# THE LUBRIZOL CORPORATION
# WICKLIFFE OH

**Employee Benefits Plan**
**Summary Plan Description**
**Transportation Benefit (NJ)**
**7670-02-415412**

**Revised 01-01-2024**

**BENEFITS ADMINISTERED BY**

UMR℠

A UnitedHealthcare Company

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# THE LUBRIZOL CORPORATION

# EMPLOYEE BENEFITS PLAN

# SUMMARY PLAN DESCRIPTION

## INTRODUCTION

The purpose of this document is to provide You with summary information on benefits available under this Plan, as well as with information on Your rights and obligations under Your employer's sponsored Flexible Spending Plan (also known as a Cafeteria Plan). You are a valued Employee of THE LUBRIZOL CORPORATION, and Your employer is pleased to provide You with benefits that can help meet Your Dependent care needs. Please read this document carefully and if you have questions, please submit a MyHR Benefits request using the following link Benefits – MyHR (service-now.com). This document summarizes the benefits and limitations of the Plan and will serve as the Summary Plan Description (SPD). It is being furnished to You in accordance with ERISA.

The Plan is intended to qualify as a Cafeteria Plan under Code §125. The purpose of the Cafeteria Plan is to allow Employees to choose between two or more benefits consisting of cash and certain qualified benefits, namely coverage under a variety of benefit plans sponsored by Your employer.

The Cafeteria Plan offers You flexible spending account choices as well as other benefit options. Benefit options offered under the Cafeteria Plan are separate plans for purposes of administration and legal compliance. The following options are components of the Cafeteria Plan:

- Dependent Care Spending Account
- Medical Benefits Plan
- Health Savings Account (HSA)
- Dental Plan
- Vision Plan
- Long Term Disability Plan
- Vacation Buy

THE LUBRIZOL CORPORATION is named the Plan Administrator for this Plan. The Plan Administrator has retained the services of an independent Third Party Administrator, UMR, Inc. (hereinafter "UMR") to process claims and perform other administrative duties for the Plan. As the Third Party Administrator, UMR does not assume liability for benefits payable under this Plan, since it is solely a claims-paying agent for the Plan Administrator.

The employer assumes the sole responsibility for funding the Plan benefits out of its general assets; however, Employees cover most of the costs of the Flexible Spending Account with pre-tax contributions from their pay. All claim Payments and reimbursements are paid out of the general assets of the employer and there is no trust or other separate fund from which benefits are paid. Even though this Plan may allow pre-tax-salary reduction contributions to an HSA, the HSA funding feature is not part of or intended to be part of an ERISA benefit plan sponsored or maintained by the Employer.

The requirements for coverage under this Plan, the provisions concerning termination of coverage, a description of the Plan benefits (including limitations and exclusions), and the procedures that must be followed in making claims for benefits and appeals of denied claims are outlined in the following pages of this SPD.

Some of the terms used in this document begin with capital letters, even though such terms normally would not be capitalized. These terms have special meaning under the Plan. Most capitalized terms are listed in the Glossary of Terms, but some are defined within the provisions in which they are used. Becoming familiar with the terms defined in the Glossary of Terms will help You to better understand the provisions of this Plan.

This document became effective on January 1, 2023.

## PLAN INFORMATION

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|---|---|
| **Plan Name** | THE LUBRIZOL CORPORATION FLEXIBLE SPENDING PLAN |
| **Name and Address of Employer** | THE LUBRIZOL CORPORATION<br>29400 LAKELAND BLVD<br>WICKLIFFE OH 44092 |
| **Name, Address, and Phone Number of Plan Administrator** | THE LUBRIZOL CORPORATION<br>29400 LAKELAND BLVD<br>WICKLIFFE OH 44092<br>440-943-4200 |
| **Named Fiduciary** | THE LUBRIZOL CORPORATION |
| **Employer Identification Number Assigned by the IRS** | 34-0367600 |
| **Type of Benefit Plan Provided** | Self-Funded Dependent Care Assistance Plan under Code §129. |
| **Type of Administration** | The administration of the Plan is under the supervision of the Plan Administrator with benefits provided in accordance with the provisions of the employer's Flexible Spending Plan. The Plan is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. UMR provides administrative services such as claim Payments and enrollment services. |
| **Funding of the Plan** | Employee contributions<br><br>Benefits are provided by a benefit Plan maintained on a self-insured basis by Your employer. |
| **Compliance** | It is intended that this Plan comply with all applicable laws. In the event of any conflict between this Plan and the applicable law, the provisions of the applicable law will be deemed controlling, and any conflicting part of this Plan will be deemed superseded to the extent of the conflict. |

