reach age 46.

If on the last day of the plan year you are an employee of Chemtool Inc.: Your employer will contribute an amount equal to 1.00% of your basic compensation (as described below) to your account.

For example, if your basic compensation is $40,000, your contribution from your employer would be calculated as follows:

$40,000 x 1% = $400

Your basic compensation is your base biweekly salary as applicable (including military pay up to six biweekly pay periods), employer-paid disability benefits under the employer's 60% option of the long-term disability program, workers' compensation, overtime, shift premiums, vacation and holiday pay, bonuses (excluding long term incentives) and commissions paid during the plan year, as applicable. Any portion of your salary which you defer as before-tax contributions under the 401(k) portion of The Lubrizol Corporation Employees' Profit Sharing and Savings Plan is included, as are any before-tax contributions made to the flexible reimbursement program and health savings accounts. Noncash or special allowances and extraordinary compensation are not included.

Your contribution will be deposited annually by no later than March 15th of the following year.

Limits on Your Contributions

Under current law the amount of basic compensation that may be used to determine your contribution is limited to **$270,000** for 2017. This limit may be adjusted by the Internal Revenue Service periodically for increases in the cost of living.

In addition, the Internal Revenue Service limits contributions to a defined contribution plan to **$54,000** in 2017. This **$54,000** includes a combination of contributions you and your employer make to The Lubrizol Corporation Employees' Profit Sharing and Savings Plan (any catch-up contributions you make are not included in the limit) plus employer contributions made to The Lubrizol Corporation Age-Weighted Defined Contribution Plan – "total annual additions". This limit also may be adjusted periodically by the Internal Revenue Service. If the Plan Administrator determines that the "total annual additions" to be credited to a Participant for a limitation year under all defined contribution plans of the Company will exceed the $54,000 limit, the first contribution to be reduced is the profit sharing contribution under The Lubrizol Corporation Employees' Profit Sharing and Savings Plan, and the second contribution to be reduced is the profit sharing contribution under the Age-Weighted Defined Contribution Plan. In the event that those reductions do not eliminate the excess annual addition amount, the Plan Administrator will then have the discretion to determine the order in which other contributions under the Company's defined contribution plans will be reduced.

Investment of Your Contributions

All contributions made to the plan are held by the plan trustee, and allocated to individual accounts established in the name of each participant. These separate accounts reflect the participant's investment choice.

The plan trustee invests your contributions according to the investment choices you have elected. If you do not have an investment election on file with Voya, your contributions will be invested in the Target Retirement Fund that most closely matches your expected retirement age of 65. These descriptions are intended as a general overview of the investment choices offered. Participants are encouraged to call Voya to obtain and read both the prospectus and the fund fact sheet for each fund to better understand its investment policy, composition, operating guidelines, historical performance, potential risks and applicable expenses. Additional fund information from mutual fund rating services such as Morningstar and Value Line may also be available at your public library. Be sure to carefully consider your options and your investment objectives before making any election. None of the investment options are guaranteed, and your account balance may decline due to investment loss.

Except as described below, there are no restrictions on your ability to transfer between any of the investment funds available under the plan. However, there may be certain restrictions on your ability to withdraw from the investment funds before you reach age 59½. Refer to the discussion under "Withdrawals and Distributions" for further information.

The **Stable Value Fund** investment objective is to provide a stable rate of return while seeking to preserve principal value. Goldman Sachs Asset Management serves as the investment manager of the Fund. The Fund invests in stable value investment contracts issued by banks, insurance companies, and other financial institutions and a diversified portfolio of fixed income instruments including U.S. government and agency securities, mortgage-backed securities, asset backed securities, corporate bonds, and interest rate futures and options. Up to 100% of the Fund may be invested in any of these types of fixed income investments. All income received by the Fund is automatically reinvested in the Fund. While the value of the underlying securities in the Fund will change, it is the intention of the Fund to maintain a $1 net asset value (NAV). Fund performance is measured against the return of the Barclays Intermediate Government/Credit Bond Index. Any assets of the Fund not invested in fixed income instruments may also be invested by the Trustee or fund manager on a temporary basis in a money market fund maintained as part of a collective trust fund. The principal value of the fund is insured by several different insurance companies through wrap contracts negotiated by the manager (Goldman Sachs) in order to help protect the principal value of the fund; however, it is not backed by the FDIC or any government agency. Participants who wish to transfer account balances from the Fund into their self-directed brokerage account must first transfer those account balances from the Fund into any of the other investment options. The transferred account balances must remain invested in investment options (excluding the Fund) for 90 days before they can be transferred into the self-directed brokerage account.

The **Core Fixed Income Fund** investment objective is to maximize total return by investing for both current income and capital appreciation, consistent with preservation of capital and prudent investment management. The Fund invests in an actively managed mutual fund, the Baird Aggregate Bond Fund (Institutional Class) (tracking fund reference ticker symbol: BAGIX), which invests in fixed income securities and can include U.S. government and corporate bond securities, mortgage and other asset-backed securities, U.S. dollar and non-U.S. dollar denominated securities of non-U.S. issuers. The fund focuses on intermediate maturity, fixed income securities and maintains an average duration ranging between three and seven years. All income received by the Fund is automatically reinvested in the Fund. The value of this Fund varies depending on the performance of the securities in the underlying actively managed fund. Fund performance is measured against the return of the BBgBarc US Aggregate Bond Index. Assets of the Fund may also be invested by the Trustee or fund manager on a short-term basis in a money market fund maintained as part of a mutual fund.

The **Retirement Ready Target Retirement Income Fund** investment objective is to allocate its assets across multiple asset classes in a conservative manner. The fund is designed for those in or near retirement or those who wish to have a more conservative investment structure. The Fund seeks to provide a balanced fund with current income from fixed income securities while maintaining a moderate exposure to global equity, real estate, and commodity investments for capital appreciation. The Fund is managed by State Street Global Advisors, an affiliate of the Trustee, and has a current target asset allocation of 65% fixed income, and 35% in equities, real estate, and commodities. Fund performance is measured against the return of a similarly weighted composite benchmark. The Fund also seeks to maintain a level of volatility which approximates that of the composite benchmark.

The **Retirement Ready Target Retirement 2020 Fund** investment objective is to allocate its assets across multiple asset classes in a manner which becomes increasingly conservative over time, while seeking to achieve the appropriate level of risk given a participant's anticipated retirement date on or within a few years of 2020. The Fund seeks to provide a balanced fund with current income from fixed income securities while maintaining a larger exposure to global equity, real estate, and commodity investments for capital appreciation. The Fund is managed by State Street Global Advisors, an affiliate of the Trustee, and has a current target asset allocation of 45% fixed income, and 55% in equities, real estate, and commodities. Fund performance is measured against the return of a similarly weighted composite benchmark. The Fund also seeks to maintain a level of volatility which approximates that of the composite benchmark.

The **Retirement Ready Target Retirement 2030 Fund** investment objective is to allocate its assets across multiple asset classes in a manner which becomes increasingly conservative over time, while seeking to achieve the appropriate level of risk given a participant's anticipated retirement date on or within a few years of 2030. The Fund seeks to provide a balanced fund with some current income from fixed income securities while mainly maintaining an exposure to global equity and some commodity investments for capital appreciation. The Fund is managed by State Street Global Advisors, an affiliate of the Trustee, and has a current target asset allocation of 26% fixed income, and 74% equities and commodities. Fund performance is measured against the return of a similarly weighted composite benchmark. The Fund also seeks to maintain a level of volatility which approximates that of the composite benchmark.

The **Retirement Ready Target Retirement 2040 Fund** investment objective is to allocate its assets across multiple asset classes in a manner which becomes increasingly conservative over time, while seeking to achieve the appropriate level of risk given a participant's anticipated retirement date on or within a few years of 2040. The Fund seeks to provide a balanced fund with a large exposure to global equity and some commodity investments for capital appreciation and some current income from fixed income securities. The Fund is managed by State Street Global Advisors, an affiliate of the Trustee, has a current target asset allocation of 14% fixed income, and 86% equities and commodities. Fund performance is measured against the return of a similarly weighted composite benchmark. The Fund also seeks to maintain a level of volatility which approximates that of the composite benchmark.

The **Retirement Ready Target Retirement 2050 Fund** investment objective is to allocate its assets across multiple asset classes in a manner which becomes increasingly conservative over time, while seeking to achieve the appropriate level of risk given a participant's anticipated retirement date on or within a few years of 2050. The Fund seeks to provide a balanced fund with a large exposure to global equity and some commodity investments for capital appreciation and some current income from fixed income securities. The Fund is actively managed by State Street Global Advisors, an affiliate of the Trustee, and has a current target asset allocation of 10% fixed income, and 90% equities and commodities. Fund performance is measured against the return of a similarly weighted composite benchmark. The Fund also seeks to maintain a level of volatility which approximates that of the composite benchmark.

The **Retirement Ready Target Retirement 2060 Fund** investment objective is to allocate its assets across multiple asset classes in a manner which becomes increasingly conservative over time, while seeking to achieve the appropriate level of risk given a participant's anticipated retirement date on or within a few years of 2060. The Fund seeks to provide a balanced fund with a large exposure to global equity and some commodity investments for capital appreciation and some current income from fixed income securities. The Fund is actively managed by State Street Global Advisors, an affiliate of the Trustee, and has a current target asset allocation of 10% fixed income, and 90% equities and commodities. Fund performance is measured against the return of a similarly weighted composite benchmark. The Fund also seeks to maintain a level of volatility which approximates that of the composite benchmark.

The **Large Cap Core Equity Passive Fund** investment objective is to provide investment results which closely replicate the overall performance of the common stocks included in the Standard & Poor's 500 Composite Stock Price Index ("S&P 500 Index"). The S&P 500 Index is a composite stock price index of 500 large capitalization common stocks, selected by Standard & Poor's Corporation, which is intended to furnish a measure of the composite price patterns of domestic, publicly-traded common stocks, weighted by capitalization, and represent a cross section of industry sectors and companies within each industry. The Fund invests in an index fund, the SSgA S&P 500 Index Fund, maintained by State Street Global Advisors, an affiliate of the Trustee, as part of a collective trust fund which invests in the common stocks included in the S&P 500 Index, futures contracts and other derivative securities. This fund does not purchase or sell any individual stock in the Index on the basis of any independent consideration relating to economic or financial conditions or market timing or analysis. All dividends and other income received by the Fund are automatically reinvested in the Fund. The value of this Fund varies depending on the performance of the securities in the underlying index fund. Fund performance is measured against the return of the S&P 500 Index. Assets of the Fund may also be invested by the Trustee or fund manager on a short-term basis in a money market fund maintained as part of a collective trust fund.

The **Large Cap Value Equity Passive Fund** investment objective is to provide investment results which closely replicate the overall performance of the common stocks included in the FTSE Russell 1000 Value Index ("Russell 1000 Value Index"). The Russell 1000 Value Index measures the performance of the large-cap value segment of the U.S. equity universe. It includes those Russell 1000 companies with lower price-to-book ratios and lower expected growth values. The Russell 1000 Value Index is constructed to provide a comprehensive and unbiased barometer for the large-cap value segment. The Index is completely reconstituted annually to ensure new and growing equities are included and that the represented companies continue to reflect value characteristics. The Fund invests in an index fund, the SSgA Russell Large Cap Value Index Fund, maintained by State Street Global Advisors, an affiliate of the Trustee, as part of a collective trust fund which invests in the common stocks included in the Russell 1000 Value Index, futures contracts and other derivative securities. This fund does not purchase or sell any individual stock in the Index on the basis of any independent consideration relating to economic or financial conditions or market timing or analysis. All dividends and other income received by the Fund are automatically reinvested in the Fund. The value of this Fund varies depending on the performance of the securities in the underlying index fund. Fund performance is measured against the return of the Russell 1000 Value Index. Assets of the Fund may also be invested by the Trustee or fund manager on a short-term basis in a money market fund maintained as part of a collective trust fund.

The **Large Cap Growth Equity Passive Fund** investment objective is to provide investment results which closely replicate the overall performance of the common stocks included in the FTSE Russell 1000 Growth Index ("Russell 1000 Growth Index"). The Russell 1000 Growth Index measures the performance of the large-cap growth segment of the U.S. equity universe. It includes those Russell 1000 companies with higher price-to-book ratios and higher forecasted growth values. The Russell 1000 Growth Index is constructed to provide a comprehensive and unbiased barometer for the large-cap growth segment. The Index is completely reconstituted annually to ensure new and growing equities are included and that the represented companies continue to reflect growth characteristics. The Fund invests in an index fund, the SSgA Russell Large Cap Growth Index Fund, maintained by State Street Global Advisors, an affiliate of the Trustee, as part of a collective trust fund which invests in the common stocks included in the Russell 1000 Growth Index, futures contracts and other derivative securities. This fund does not purchase or sell any individual stock in the Index on the basis of any independent consideration relating to economic or financial conditions or market timing or analysis. All dividends and other income received by the Fund are automatically reinvested in the Fund. The value of this Fund varies depending on the performance of the securities in the underlying index fund. Fund performance is measured against the return of the Russell 1000 Growth Index. Assets of the Fund may also be invested by the Trustee or fund manager on a short-term basis in a money market fund maintained as part of a collective trust fund.

The **Mid Cap Value Equity Fund** investment objective is to seek long-term capital appreciation and income from mid-capitalization stocks. The Fund invests in an actively managed mutual fund, the Vanguard Selected Value fund (ticker symbol: VASVX), which invests in equity securities which are believed to be undervalued. The fund is currently sub-advised by three investment managers with complementary investment processes. Vanguard oversees the allocations to the sub-advisors, and the resulting portfolio typically has 100-160 stocks. All dividends and other income received by the Fund are automatically reinvested in the Fund. The value of this Fund varies depending on the performance of the securities in the underlying actively managed fund. Fund performance is measured against the return of the Russell Mid Cap Value Index. Assets of the Fund may also be invested by the Trustee or fund manager on a short-term basis in a money market fund maintained as part of a collective trust fund. The Vanguard Selected Value Fund has a short-term trading restriction to protect investors from the cost impact of short-term trading. Participants who transfer/reallocate money out of this fund will be prohibited from transferring/reallocating money back into this fund for 60 calendar days.

The **Mid Cap Growth Equity Fund** investment objective is to seek long-term capital growth. The Fund invests in an actively managed mutual fund, the MassMutual Select Mid Cap Growth Equity Fund II Class I (ticker symbol: MEFZX), which invests primarily in securities of companies which are expected to grow at a faster rate than the average company. The fund is currently sub-advised by two investment managers with complementary investment processes. MassMutual oversees the allocations to the sub-advisors, and the resulting portfolio typically has 150-250 stocks. All dividends and other income received by the Fund are automatically reinvested in the Fund. The value of this Fund varies depending on the performance of the securities in the underlying actively managed fund. Fund performance is measured against the return of the Russell Mid Cap Growth Index. Assets of the Fund may also be invested by the Trustee or fund manager on a short-term basis in a money market fund maintained as part of a collective trust fund.

The **Small Cap Value Equity Fund** investment objective is to seek long-term growth through capital appreciation and income. The Fund invests in an actively managed mutual fund, the DFA US Small Cap Value fund (ticker symbol: DFSVX), which invests primarily in a portfolio of common stocks of small capitalization companies which are believed to be undervalued versus their peer group. DFA utilizes a quantitative investment approach, and the fund is broadly diversified across industries and typically holds over 1,000 different stocks. Under normal market conditions, at least 80% of the fund will be invested in securities of companies with a market value capitalization consistent with equities in the Russell 2000 Value Index. All dividends and other income received by the Fund are automatically reinvested in the Fund. The value of this Fund varies depending on the performance of the securities in the underlying actively managed fund. Fund performance is measured against the return of the Russell 2000 Value Index. Assets of the Fund may also be invested by the Trustee or fund manager on a short-term basis in a money market fund maintained as part of a collective trust fund.

The **Small Cap Growth Equity Fund** investment objective is to seek long-term capital appreciation. The Fund invests in an actively managed mutual fund, the Hartford Small Cap Growth HLS fund (ticker symbol: HISCX), which invests primarily in a portfolio of common stocks of small market capitalization companies which are believed to have superior growth potential. The fund is sub-advised by Wellington Management, and employs both a quantitative and fundamental investment process. The fund is broadly diversified across industries and typically holds 300-400 stocks. All dividends and other income received by the Fund are automatically reinvested in the Fund. The value of this Fund varies depending on the performance of the securities in the underlying actively managed fund. Fund performance is measured against the return of the Russell 2000 Growth Index. Assets of the Fund may also be invested by the Trustee or fund manager on a short-term basis in a money market fund maintained as part of a collective trust fund.

The **International Core Equity Fund** investment objective is to achieve long-term capital growth by investing in securities of issuers domiciled outside the United States. The Fund invests in an actively managed mutual fund, the Fidelity Advisors Diversified International Fund Z (ticker symbol: FZABX), which invests in a diversified portfolio of common stocks and other equity-like securities of companies based outside the United States. The assets of this fund may be invested with geographic diversity; however, there is no limitation on the percentage of assets which may be attributable to any one country, nor will all countries be represented. In addition to investing directly in common stocks, investments may also be maintained in securities convertible into common stocks, preferred stocks and warrants. All dividends and other income received by the Fund are automatically reinvested in the Fund. The value of this Fund varies depending on the performance of the securities in the underlying actively managed fund. Fund performance is measured against the return of the MSCI EAFE Index. Assets of the Fund may also be invested by the Trustee or fund manager on a short-term basis in a money market fund maintained as part of a collective trust fund. To help offset the negative impact of short-term trading, this Fund has added redemption fees. Charged as a percentage of the money withdrawn, the redemption fee only applies if you sell your shares before the end of the required holding period. There is a 1% redemption fee for shares sold before the required holding period of 30 days has elapsed.

The **International Small Cap Equity Fund** investment objective is to achieve long-term capital growth by investing in securities of issuers domiciled outside the United States. The Fund invests in an actively managed mutual fund, the Vanguard International Explorer Fund (ticker symbol: VINEX), which invests primarily in the equity securities of small-capitalization companies located outside the United States that the advisors believe offer the potential for capital appreciation. The fund is currently sub-advised by two investment managers with complementary investment processes. Vanguard oversees the allocations to the sub-advisors, and the resulting portfolio typically has approximately 300 holdings. Under normal market conditions, at least 80% of the assets will be invested in securities of international small capitalization companies. All dividends and other income received by the Fund are automatically reinvested in the Fund. The value of this Fund varies depending on the performance of the securities in the underlying actively managed fund. Fund performance is measured against the return of the MSCI ACWI ex US Small Cap Index. Assets of the Fund may also be invested by the Trustee or fund manager on a short-term basis in a money market fund maintained as part of a collective trust fund. The Vanguard International Explorer Fund has a short-term trading restriction to protect investors from the cost impact of short-term trading. Participants who transfer/reallocate money out of this fund will be prohibited from transferring/reallocating money back into this fund for 30 calendar days.

The **Emerging Markets Equity Fund** investment objective is to achieve long-term capital growth by investing in securities of issuers domiciled in the Emerging Markets. The Fund invests in an actively managed mutual fund, the DFA Emerging Markets Core Equity fund (ticker symbol: DFCEX), which invests in a diversified portfolio of equity securities that are traded principally in the Emerging Markets. DFA utilizes a quantitative investment approach, and the fund is broadly diversified across countries and typically holds approximately 3,000 different stocks. Under normal market conditions, at least 80% of the assets will be invested in securities of Emerging Markets companies. All dividends and other income received by the Fund are automatically reinvested in the Fund. The value of this Fund varies depending on the performance of the securities in the underlying actively managed fund. Fund performance is measured against the return of the MSCI Emerging Markets Index. Assets of the Fund may also be invested by the Trustee or fund manager on a short-term basis in a money market fund maintained as part of a collective trust fund.