**Discretionary Authority**

The Plan Administrator will perform its duties as the Plan Administrator, and in its sole discretion, will determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator will have full and sole discretionary authority to interpret all Plan documents, including this SPD, and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any Plan document and any determination of fact adopted by the Plan Administrator will be final and legally binding on all parties, except that the Plan Administrator has delegated certain responsibilities to the Third Party Administrators for this Plan. Any interpretation, determination, or other action of the Plan Administrator or the Third Party Administrators will be subject to review by a legal authority only if a court of proper jurisdiction determines its action is arbitrary or capricious or otherwise a clear abuse of discretion. Any review of a final decision or action of the Plan Administrator or the Third Party Administrators will be based only on such evidence presented to, or considered by, the Plan Administrator or the Third Party Administrators at the time they made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator or the Third Party Administrators make, in their sole discretion, and further, means that the Covered Person consents to the limited standard and scope of review afforded under law.

## CAFETERIA PLAN HIGHLIGHTS

THE LUBRIZOL CORPORATION's Cafeteria Plan allows Employees to use pre-tax dollars to pay for their portions of the necessary contributions on a Salary Reduction basis for the component benefits offered.

The following benefits and accounts are offered under this Cafeteria Plan:

- Dependent Care Spending Account
- Medical Benefits Plan
- Health Savings Account (HSA)
- Dental Plan
- Vision Plan
- Long Term Disability
- Vacation Buy

Note: Any HSA that Lubrizol may make available to You is not provided under an employee benefit plan within the meaning of ERISA and is not subject to ERISA, the Health Insurance Portability and Accountability Act ("HIPAA") or the Consolidated Omnibus Budget Reconciliation Act ("COBRA").

### PARTICIPATION IN A COMPONENT BENEFIT PLAN / ACCOUNT

In order to participate in a specific component benefit offered under this Cafeteria Plan, You must elect that component benefit on forms provided by the Plan Administrator, and You will be required to share the cost of the component benefit as explained below. Further, You must meet any eligibility, participation, or other requirements applicable to that component benefit plan or account.

### EMPLOYEE CONTRIBUTIONS

Other than for the Dependent Care Spending Account and HSA, Your contribution amount for the component benefits offered under this Cafeteria Plan will be established by the Plan Administrator in its sole discretion.

### PAYING THE CONTRIBUTIONS FOR THE APPLICABLE BENEFIT PLAN / ACCOUNT

As an Employee, You will pay the applicable contribution amount on a pre-tax Salary Reduction basis. Your election will be irrevocable for the entire Plan Year, unless You experience a Change In Status event (see below) that would permit an election change, or unless some other regulatory exception applies. With regard to the Health Savings Account Benefit, a Participant who is actively enrolled in a qualified high deductible Health Plan and not enrolled, including as a Dependent, under a non-qualified high deductible Health Plan or any other disqualifying coverage, and has elected to make elective contributions under such arrangement, may modify or revoke the election at any time, prospectively, provided such change is consistent with Code Section 223 and the Treasury regulations thereunder. If you have questions, please submit a MyHR Benefits request using the following link Benefits – MyHR (service-now.com).

### USE-OR-LOSE RULE (Does not apply to the HSA)

Plan Your dependent care elections carefully. Any unused benefits or contributions in Your Dependent Care Spending Account will be forfeited if they are not used to pay or reimburse expenses that You or Your Dependents (if applicable) incur by the end of the Plan Year. Forfeited amounts will be used to offset reasonable administrative expenses and future costs of the applicable benefit plan. Refer to the Plan's timely filing provision for details regarding the deadline for submitting claims.