The **Berkshire Hathaway Class B Stock Fund** investment objective is to provide long-term growth of capital by investing solely in shares of Class B Common Stock of Berkshire Hathaway Inc. (ticker symbol: BRK-B). The shares of Berkshire Hathaway Class B Common Stock held by the Fund are purchased at the then-current market price on the open market. All income received by the Fund automatically is reinvested in the Fund. The value of investments in this Fund varies depending on the market price of Berkshire's Class B Common Stock. Any assets of this Fund not invested in Class B Common Stock may also be invested by the Trustee on a short-term basis in a money market fund maintained by the Trustee as part of a collective trust fund. Because the Fund typically holds a small amount of cash in order to provide liquidity to participants, the performance of the Fund may deviate slightly from the actual Berkshire Hathaway stock. This Fund is part of an employee stock ownership plan (ESOP) contained in the plan. Note that, effective July 1, 2015, certain limitations with respect to the Berkshire Hathaway Class B Stock Fund went into effect:

- You may not make a transfer into the Berkshire Hathaway Class B Stock Fund if the percentage of your account balance invested in the Berkshire Hathaway Class B Stock Fund exceeds 50%, or to the extent that the transfer would cause your account balance invested in the Berkshire Hathaway Class B Stock Fund to exceed 50%.
- You may not make a reallocation election or a rebalancing election for the Berkshire Hathaway Class B Stock Fund that exceeds 50%.
- You may not make a rollover election into the Berkshire Hathaway Class B Stock Fund that exceeds 50%.
- You may not make an election to invest more than 50% of your future contributions in the Berkshire Hathaway Class B Stock Fund.
- On the last day of the quarter, if 50% or more of your account balance is invested in the Berkshire Hathaway Class B Stock Fund, any election you have on file to invest future contributions into the Berkshire Hathaway Class B Stock Fund will automatically be reduced to 0%. In that event, however, you will not be restricted from restoring your prior election for the Berkshire Hathaway Class B Stock Fund or electing another percentage for the Berkshire Hathaway Class B Stock Fund, as long as your election does not exceed 50%.
- If you attempt to make a transaction or election online that does not comply with the limits on the Berkshire Hathaway Class B Stock Fund, the transaction or election will not be processed, and you will receive a message prompting you to revise your transaction or election to comply with the limit. If your rollover election form shows an election for the Berkshire Hathaway Class B Stock Fund that exceeds 50%, your election for the Berkshire Hathaway Class B Stock Fund will automatically be reduced to 50%, and the excess percentage will be invested in the SSgA Target Date Retirement Fund that most closely corresponds to your age.

Annual Returns of Plan Investment Options						
	Annual Returns (%)					
Periods Ending 12/31	**2016**	**2015**	**2014**	**2013**	**2012**	**2011**
Stable Value Fund	2.04	2.01	2.02	1.99	1.96	2.37
Core Fixed Income Fund	3.52	0.55	6.89	-1.25	7.92	7.85
Retirement Ready Target Retirement Income Fund	5.82	-1.37	3.69	5.14	9.73	4.68
Retirement Ready Target Retirement 2020 Fund	7.60	-1.88	6.00	13.29	13.85	5.94
Retirement Ready Target Retirement 2030 Fund	8.42	-2.02	6.49	18.24	15.02	3.56
Retirement Ready Target Retirement 2040 Fund	9.12	-2.32	6.31	21.38	16.09	0.10
Retirement Ready Target Retirement 2050 Fund	9.48	-2.43	6.27	21.51	16.08	0.12
Retirement Ready Target Retirement 2060 Fund	9.49	N/A	N/A	N/A	N/A	N/A
Large Cap Core Equity Passive Fund	11.96	1.36	13.63	32.34	15.97	2.09
Large Cap Equity Value Passive Fund	17.29	-3.70	13.37	32.44	17.52	0.38
Large Cap Equity Growth Passive Fund	7.09	5.65	13.02	33.44	15.27	2.56
Mid Cap Value Equity Fund	16.34	-3.80	6.36	42.04	15.25	0.82
Mid Cap Growth Equity Fund	6.19	5.95	13.00	36.31	14.71	-1.74
Small Cap Value Equity Fund	28.26	-7.81	3.48	42.38	21.72	-7.55
Small Cap Growth Equity Fund	12.37	-0.55	5.83	44.87	17.40	1.42
International Core Equity Fund	-2.52	4.30	-3.02	26.42	20.49	-13.41
International Small Cap Equity Fund	-1.77	8.60	-2.88	30.24	17.93	19.74
Emerging Markets Equity Fund	12.35	-14.86	-0.91	-2.64	20.49	-20.65
Berkshire Hathaway Class B Stock Fund	22.77	-11.92	25.80	30.86	N/A	N/A

Valuation of the Funds

The value of each separate account is determined daily (based on the most recent valuation of the fund(s) and the best available information). It reflects increases or decreases in the value of the assets of each investment fund due to contributions, withdrawals, investment gains and losses, as well as income earned. There are limited circumstances where the value of an investment fund reflects the most currently available information. The value of each separate account will be a proportionate amount of the total value of the fund in which it is invested.

Allocation and Transfer of your Investments

When you begin to participate in the plan, you will indicate your investment choices for contributions in multiples of 1%.

Once a day, you may change the manner in which future contributions are to be invested through Voya. The change will take effect on the next contribution date.

Once a day, you may transfer the balance in each of your separate accounts to any of the investment funds in 1% increments, subject to the limitations described below. This change may be made through Voya. These changes will occur at the end of the first available business day (i.e., 4:00 p.m. Eastern Time on the first available day the New York Stock Exchange is open). Your account will reflect these changes on the next available business day.

Vesting

Vesting refers to your right to receive a benefit under The Lubrizol Corporation Age-Weighted Defined Contribution Plan. If your participation in the plan ends because of your retirement at or after age 55, because you become totally and permanently disabled and are placed on long-term disability leave, or because of your death, you or your beneficiary will be automatically 100% vested in the employer's contributions made to your account.

Except for retirement, disability, or death, you are vested in the value of the employer's contributions made on your behalf based on your years of service with the company and related companies.

If you have completed at least	**The percentage of employer's contributions in which you are vested**
1 year of service	34%
2 years of service	67%
3 years of service	100%

TD Ameritrade Self-Directed Brokerage Account

The self-directed brokerage account is a brokerage account offered in the plan and provided through TD Ameritrade. It gives you access to more than 13,000 mutual funds (of which more than 2,100 are no-load, no-transaction-fee (NTF) mutual funds.) However, unlike the plan's current investment options, transaction fees and operating expense fees generally apply to the mutual funds available through the self-directed brokerage account.

You may invest up to 50% of your total vested plan account balance through the self-directed brokerage account. Your minimum initial transfer into your self-directed brokerage account must be $1,000 for amounts transferred from the Employer's contributions. The mutual fund you select may also require a minimum investment. An investment in the self-directed brokerage account must come from your current plan balance through a funds transfer; you cannot elect to directly invest future contributions into the self-directed brokerage account.

Fees

Transaction fees and operating expense fees may apply to the mutual funds available within the plan's self-directed brokerage account. Once you open a self-directed brokerage account, there is a $50.00 annual fee (billed quarterly in $12.50 installments) to maintain the self-directed brokerage account. In addition, any investment you purchase or sell through the self-directed brokerage account may carry with it additional fees. Please read the TD Ameritrade Fee Schedule, which can be found on the TD Ameritrade website at www.tdameritraderetirement.com. In addition, be sure to ask TD Ameritrade about any fees, including any undisclosed fees, that may be charged in connection with the purchase or sale of any investment in the self-directed brokerage account, including a redemption fee of $49.99 for almost any mutual fund investment that you do not hold for at least 90 days.

Withdrawals, Distributions and Qualified Domestic Relations Orders

If you are eligible to take a withdrawal from the plan, you cannot withdraw directly from your investments in the self-directed brokerage account. If you need to access the money you have invested in the self-directed brokerage account for a withdrawal under the plan, you first need to sell some or all of your mutual fund investment(s) in the self-directed brokerage account and transfer the assets back to the plan's other investment funds.

You cannot take a distribution directly from your investments in the self-directed brokerage account. If a distribution is to be made from your plan account that cannot otherwise be funded from your account balances outside the self-directed brokerage account, you must first transfer money from the self-directed brokerage account back into any of the plan's other investment funds. Once this has been completed, you can request the distribution from the plan according to plan rules.

Similar rules apply in the case of a qualified domestic relations order, where a separate interest in your plan account is established for your former spouse or other dependent. If the separate interest cannot be established entirely from money in your plan accounts not invested in the self-directed brokerage account, you will be asked to transfer money out of the self-directed brokerage account and into any of the plan's other investment options, so that the separate interest may be established entirely from your plan balances held outside the self-directed brokerage account.

Dividends and Interest
Any dividends and/or interest on your investments in the self-directed brokerage account will be reinvested in the mutual fund that paid the dividend and/or interest.

Required Minimum Distributions
If your plan account balance outside of the self-directed brokerage account is not sufficient to satisfy the required minimum distribution amount after you attain age 70½, you must transfer sufficient funds from your investments in the self-directed brokerage account back to the other funds available under the plan to make up for the shortfall and meet the required minimum distribution rules. If you do not make the required transfer, the plan administrator may cause investments in your self-directed brokerage account to be liquidated sufficient to fund the required minimum distribution.

Statements
You will receive a monthly statement regarding your self-directed brokerage account, unless there has been no activity in your account, in which case you will receive a quarterly statement. You will also receive trade confirmations made through your self-directed brokerage account.

Other Terms and Conditions
The self-directed brokerage account feature is subject to any additional terms and conditions which the plan administrator may adopt from time to time.

Customer Service Support
If you have questions about making a trade on the TD Ameritrade website, or about any account alerts or notifications you may receive if you request a trade, call a TD Ameritrade representative at 1-866-766-4015. Representatives are available between 8:00 a.m. and 7:00 p.m. Eastern Time on weekdays, except New York Stock Exchange holidays.

Withdrawals and Distributions

Withdrawals While Employed
Because The Lubrizol Corporation Age-Weighted Defined Contribution Plan is designed as a long-term investment vehicle to provide you with retirement income, there are certain restrictions on withdrawals. If you are vested in the plan, you may take an in-service withdrawal beginning at the later of age 55 or 5 years of service. If you elect to make a withdrawal prior to reaching age 59½, it must be in the form of monthly, quarterly or annual installments over a fixed period of time not to exceed your lifetime. You may adjust these installments in the year you reach age 59½ or if you become disabled.

Full Distributions
Distributions of your total vested interest in the plan may be made if you terminate employment through retirement, death or otherwise. Other than as described below, any distribution will be made only with your written consent.

If you terminate your employment through retirement, death or otherwise and your vested balance does not exceed $1,000, your balance will be paid automatically in a single lump sum payment as soon as possible after your termination or death.

If you leave employment prior to age 70½ and choose to defer your benefit distribution or if you make no election to receive your benefits when you terminate or retire, your benefit distribution will begin at the earlier of your distribution request or the April 1 of the calendar year following the year in which you reach age 70½. If you retire after age 70½, benefit distribution will automatically begin on the April 1 of the calendar year following the year in which you retire.

Methods of Payment

Your vested account balance may be paid in a single lump sum, which is the normal form of benefit under the plan, partial payments, or monthly, quarterly or annual installments over a fixed period of time not to exceed your life expectancy or the joint life expectancy of you and your designated beneficiary, whichever you elect.

The lump-sum distribution is the normal form of benefit under the plan. All distributions from the Berkshire Hathaway Class B Stock Fund are made in shares of Berkshire Class B Common Stock, except that cash is paid in place of a fractional share. You have the right, however, to choose cash in place of the shares of Class B Common Stock which you would otherwise receive. You may make this election by submitting a written form to Voya. Distributions from the rest of the investment funds are made in cash.

Death Benefits

If you die before benefit payments begin, a benefit may be payable to your spouse or other designated beneficiary as follows:

If you are married at the time of your death, your spouse will receive the full amount of your account balance in one lump sum. This benefit is provided whether or not you are actively employed by Lubrizol at the time of your death (provided you have not yet begun to receive benefits under the plan), and may be waived only with your spouse's written, notarized agreement.

If you are unmarried at the time of your death, or if you have waived the surviving spouse benefit described above, your entire account balance will be paid to your designated beneficiary in one lump sum.

Designation of Beneficiary

You may designate a beneficiary for your benefit in the plan, or change your beneficiary designation, at any time through the Participant website (http://lzs401k.voya.com) or by calling Voya to obtain a Designation of Beneficiary form. The Plan does not recognize oral beneficiary designations.The form must be returned to Voya to the address provided on the form. If you are married, your spouse is automatically your beneficiary, even if you designate another, unless your spouse provides written, notarized agreement to your designation. If you die with no surviving designated beneficiary, your account balance will be paid to your estate. If you do not separately designate a beneficiary under the plan, but you have designated a beneficiary under The Lubrizol Corporation Employees' Profit Sharing and Savings Plan, your beneficiary under The Lubrizol Corporation Employees' Profit Sharing and Savings Plan will be your designated beneficiary under the plan, but if you are married, that designation will be effective only if you have named your spouse as your beneficiary and you are married to that spouse at the time of your death.

Tax Implications

Because the plan is a tax-qualified plan and meets the requirements of the Internal Revenue Code, under current law there are special tax advantages for participants. Your employer's contributions and any earnings or gains are not subject to federal income tax until they are distributed or withdrawn.

Any distribution or withdrawal of contributions or earnings which have not already been taxed will be subject to ordinary income tax unless rolled over to another qualified plan or to an IRA.

The taxable portion of any distribution or withdrawal that is paid directly to you will be subject to an automatic 20% federal income tax withholding requirement. There may be additional tax consequences if you do not roll over the entire taxable amount of your distribution (including the 20% withheld) to an IRA or a new employer's qualified retirement plan within 60 days of your receipt of the distribution.

To avoid the 20% withholding requirement and additional tax consequences, you may elect instead to have the taxable amount of your distribution or withdrawal directly transferred to an IRA or a new employer's qualified retirement plan.

Because tax laws are complex and frequently change, this information is intended only as a general outline. Before you withdraw or receive any distribution from the plan, you should consult a tax advisor.

How to Apply for Withdrawal or Distribution

Applications for withdrawals and distributions may be obtained through the Participant website at http://lzs401k.voya.com or by calling the Information Line at 1-866-597-4015. Applications must be properly filled out, signed and sent to Voya for processing.

Withdrawals of your contributions while you are employed may be made by calling the Voya Information Line at 1-866-597-4015.

A completed written application for distribution of your entire age weighted defined contribution balance upon separation of employment must be sent to Voya at the following address:

Mail
Voya
Attention: Lubrizol Plan Administration
P.O. Box 24747
Jacksonville, FL 32241-4747

Overnight Delivery
Voya
U.S. Retirement Services
Attention: Lubrizol Plan Administration
30 Braintree Hill
Braintree, MA 02184

Plan Loans

Loans are not available from The Lubrizol Corporation Age-Weighted Defined Contribution Plan. You may have loan options available to you through The Lubrizol Corporation Employees' Profit Sharing and Savings Plan. Please consult that SPD for further details.

Expedited Mailing

You may request expedited mailing from Voya. A fee of $50.00 for each mailing for which you request expedited delivery will be deducted from your account.

Other Plan Information

Who Administers the Plan

Lubrizol (also referred to in this SPD as "the company") is the administrator of this plan. Day-to-day administration, such as receiving and approving applications for benefits and directing the trustee to pay benefits, is handled by the Employee Benefits Administrative Committee ("the committee"). Contact information for the committee is as follows: Employee Benefits Administrative Committee, c/o Human Resources Director – Employee Benefits, The Lubrizol Corporation, 29400 Lakeland Boulevard, Wickliffe, Ohio 44092. You can also call (440) 943-4200. Benefits under this plan will be paid only if the plan administrator decides in its discretion that the applicant is entitled to them. The administrator has the sole right to interpret and construe the plan, to make factual determinations and to determine any disputes under the plan.

Notification of Benefit Determination

You will be notified of the benefit determination within 90 days after receipt of your claim. This period may be extended for an additional 90 days if more time is needed due to special circumstances. You will be notified prior to the end of the first 90 days if more time is needed. This notice will tell you how much more time is needed and why it is needed.

If Your Claim is Denied

If your claim is denied, you will receive a notice explaining the reason for the denial, including specific plan provisions on which the decision was made. You will be given a description of any additional information needed to complete the claim and why the information is necessary. You will also be given a description of the plan's review procedure and time limits, including a statement of your rights to bring suit.

Claims Review Procedure

If you disagree with a decision made by the committee regarding a claim under the plan, you have the right to ask for a review of the decision. You should contact the Employee Benefits Administrative Committee, in writing, within 60 days of the date on which you receive notice of denial of the claim. Your request for review must include the date on which your request is filed; the specific part of the claim you want reviewed; the reasons you think the decision should be revised; and any written material that you think is pertinent to your claim. The written notification will include a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim. The review of the decision will take into account all comments, documents, records and other information you submit.

Within 60 days of the date your request is filed, the committee will review the denial of the claim and notify you in writing of its decision, unless special circumstances require an extension of not more than an additional 60 days. You will be notified prior to the end of the first 60 days if more time is needed. The notice will tell you how much more time is needed and why it is needed. You will receive a written notification of the committee's decision, which will include the specific reasons for the action taken as well as indicate the specific plan provisions on which the decision is based. The written notification will include a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim.

Lawsuits Against the Plan

You must exhaust the plan's claims procedure before you can bring a lawsuit against the plan. The lawsuit must be filed within 18 months of the earlier of the date of the committee's decision following the review of your claim, or the date the review period described above expires. Any lawsuit must be filed in the U.S. District Court for the Southern District of Texas. In the unlikely event that the United States District Court for the Southern District of Texas lacks jurisdiction over a particular lawsuit, such lawsuit may be brought in the United States District Court for the Northern District of Ohio. In the event that the United Stated District Court for the Northern District of Ohio lacks jurisdiction of such lawsuit, it may be brought in any federal or state court that does have jurisdiction.

Voting Berkshire Class B Common Stock

As a participant in The Lubrizol Corporation Age-Weighted Defined Contribution Plan, you are considered a "named fiduciary" with respect to the voting of the Berkshire Hathaway Class B common stock credited to your separate accounts in the Berkshire Hathaway Class B Stock Fund.

As the named fiduciary, you have the right to give the trustee voting instructions for the Berkshire Hathaway Class B common stock held in your accounts. You also have the right to direct the trustee to vote Berkshire Hathaway Class B common stock for which the trustee does not receive voting instructions. In this case, your instructions to the trustee will be to vote the portion of unvoted shares of Berkshire Hathaway Class B common stock which reflects the ratio of your shares in the plan to the total number of shares in the plan for which instructions have been received.

Your exercise of voting and tender rights with respect to the common stock held in the Berkshire Hathaway Class B Common Stock Fund is kept confidential. To ensure confidentiality of participant voting or tender instructions, you will be provided with a form on which you can give confidential instructions to the trustee by mail or telephone on how to vote or tender the number of shares of common stock allocated to your account. All such instructions are held in strict confidence and are not divulged to any person associated with Lubrizol or Berkshire Hathaway Inc., including the Employee Benefits Administrative Committee, and employees, officers and directors of Lubrizol or Berkshire Hathaway Inc. or their affiliates.

Disability

If you become disabled and qualify for benefits under The Lubrizol Corporation Long Term Disability Plan, you will be placed and remain on a long-term disability leave so long as you are eligible for those benefits. While you are on long-term disability leave, you will continue to be credited with earnings and any changes in the investment values in your accounts. You will receive your portion of your employer's contribution if you are on an approved leave of absence on the last day of the plan year.