## IRREVOCABILITY OF YOUR ANNUAL ELECTIONS

Before You decide how much to deposit, carefully estimate Your Dependent Care Expenses for the year. Since the amount reimbursed to You from Your account is not subject to taxes, the IRS places the following restrictions on Your deposits:

- Once You have made Your election, You may not change the amount of money You contribute to Your account until the beginning of the next Plan Year with the exception of an IRS-permitted event (refer to the Change in Status section for further details)
- Any money that You do not claim for expenses Incurred during the Plan Year will be forfeited. These forfeitures are used to offset the administrative expenses of the Plan.

## DUPLICATE REIMBURSEMENTS NOT ALLOWED

If You submit a claim to Your Dependent Care Spending Account, You may not claim the same expense as a deduction on Your income tax return. If You receive a reimbursement from a third party for expenses already reimbursed by Your Dependent Care Spending Account, You will be required to reimburse the Plan for the benefits received.

## PAYING THE CONTRIBUTIONS FOR THE APPLICABLE BENEFIT PLAN / ACCOUNT

As an Employee, You will pay the applicable contribution amount on a pre-tax Salary Reduction basis. Your election will be irrevocable for the entire Plan Year, unless You experience a Change In Status event (see below) that would permit an election change, or unless some other regulatory exception applies. With regard to the Health Savings Account Benefit, a Participant who is actively enrolled in a qualified high deductible Health Plan and not enrolled, including as a Dependent, under a non-qualified high deductible Health Plan or any other disqualifying coverage, and has elected to make elective contributions under such arrangement, may modify or revoke the election at any time, prospectively, provided such change is consistent with Code Section 223 and the Treasury regulations thereunder. If you have questions, please submit a MyHR Benefits request using the following link Benefits – MyHR (service-now.com).

## BENEFITS WILL BE PROVIDED BY THE APPLICABLE BENEFIT PLAN / ACCOUNT

The applicable benefit plan or account in which You participate will provide You with the benefits to which You may be entitled under that plan or account. Information regarding those benefit plans and accounts are explained in a separate section of this SPD. (See the Table of Contents.)

## ELIGIBILITY AND ENROLLMENT
**(Participating in the Plan)**

### ELIGIBILITY REQUIREMENTS

You are eligible to participate in the Plan if You are a common-law employee under IRS rules and meet the requirements below.

#### Eligible Employee

An **eligible Employee** will be eligible to participate hereunder as of the date the individual satisfies the eligibility conditions for the Employer's group medical plan, the provisions relating to which are specifically incorporated herein by reference. For purposes of this Plan, it does not include the following classifications of workers except as determined by the employer in its sole discretion:

- Leased or temporary Employees.
- Independent Contractors as defined in this SPD.
- Consultants who are paid on other than a regular wage or salary basis by the employer.
- Members of the employer's Board of Directors, owners, partners, or officers, unless engaged in the conduct of the business as regular employees.
- Self-employed individuals.
- Partners in a partnership.
- 2% or greater shareholders in a Subchapter S corporation.
- Any person who is covered by a collective bargaining agreement, unless the agreement specifically provides for Plan coverage.
- Any person who waives participation in the Plan.

A component program of the Plan may have additional or separate eligibility requirements. Check the program's Summary Plan Description.

For purposes of this Plan, eligibility requirements are used only to determine an Employee's initial eligibility for coverage under this Plan. An Employee may retain eligibility for coverage under this Plan if the Employee is temporarily absent on an employer-approved leave of absence, which may be combined with the employer's short-term disability policy, with the expectation of returning to work following the approved leave as determined by the employer's leave policy. The employer's classification of an Employee is conclusive and binding for purposes of determining eligibility under this Plan. No reclassification of an Employee's status, for any reason, by a third party, whether by a court, governmental agency, or otherwise, without regard to whether or not the employer agrees to such reclassification, will change a person's eligibility for benefits.

### EFFECTIVE DATE / ENROLLMENT

An Eligible Employee will become a Participant effective as of the date on which the eligibility and enrollment requirements are satisfied. Your Salary Reduction for elected benefits will be effective the first pay period beginning on or after the Employee's effective date of participation.