Forfeitures

If you terminate employment other than by retirement at or after age 55, disability, or death before you have completed three years of service with Lubrizol, you will forfeit the non-vested portion of your interest in this plan. These forfeitures may be used at the company's discretion to offset administrative expenses of the Plan or Trust.These forfeitures may be reinstated under certain conditions if you return to covered employment within 60 months.

If you terminate employment during the course of a plan year, whether by retirement, death or otherwise, you will not be entitled to a share of your employer's contribution which is made for that plan year. You must be employed on December 31 of the plan year to qualify for a contribution.

You may not assign, alienate, pledge, or encumber your benefits under this plan. You may not cause your benefits to be paid to anyone other than yourself, or, in the event of your death, to your spouse or other designated beneficiary, except as provided by a qualified domestic relations order in the event of your divorce or separation.

Missing Participants
A participant who does not apply for benefits within 120 days of attaining age 55 will have his/her balances forfeited if the plan administrator is unable to locate the participant. If the participant later applies for distribution, the amounts will be reinstated and distributed to the participant.

Voya
Voya provides the Participant Account Information System which gives you access to your account information from a touch tone phone or through the Internet. You may call Voya at any time by calling the Information Line at 1-866-597-4015. Or, you may visit the Participant website at http://lzs401k.voya.com. You can also speak with a Customer Service Associate at Voya for more information. They are available from 8:00 a.m. to 8:00 p.m. Eastern Time, Monday through Friday (except on stock market holidays).

Investment Advice
Independent investment advice is available through VoyaRetirement Advisors, LLC, powered by Financial Engines. This service provides personalized advice on your retirement account and is accessible through the phone or website. Through the Information Line you can speak to a licensed and trained Financial Advisor. Financial Advisors are available from 8:00 a.m. to 8:00 p.m. Eastern Time, Monday through Friday (except on stock market holidays).

Qualified Domestic Relations Orders
Participants and beneficiaries can obtain, without charge, a copy of the plan's procedures governing Qualified Domestic Relations Orders from the plan administrator.

Miscellaneous
The value of your accounts may fluctuate due to increases or decreases in the value of the funds.
At the current time, there are no fees charged to participants for plan administrative and operating expenses. Currently, plan administrative and operating expenses incurred are either paid by Lubrizol or are offset by revenue sharing payments received by the plan trustee and recordkeeper from investment fund managers for providing administrative, recordkeeping and other plan services for which the fund managers may have otherwise had to provide. Such payments made by investment fund managers to the plan service providers are made from the total expense charges paid by participants investing in the funds offered under the plan. Lubrizol monitors the payments received by the plan service providers to ensure that these are properly used for qualifying plan administrative and operating expenses. Lubrizol also reserves the right to initiate charges to participants for plan administrative and operating costs in future periods if offsetting revenue sharing payments are not sufficient to cover such costs.

The Lubrizol Corporation Age-Weighted Defined Contribution Plan is intended to be a long-term, retirement savings vehicle for employees. It is not intended as a short-term trading vehicle. Since excessive short-term trading can negatively impact fund performance, the plan's investment fund managers may reserve the right to revise or terminate your exchange (purchase or sale) privileges or charge redemption fees to combat short-term trading. Please refer to the fund prospectuses, quarterly fund fact sheets, and the Investment Information section of the Voya participant web site for information on any trading restrictions and redemption fees currently in effect. You can request fund literature by calling the Information Line at 1-866-597-4015.

Service for vesting purposes will include up to one year following termination of employment, but only if you return to covered employment before that year ends. If your absence is for maternity or paternity reasons, you may return within two years and receive some credit for vesting service. However, the second year of such a period will not be included as service for vesting purposes. Re-employment during or after that period will be subject to company policies and practices.

Any amount payable to a person who is found to be mentally or physically incapable of attending to his/her own financial affairs may be paid to a qualified guardian or other legal representative. If there is no such guardian or representative, at the discretion of the committee the benefits may be paid to another person for the use and benefit of the person found to be incapable, or benefits may be paid in satisfaction of legal obligations incurred by or on behalf of that person. Because the plan funds are held in separate accounts in the name of each participant, and because the amount in these accounts is never less than the total benefits payable to participants, insurance of benefits by the Pension Benefit Guaranty Corporation is neither necessary nor available.

Lubrizol intends for this plan to comply with the optional provisions of ERISA § 404(c) and Title 29 of the Code of Federal Regulations, Section 2550.404c-1, on participant-directed investments. To the extent that investments for your account are made as you have directed, the plan fiduciaries (the company, the committee and the trustee) may not be held responsible for the investment performance of your account.

Berkshire Hathaway Inc., the parent company of Lubrizol, is subject to the information requirements of the Securities Exchange Act of 1934. In accordance with those requirements, Berkshire Hathaway files reports and other information with the Securities and Exchange Commission. These documents are incorporated by reference into the registration statement relating to the plan. Lubrizol will provide without charge to each participant, upon written or oral request, a copy of any or all of the information that has been incorporated by reference into the registration statement for the plan. Lubrizol will also provide without charge to each participant a copy of any reports, proxy statements and other communications that Berkshire Hathaway distributes to its security holders generally. Requests for copies of any of these materials may be made orally or in writing and should be directed to The Lubrizol Corporation, 29400 Lakeland Boulevard, Wickliffe, Ohio 44092-2298, telephone (440) 943-4200, attention: Anthony M. Smits.

Change of Address

It is your responsibility to notify Lubrizol of a change in your mailing address.

If you are an active employee you must complete a Personnel Action Request (PAR) – Address and Phone Number Change form. The form can be completed online or by submitting a hard copy. For the online and hard copy versions of the form visit the Channel at ***Corporate Services > Human Resources***. Under **"U.S. Benefits and Payroll"** click on link for **"U.S. Payroll."**

If you are a retired or terminated participant with a balance in your account, you must notify Lubrizol of your address change in writing. Correspondence should be sent to the following address:

The Lubrizol Corporation
c/o The Employee Benefits Administrative Committee
29400 Lakeland Blvd.
Wickliffe, Ohio 44092

Or via email to: **lzretirementplans@Lubrizol.com**

Sick Leave and Salary Continuation Policy

Table of Contents

Sick Leave and Salary Continuation Practice

The company expects regular and prompt attendance from all employees because each employee plays an important role in the success of our company. While the company realizes that some employees may not be able to achieve perfect attendance all the time, there is an expectation that all employees will strive to be at work if at all possible and establish a consistent and reliable record of attendance.

All employees who miss 3 consecutive days (shifts) for illness or injury are required to notify their supervisor, facility Medical Department or Human Resource site representative. You must also notify your supervisor in the event your physician has placed you on any work restrictions.

Under Policy HR-01-27, a regular employee of Lubrizol and its participating subsidiaries eligible for sick leave of absence will be entitled to receive continuation of full salary up to a maximum of 1,040 equivalent work hours (or a proportionate number of hours based on the ratio of your normal scheduled work hours divided by 40). All leaves shall be considered continuous service. The company reserves the right to make the final judgment regarding the employee's ability to continue or to return to work. However, local practices may vary. This practice does not apply to California, Washington or Illinois locations or employees covered under a collective bargaining agreement. Please see your supervisor for details on sick leave at your site.

Return to Work

If it is expected that you will make a full recovery and return to full duty, and if appropriate restricted duty (other than vocational rehabilitation) is available which you are able to perform, you may be required to return to work to the restricted duty in order to receive continuation of full salary. If you do not return to work to perform the restricted duty, your employment will be terminated. However, if your sick leave qualifies, and has been designated as a leave under the Family & Medical Leave Act of 1993 (see HR-01-10), you will not be required to return to work to restricted duty for the duration of the Family & Medical Leave. In the case that you choose not to return to restricted duty, you will not be eligible for salary continuation and your sick leave will be unpaid. Hours worked on restricted duty will not count towards long-term disability.

You must return to work: 1) as soon as the physician certifies that you are able to resume normal work duties at your regular schedule, or 2) if your physician does not cooperate with the medical department. If you do not return to work at that time, your employment will be terminated.

As an employee (including shift personnel), if you are absent due to illness for more three (3) or more consecutive days, you must report to the medical department before returning to work. A "Return to Work" authorization must be provided by your physician; it should include any temporary or permanent work restrictions, if needed.

Following a sick leave of absence, you will: 1) return to your regular job, if possible or, 2) return to an equivalent position with equivalent pay, benefits and other terms and conditions of employment. The company reserves the right to make the final judgment regarding your ability to return to work or to continue sick leave.

If there is no expectation that you will make a full recovery and/or return to full duty, and a position which pays at least 60% of your biweekly basic earnings is available for which you are otherwise qualified, the company may offer the position to you. If you do not accept the position, your employment will be terminated. However, if your sick leave qualifies, and has been designated as leave under the Family & Medical Leave Act of 1993 (see HR-01-10), you will not be required to return to work to take the new position for the duration of the Family & Medical Leave. In that case, you will not be eligible for salary continuation and your sick leave will be unpaid.

Payment of Salary During Sick Leave

You will be paid 100% of your biweekly basic earnings for up to a maximum of 1,040 equivalent work hours (or a proportionate number of hours based on the ratio of your normal scheduled work hours divided by 40) of total sick leave. The total number of equivalent work hours you are absent due to separate periods of the same or a related illness or injury will be added together for purposes of determining the maximum number of paid hours, unless those periods are separated by 12 months during which you incur no absences due to the same or related illness or injury. If you incur another related or unrelated illness or injury while on sick leave, the total equivalent work hours you are absent due to separate periods of the multiple illnesses or injuries will be added together for purposes of determining the maximum number of paid hours, unless those periods are separated by 12 months during which you incur no absences due to these illnesses or injuries.

If you return to work for less than 12 consecutive months after being on long-term disability leave, and incur a work absence due to the same illness or injury, you will be returned to long-term disability leave.

Your sick leave salary will be reduced by your receipt of other compensation including Social Security (including family benefits), workers' compensation, pension benefits, other earnings and any applicable settlements.

Effect of Unpaid Leave on Salary Continuation

If you are on an unpaid leave of absence, you are eligible for salary continuation for injuries or illness only if the illness or injury is incurred during the first 90 calendar days of the unpaid leave.

Effect of Salary Continuation on Other Benefits

Participation of all other employee benefits plans will continue for the duration of the sick leave. Decisions with regard to vacation time will be made in accordance with the provisions of the vacation practice of your employer.

State Law

The provisions of this policy are subject to state law requirements.

Education and Matching Gift Programs

Table of Contents

General Information

The Tuition Reimbursement Program provides direct financial assistance to employees who are interested in furthering their education. The Lubrizol Foundation Matching Gift Program matches employee contributions to educational, civic, cultural, human services, and youth-related organizations. The Lubrizol Foundation Merit Scholarship Program provides up to four years of scholarship aid for employees' children who qualify as semi-finalists on the National Merit Scholarship Qualifying Test.

This summary description describes the main features of the Tuition Reimbursement Program, Matching Gift Program and Merit Scholarship Program. Please read the entire summary description carefully to understand the benefits available under the programs. If you have any questions, a member of your local human resources staff will be able to assist you.

The Lubrizol Corporation has full authority to make rules and regulations governing the Tuition Reimbursement Program, and to make final decisions on all matters arising in connection with it. The Lubrizol Corporation reserves the right to modify or discontinue this program at any time.

The Lubrizol Foundation has full authority to determine the rules and regulations for the Matching Gift Program and the Merit Scholarship Program, and to make final decisions on all matters arising in connection with them. The Foundation reserves the right to modify or discontinue these programs at any time.

Tuition Reimbursement Program

Because Lubrizol recognizes that the education process is a continuing one, your employer will participate, under certain conditions, in the tuition costs with those employees who successfully complete educational courses at accredited institutions.

Eligibility

A regular, full-time employee of Lubrizol and its participating subsidiaries working a normal schedule will be eligible for tuition reimbursement upon receiving approval from his/her department head. Part-time employees who work at least an average of 20 hours per week or who are participating in a phased-in retirement program are eligible for tuition reimbursement at a rate of 50% of that which regular full-time employees would receive. Co-op students are eligible to receive 100% tuition reimbursement, to a maximum of $1,500, for one course in their designated degree program each work period. In addition to these approvals, the following requirements must be met:

1. An employee will be eligible for tuition reimbursement upon receiving approval from his/her department head. Approval is normally based upon the employee continuing to being a good, consistent performer, the program contributing to the person's ability to help Lubrizol achieve its vision and business goals, the school schedule not impacting the employee's job and the employee and supervisor planning for the reimbursement at budget time.

2. In addition to the proper approval, the following requirements must be met:
    a. The person must remain an employee of the corporation for the duration of the semester/quarter of study.
    b. If the employee plans to enroll in a college degree or certificate program, he/she must complete The Lubrizol Corporation Tuition Reimbursement Enrollment Form and Manager Discussion Checklist prior to the start of the program. If the employee plans to enroll in courses in a non-college degree or non-certificate program, he/she must complete The Lubrizol Corporation Tuition Reimbursement Enrollment Form prior to the start of each course/program.
    c. For reimbursement, the employee must present to his/her department head proof of tuition paid or due (not a cancelled check) and proof of completing the course with a passing grade of at least a "C" or higher.

    d. The subject studied fits at least one of the categories in Amount of Reimbursement section.
    e. The employee should first try to exhaust all other forms of financial assistance. Employees who qualify for educational assistance under the G.I. Bill or other public/privately sponsored programs will be expected to draw on these resources until they are exhausted. In the event that this financial assistance does not cover the entire cost of educational courses, Lubrizol will reimburse up to the amount allowable, provided that the combined assistance does not exceed the cost of the allowable covered course expenses as outlined in this policy, and that the conditions in Amount of Reimbursement section below are met. Documentation of G.I./government payments, all other financial assistance (both public and/or private), total tuition costs and completion certificates or grade reports must be presented to the department head and Lubrizol University (LZU) at the conclusion of the course.
3. Part-time employees are eligible for tuition reimbursement at a rate of 50% of that which full-time employees would receive.
4. An employee attending school under a leave of absence will not be reimbursed for his/her tuition under this policy.
5. Co-op students will be eligible to receive 100% tuition reimbursement, to a maximum of $1,500, for one course in their designated degree program each work period upon successful completion of the course with a grade of "C" or higher. Reimbursement to co-op students will follow the same procedure in effect for regular employees.

Amount of Reimbursement

Reimbursement, up to the maximum allowance, will be made for any subject (excluding non-degree/non-certificate-related games, hobbies and sports) given by a satisfactorily accredited or recognized school or institution that has been approved in advance under guidelines in the Eligibility section above, as follows below.

Notes:

- Maximum allowance refers to each calendar year (January 1-December 31)
- Calendar year reflects when the employee receives the reimbursement in his/her pay, not when the course actually was attended
- Reimbursement requests must be submitted within three months of course completion

Job related graduate programs directly related to the employee's job or career path will be reimbursed up to a maximum of $10,500. For this reimbursement to be non-taxable, the coursework:

- must be job related
- cannot qualify the employee for a new trade or business
- cannot be taken to meet the minimum education requirements for qualification in his/her employment, trade or business.

Level of Coursework	Job Relation / Career Factors	Annual Limit
Graduate	▪ Directly-related to the employee's job or career path at the time of application; ▪ Coursework is **recommended by Lubrizol** for a bona fide business reason; ▪ Determined by tuition reimbursement review team to pass three-prong test*	$10,500 (Not taxable)
Graduate	▪ Directly-related to the employee's job or career path at the time of application; ▪ Coursework is **recommended by Lubrizol** for a bona fide business reason; ▪ Determined by tuition reimbursement review team to **NOT** pass three-prong test*	$10,500 (Taxable above $5250)
Undergraduate/ Graduate	Degree or certificate program directly-related to employee's job or career path at time of application	$5,250
Undergraduate / Graduate	Individual courses directly-related to employee's job or career path at time of application which are NOT part of degree / certificate program	$2,000
Undergraduate / Graduate	Non-job / non-business-related courses / programs	$1,000
Co-ops	Courses taken as part of school program	$1,500
	▪ CLEP Test and life experience credits; ▪ Books, lab fees, etc. related to a specific course	Included in annual eligibility amount; tax status same as related coursework
	▪ University fees (e.g. registration, parking, facility, college services, graduation, etc.) outside of books and materials needed for a particular course ▪ Entrance exams (e.g. SAT, GMAT, LSAT) and costs associated with preparation courses for these exams ▪ Games, hobbies, sports	Not covered
Note: Professional certification preparation courses (e.g. SPHR) should be paid for through department training budget		

***Three-prong test to determine eligibility for maximum non-taxable $10,500 graduate allowance:**

Note: Approval for this reimbursement is determined by the LZU Tuition Reimbursement Team based upon information provided by the applicant and his/her department manager and is subject to guidelines related to applicable tax laws.

1. The course must be job related (see examples below).
2. The courses cannot qualify the employee for a new trade or business.
3. The course cannot be taken to meet the minimum education requirements for qualification in his/her employment or trade or business.

Examples:
Test #1 - the coursework must be related to the person's current line of work, so a non-chemist (or related type job) would not meet the test if he/she were pursuing a masters degree in chemistry.

Test #2 - is never met when a non-attorney attends law school.

Test #3 - is not met when a person is in a position that requires a specific degree and that person is currently taking courses to attain that degree.

How to Apply

Before you register, discuss your plans with your department head and obtain the necessary approval. Prior approval of your department head is required for reimbursement of associated costs. Following these procedures, you will know beforehand whether or not your plans qualify for tuition reimbursement and to what extent they qualify.

When you satisfactorily complete the approved course, you need to present to your manager a certificate of completion or grade report and a tuition receipt along with a cash disbursement voucher. (Cancelled checks will not be accepted in lieu of a tuition receipt.) Your manager then will approve the cash disbursement voucher to reimburse the appropriate amount to you. Submit the approved cash disbursement voucher, a copy of your grades or certificate and the tuition receipt to your human resources tuition reimbursement representative. The approved amount will be included in your paycheck.

Other Information

Any exceptions to the above guidelines will be submitted to the Corporate Vice President - Human Resources of The Lubrizol Corporation for review after approval by the department head or division leader.

Successful completion of educational courses under this program does not guarantee changes in your current or future job status. Lubrizol also reserves the right to verify school/program enrollment and completion of the course(s) prior to reimbursement.

This policy does not represent a contract between Lubrizol and its employees, co-ops and interns, and is subject to change without prior notification.

Lubrizol management reserves the right to re-evaluate an individual's participation in the tuition reimbursement program should circumstances regarding the employee's performance and/or job situation change.

All corporate information is confidential. Before an employee uses any data or information about Lubrizol in projects or papers required for education courses, he/she must obtain permission from the division leader or general plant manager. Breaching this directive may be cause for withholding tuition reimbursement from an employee.

Please refer to the full Policy located on The Channel for additional information.

Matching Gift Program

The Lubrizol Foundation was established in 1952 to make gifts to educational institutions and other non-profit charitable organizations on behalf of Lubrizol. One of the Foundation's activities in this connection is that it has a Matching Gift Program. The purpose of the matching gift program is to provide an incentive for gifts by employees to charitable organizations and, in this manner, both encourage and support the employee's volunteer work in the community. The requirements of the program are described below.

Eligibility to Participate

All regular, full-time or part-time employees of The Lubrizol Corporation or of its participating subsidiaries; a retiree of such companies (for participating subsidiaries, the retirement must have occurred after December 31, 1994) and a non-employee director of The Lubrizol Corporation are eligible to participate.

Gift Matching Recipients

The program applies only to gifts made by participants to nonprofit, tax-exempt, educational institutions and charitable organizations in the United States. The recipient must provide its IRS tax-exempt number. Nothing of monetary value such as dues, memberships, tickets, subscriptions, a reduction in tuition or student fees, etc. may be received in return for the gift. Gifts to educational institutions to promote athletics or other nonacademic programs are not eligible.

Educational Institutions and Other Charitable Organizations

The Foundation matches employee gifts to educational institutions and other charitable organizations, dollar-for-dollar, up to **$5,000 per employee** and **$2,500 per retiree** annually, with a maximum of five (5) gifts matched per year.

Gifts

The minimum gift is $100. Only gifts made in cash or marketable securities will be matched. Employee pledges that are made during the annual United Way campaign at Lubrizol facilities will be matched dollar for dollar up to $1,000 with no minimum. These pledges do not count toward the 5 gifts or $5,000 annual maximum.

Limitations

Gifts to United Way outside of the campaign period will not be matched, as the Foundation uses a special program to support employee pledges during facility campaigns. The Foundation will not match pledges, unless paid in full during a single calendar year. Gifts to individuals and gifts-in-kind are ineligible. In addition, gifts to religious or political organizations or for religious or political purposes are not matched.

How to Apply

Official matching gift forms are available in Lubrizol human resources offices and from The Foundation. The donor must complete Step 1 of the form and send it with his or her gift to the recipient organization. An official designated by the recipient should complete Step 2 of the form and return the entire form to the Matching Gift Administrator of The Lubrizol Foundation. The completed form must be received by The Foundation not later than January 30 of the year following that in which your gift is made. Please advise the recipient organization of this requirement.

Donation verification will be sent to the donor when the match has been made. Applications for matching funds are currently processed on a monthly basis.

Determinations

The Foundation reserves the right to amend or terminate the Matching Gift Program at any time and, at its sole discretion, to determine all matters concerning the administration and operation of the program including the eligibility of participants, organizations and gifts.

Inquiries

The Matching Gift Administrator at Lubrizol (440) 347-1797 or the human resources offices of Lubrizol's U.S. plants will be pleased to answer inquiries concerning the Matching Gift Program.

Community Connection Program

Starting January 1, 2002, the Lubrizol Foundation began to fund a program called Community Connection. The purpose of this program is to encourage and recognize employees for their community service and volunteer work. Full or part time U.S. employees of Lubrizol and its wholly owned U.S. subsidiaries who complete 40 or more hours of volunteer work in a calendar year for an eligible non-profit organization can apply for a $500 grant from the Foundation.

Merit Scholarship Program

This scholarship program was established by The Lubrizol Foundation for sons and daughters of The Lubrizol Corporation employees and its participating subsidiaries. The annual Merit Scholarship competition is conducted by National Merit Scholarship Corporation (NMSC), an independent, not-for-profit organization. The Merit Program's purposes are: 1) to identify and honor exceptionally able high school students and 2) to provide a system of services for corporations, foundations, and other organizations who wish to sponsor college undergraduate scholarships for outstanding students who interest them. All aspects of the selection of winners and the administration of their awards are handled by NMSC.

Who is Eligible

Only high school students who are sons and daughters of The Lubrizol Corporation (or its U.S. subsidiaries) employees can compete for these scholarships. Such students also must meet all requirements for participation in the Merit Program that are published in the PSAT/NMSQT Student Bulletin, which is updated annually and distributed to students through their high schools.

To participate in the program, students must take the qualifying test, the Preliminary SAT/National Merit Scholarship Qualifying Test (PSAT/NMSQT) during the proper high school year. In general, students who spend the usual four years in grades 9 through 12 must take the PSAT/NMSQT when they are in their third year (grade 11/junior year). Students who plan to leave high school a year (or more) early to enroll in college full time should refer to the PSAT/NMSQT Student Bulletin (or contact NMSC) about when to take the test. A participant also must be a U.S. citizen; or if not now a citizen, a permanent U.S. resident (or have applied for permanent residency) and be in the process of becoming a U.S. citizen. The PSAT/NMSQT Student Bulletin explains these and other requirements for the competition, gives detailed information about the test (including sample questions and a complete practice test), and describes the scholarship programs NMSC administers.

How does a student enter the Lubrizol Foundation Merit Scholarship Program?

To enter the competition for The Lubrizol Foundation Merit Scholarships to be awarded in the spring of each year, children of employees who will complete high school and enroll full time in college must take the PSAT/NMSQT in the fall, on the date their school chooses for the administration.

NOTE: A student who does not take the PSAT/NMSQT because of illness, an emergency or other extenuating circumstances (but meets all other participation requirements), may still be able to enter the competition. To request information about possible arrangements for alternate testing, the student must write directly to NMSC as soon as possible but no later than March 1. The student should not delay; the earlier the student writes, the more options there are for scheduling test dates. The letter must be postmarked on or before March 1, for the request to be considered. Write to National Merit Scholarship Corporation, Attn: Educational Services, 1560 Sherman Ave, Suite 200, Evanston, Illinois 60201-4897; telephone 847-866-5100.

How are winners selected?

All Lubrizol Foundation Merit Scholarship winners will be chosen from a group of candidates who qualify as Merit Program Semifinalists on the basis of their PSAT/NMSQT scores and who then advance to the Finalist level by meeting several academic and other requirements set by NMSC. Semifinalists will be notified through their schools in September. These students and their high school principals will complete applications that include biographical and academic information that must be filed with NMSC. Scholarship winners will be chosen on a competitive basis and without regard to family financial circumstances. An NMSC committee of professionals trained in selection will choose the winners by evaluating several factors about each candidate, and the student's essay about personal characteristics, activities, plans and goals. In most cases, winners will be notified by NMSC in March. All winners are notified directly, prior to any public announcement that may be made about recipients.

What is the amount of the award?

Each Lubrizol Foundation Merit Scholarship is $3,500 per year for up to four years of college undergraduate study or until baccalaureate degree requirements are completed, whichever occurs first. The winner's annual stipend will not be affected by other scholarship aid or by an approved change in college.

Are there terms and conditions that Merit Scholarship winners must meet?

Yes. The formal offer of a Lubrizol Foundation Merit Scholarship that NMSC sends to each winner specifies terms for acceptance and continuation of the award. A winner must enter college in the fall term following selection and must enroll as a full-time undergraduate in a college or university in the United States that holds accredited status with a regional accrediting commission on higher education. (Scholarship stipends are not payable for attendance at service academies, virtual universities, and certain institutions that are limited in their purposes and training.) Also, the winner must attend college during the day, enroll in a course of study leading to one of the traditional baccalaureate degrees, and remain in good academic and disciplinary standing.

Who handles scholarship procedures?

All phases of the competition, including the selection of winners and payment of scholarship stipends are handled for The Lubrizol Foundation by National Merit Scholarship Corporation.

Questions may be addressed to:

The Lubrizol Foundation
29400 Lakeland Boulevard
Wickliffe, Ohio 44092

This page left blank intentionally

Family & Medical Leave of Absence And Adoption Policy

Table of Contents

General Information

The Lubrizol Corporation Family & Medical Leave of Absence (FMLA)/Adoption Policy and Practice under HR-01-10 provides assistance to employees who need time off to attend to family matters or for the employee's own serious health condition.

Who is Eligible

This practice applies to all U.S. employees on the payroll of The Lubrizol Corporation or of one of its U.S. Subsidiaries and who (i) have been employed at least 12 months and (ii) who have worked at least 1,250 hours during the 12-month period immediately preceding the leave.

Family & Medical Leave of Absence

Eligible employees may receive up to 12 weeks (or up to 26 weeks in some circumstances) of family/medical leave (unless governed otherwise by state law) within a rolling 12-month period provided that they meet the requirements of the Family & Medical Leave Act. The 12-month period will be measured backward from the start date of the employee's leave.

An FMLA leave may be taken for up to 12 weeks for birth of the employee's child or newly adopted child or for a newly placed foster child within 12 months of the birth or placement, to care for a family member with a serious health condition, or for your own serious health condition.

An FMLA leave also may be taken for up to 12 weeks to address certain qualifying exigencies related to your spouse, child or parent being called to or being on covered active duty in a foreign country with the U.S. Armed Forces. These may include short-notice deployment, attending certain military events, arranging for childcare and school activities, addressing certain financial and legal arrangements, attending certain counseling sessions, rest and recuperation, and attending post-deployment activities.

An FMLA leave may be taken for up to 26 weeks to care for a spouse, child, parent or nearest blood relative who is, or was within the past five years, a member of the U.S. Armed Forces, with a serious illness or injury incurred during active duty, or aggravated by services in the line of duty, with the U.S. Armed Forces. This FMLA leave is available only during one 12-month period. It is combined with all other FMLA leaves in that period, resulting in a maximum total FMLA leave of 26 weeks in that 12-month period.

FMLA may be taken intermittently or on a reduced leave schedule when: 1) medically necessary due to the serious health condition of the employee or the serious health condition of a family member; 2) the leave is due to an exigency relative to the call to active duty of the employee's spouse, child or parent; or 3) the leave is due to taking care of the employee's spouse, child, parent or nearest blood relative with a serious illness or injury incurred during or aggravated by active duty. If the employee and the employee's supervisor agree, FMLA leave may be taken intermittently or on a reduced leave schedule after the birth or placement of a child for adoption or foster care. Medical documentation is required. For all intermittent and reduced leave schedules, Lubrizol may assign you to an alternative position temporarily to accommodate the needs of the company and the employee. Such temporary assignments would have equivalent pay and benefits.

FMLA is unpaid; however, you may be eligible for wage or benefit programs under the Salary Continuation Program or Workers Compensation. Those programs have their own eligibility requirements to receive benefit payments that may be different from the requirements of FMLA leave. If the employee fails or chooses not to comply with those other requirements, the employee will still be eligible for FMLA leave, but the leave will be unpaid. If you are eligible for wage or benefit payments, the leave will run concurrently with the paid time off for the purpose of calculating FMLA time. You have the option to apply vacation or employee's choice holidays to any unpaid leave, however, all such periods will be counted against the FMLA leave. Lubrizol will notify you if your leave is designated as FMLA.

Definitions

1. "family member" is:
    a. your biological child, adopted child, foster child, step child, legal ward, or a child for which you stand in the place of the parent, who is under age 18, or if 18 or over, who is incapable of self-care because of mental or physical disability;
    b. your legal spouse; and
    c. your biological parent or a person who stood in the place of a parent to you as a child.

2. A "serious health condition" is defined as an illness, injury, impairment or physical or mental condition that involves either:
    a. any period of incapacity or treatment connected with inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical-care facility, and any period of incapacity or subsequent treatment in connection with such inpatient care; or
    b. Continuing treatment by a health care provider which includes any period of incapacity (i.e., inability to work, attend school or perform other regular daily activities) due to:
        i. A health condition (including treatment therefor, or recovery therefrom) lasting more than three consecutive days, and any subsequent treatment or period of incapacity relating to the same condition, that also includes:
            1. treatment two or more times within a 30-day period, unless extenuating circumstances exist, by or under the supervision of a health care provider; or
            2. at least one treatment by a health care provider with a continuing regimen of treatment under the provider's supervision; or
        ii. Pregnancy or prenatal care. A visit to the health care provider is not necessary for each absence; or
        iii. A chronic serious health condition which continues over an extended period of time, requires periodic visits to a health care provider at least twice per year for treatment, and may involve occasional episodes of incapacity (e.g., asthma, diabetes). A visit to a health care provider is not necessary for each absence; or
        iv. A permanent or long-term condition for which treatment may not be effective (e.g., Alzheimer's, a severe stroke, terminal cancer). Only supervision by a health care provider is required, rather than active treatment; or
        v. Any absences to receive multiple treatments for restorative surgery or for a condition which would likely result in a period of incapacity of more than three days if not treated (e.g., chemotherapy or radiation treatments for cancer).

Examples of conditions that may be considered a serious health condition include heart attack, heart conditions requiring heart bypass or valve operations, most cancers, back conditions requiring extensive therapy or surgical procedures, strokes, severe respiratory conditions, spinal injuries, appendicitis, pneumonia, emphysema, severe arthritis, severe nervous disorders, injuries caused by serious accidents on or off the job, ongoing pregnancy, severe morning sickness, the need for prenatal care, childbirth and recovery from childbirth.

Examples of conditions that are not ordinarily serious health conditions (unless complications arise) include the common cold, the flu, ear aches, upset stomach, minor ulcers, headaches other than migraine, routine dental or orthodontia problems, periodontal disease, etc.

3. A “health care provider” is defined to mean:
    a. Doctor of medicine or osteopathy who is authorized to practice medicine or surgery (as appropriate) by the State in which the doctor practices;
    b. Podiatrists, dentists, clinical psychologists, optometrists and chiropractors (limited to manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist) authorized to practice, and performing within the scope of their practice, under state law;
    c. Nurse practitioners, nurse midwives and clinical social workers authorized to practice, and performing within the scope of their practice, as defined under state law;
    d. Christian Science practitioners listed with the First Church of Christ, Scientist in Boston, Massachusetts; or
    e. Any health care provider recognized by the company.
4. A “reduced leave schedule” means a leave schedule that reduces the usual number of hours per work week, or hours per work day, of an employee.
5. An “intermittent leave” is leave taken in separate blocks of time due to a single illness or injury, rather than for one continuous period of time.

How to Apply for Family & Medical Leave

Your request for a family & medical leave of absence must be submitted to your supervisor. Your supervisor will coordinate the leave with the facility Medical Department or local Human Resources site representative. You should provide the following information: reason for the leave, anticipated length of time of leave, and your address during the leave. You are required to provide 30-day advance notice of the need to take FMLA when the need is foreseeable and the notice is practicable.

Request for leaves due to the serious health condition of an employee or family member require the employee to provide appropriate medical certification from the relevant health care provider. The employee may be required to provide reasonable documentation to confirm the family relationship. Request for FMLA leaves due to adoption of a child or related to a family member’s military service require the employee to furnish certification of the need for leave, the relationship, and copies of relevant adoption or guardianship documents or the military orders of the covered service member.

If Lubrizol has questions about a medical certification, you may be required to obtain a second opinion by a physician of Lubrizol’s choice at its expense. If the first and second opinions conflict, a third physician, selected jointly by you and Lubrizol will be requested to make the final determination of medical necessity at Lubrizol’s expense. Employees who take leave because of their own serious health condition, or to take care of a family member, will be required to periodically contact the company regarding the status of the health condition and your intention to return to work.

Effect on Other Benefits

Participation in the following corporate benefit plans and policies will be continued during a family & medical leave of absence: pension plan; profit-sharing contribution is based only on compensation earned during the year. Salary deferrals or contributions will continue if you are on a paid leave of absence. If the leave is unpaid, 401(k) contributions will resume automatically on the first full pay period after returning to work; life insurance plan, medical, prescription drug, vision and dental care coverage and flexible reimbursement accounts will continue provided you pay the required contributions. Required contributions will be made as usual if you are on a paid leave of absence. If the leave is unpaid, any required deductions will resume automatically on the first full pay after returning to work (you can choose to prepay the required premiums during leave; however, if your leave is scheduled to continue into the next plan year, you will be billed on an after-tax basis). Vacation may be taken before or after the FMLA leave and will not affect the duration of the FMLA leave. Your use of FMLA will not result in the loss of any employment benefit that you earned or were entitled to before using the leave, nor will it be counted against the employee under any “no fault” attendance policies.

Tuition reimbursement is available only under the terms of the tuition reimbursement policy. Year-end variable pay or annual bonus plans will be prorated due to unpaid leave. Qualified leave will not be counted under any attendance guidelines.

Effect on Your Position

Upon your return to work after a family & medical leave of absence, you will be returned to your regular job, if possible, or an equivalent position with equivalent pay, benefits and other terms and conditions of employment. If leave was due to your serious health condition, you must provide medical evidence that you are able to return to work.

Certain highly compensated employees (generally the top 10% by pay) may be denied restoration of his/her same or equivalent position if:

1. the denial is necessary to prevent substantial and grievous economic injury to Lubrizol,
2. Lubrizol notifies the employee of the intent to deny restoration at the time Lubrizol decides the economic injury would occur, and
3. in the case where the leave has commenced, the employee elects not to return to work after receiving such notice.

Your Rights under the Family and Medical Leave Act of 1993

The Lubrizol Corporation Family & Medical Leave of Absence Policy is intended to comply with The Family and Medical Leave Act of 1993 (FMLA). The FMLA makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA;
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA; and
- discharge or discriminate against any person because of involvement in any proceeding under or related to FMLA.

An eligible employee may bring a civil action against an employer for violations of FMLA. Employers who act in good faith and have reasonable grounds to believe their actions did not violate FMLA may have any damages reduced to actual damages at the discretion of a judge. For more information, you may contact the nearest office of the Wage and Hour Division, listed in most telephone directories under U.S. Government, Department of Labor, Employment Standards Administration.

State Law

The provisions of this Practice are subject to state law requirements.

Adoption Benefit

Regular employees adopting a child that is not related to either the employee or employee's spouse through an agency are eligible for reimbursement of up to $3,000 for adoption expenses incurred. Included in these expenses are adoption agency fees, court costs, attorney fees and other expenses that are directly related to, and the principal purpose of which is for, the legal adoption of an eligible child. The child must be either under age 18 or physically or mentally incapable of caring for him or herself. This reimbursement is per family per adoption event. Lubrizol does not withhold income taxes from this benefit, but employees may have to include all or part of the payment in their income when they file their taxes. Request for reimbursement should be in writing and made to your local Human Resources site representative.

Important Benefits Contact Information

Reference the table below for general contact information for the programs contained in this Employee Resource Guide. You may also contact your local benefits representative for general questions.

Please visit the benefits website at http://benefits.lubrizol.com for general plan information.

If you have questions about…	Contact…
Employee benefits including billing, claims, scheduling appointments, locating in-network doctors and hospitals, price comparisons and more	**Health Advocate** **1-866-799-2731** **www.HealthAdvocate.com/Lubrizol**
Enrolling, changing coverage, adding or dropping a dependent, etc.	**Alight** **1-844-747-1641** **http://Lubrizol.BenefitsNow.com**
COBRA Billing	**Conexis** **1-866-206-5751**
Lubrizol CDHP, Lubrizol EPO or Lubrizol OOA	**UnitedHealthcare** **1-877-706-1735** **www.myuhc.com** **Group #: 730140**
Behavioral Health Coverage	**OptumHealth** **1-877-706-1735** **www.myuhc.com** **Group #: 730140**
Prescription Drug Coverage	**Caremark** **1-800-776-1355** **https://www.caremark.com/** **Group: LZRX**
Dental Coverage	**MetLife** **1-800-942-0854** **www.metlife.com/dental** **Group #: 304841**
Vision Coverage	**EyeMed** **1-866-9EYEMED** **www.eyemedvisioncare.com** **Group #: 979 5972**
Health Care and Dependent Care Reimbursement Accounts	**UnitedHealthcare** **1-877-706-1735** **www.myuhc.com** **Group #: 730140**
EAP and WorkLife Program	**United Behavioral Health** **866-248-4094** **www.liveandworkwell.com**
Supplemental Life Insurance	**Mercer** **1-800-905-1768** **www.personal-plans.com/lubrizol**
Long Term Care Insurance	**CNA Group Long Term Care Customer Service Center** **1-877-777-9072**
401(k) and AWDC	**Voya** **1-866-597-4015** **https://lzs401k.voya.com**

Pension	**If you are nearing retirement and you are seeking a Pension calculation, you should access the PensionPath tool to run an estimate. If you have a retirement date set and you need your final Pension calculation, you can email benefits@lubrizol.com for assistance.**
UnitedHealthcare's Nurseline	**1-877-201-1641**
Wellness	**LiveHealthier** **Portal: https://lzessentials.livehealthier.com** **Customer Support: 1-888-960-0432**

This page left blank intentionally

This page left blank intentionally

The Lubrizol Corporation
29400 Lakeland Boulevard, Wickliffe, Ohio 44092
Telephone: 440.943.4200

www.lubrizol.com

Lubrizol