**New Employees**

If You are an Employee who meets the eligibility requirements on the first day of, or during, a Plan Year, You may elect to participate in this Plan for all or the remainder of such Plan Year, provided You elect to do so by returning Your election form within the timeframe established by Your employer, and in no event later than Your effective date of participation. An election form will be provided to You by Your employer. The election form will enable You to elect to participate in the Plan and to authorize the necessary Salary Reductions to pay for the benefits You elect. If You are an eligible Employee and fail to return the election form within the specified timeframe, You will not be permitted to elect to participate in the Plan until the next annual open enrollment period.

**Existing Employees**

If You are an existing Employee who wishes to continue or to begin to participate (for those Employees who did not elect when first eligible) in the Plan, You must elect to do so during the annual open enrollment period. Each year, during the annual open enrollment period, You will be provided an opportunity to elect to participate in the Plan or to choose not to participate.

**ANNUAL OPEN ENROLLMENT PERIOD**

If You are an eligible Employee who previously waived coverage under this Plan, including coverage under the Dependent Care Spending Account, You may apply for coverage during the annual open enrollment period in the form and manner prescribed by the employer. Similarly, if You wish to change Your benefit election(s) under Your Dependent Care Spending Account, You may request the change during the annual open enrollment period as well.

The employer will provide You with a written notice prior to the start of an annual open enrollment period. Your Effective Date of coverage will be January 1 following the annual open enrollment period.

Please review the annual open enrollment materials carefully for information about the carryover of your existing Plan elections. They will tell you if your current Plan elections for Medical, Dental and Vision will carry over to the next Plan Year if you do not make an affirmative election during open enrollment. You will have the right to change any election you previously made, and You may elect to waive coverage for the next Plan Year. If any of Your elections carry over, You will be deemed to have elected to have your contributions taken from your pay in an amount necessary to purchase those benefit options.

You must re-enroll each year for the Dependent Care FSA. Similarly, your contribution election for the Health Savings Account does not carry over to the next Plan Year. The benefit option(s) You elect (or have deemed to have elected by carryover of your current elections) will be effective during the Plan Year following open enrollment for as long as You are eligible.

After the open enrollment period has closed, you will receive a notice confirming the elections that have been recorded for You for coverage for the next Plan Year. Please review the notice carefully to ensure that it correctly reflects your elections (including the Dependents for whom you intend to elect coverage), and promptly notify the Lubrizol Benefits Center at 844-747-1641 if there are any errors. You may be unable to request a change in your elections to correct an error once the next Plan Year has commenced.

Your contributions will be deducted from Your paycheck beginning with the first pay period in which You are enrolled or the first pay period of the new Plan Year if You enroll during open enrollment.

**TERMINATION OF PARTICIPATION**

You will cease to be a Participant in the Plan upon the earlier of:

- The expiration of the Plan Year for which You have elected to participate (unless during the annual open enrollment period for the next Plan Year, You elect to continue participating);
- The termination of the Plan;

- The date on which You cease (because of retirement, termination of employment, layoff, reduction in hours, or any other reason) to be an eligible Employee;
- The date You revoke Your election to participate due to a qualifying event when such change is permitted under the terms of the Plan; or
- The date You submit a false claim or are involved in any other fraudulent act related to this Plan or any other group plan.

Medical, Dental and Vision benefits will terminate as of the date(s) specified in the respective Plans.

When You cease to be a Participant in the Plan, Your Salary Reductions will terminate under the Cafeteria Plan, as will Your ability to receive reimbursements from Your Flexible Spending Accounts (FSAs) for expenses Incurred after Your termination, unless otherwise stated within this SPD.

However, for Your Dependent Care Spending Account, You (or Your estate) may claim reimbursement for any eligible expenses Incurred during the Period of Coverage prior to termination, provided You (or Your estate) file a claim within the timely filing requirements of this Plan. Refer to the Timely Filing section of the Claims and Appeal Procedures provision of this SPD.

**PARTICIPATION FOLLOWING TERMINATION OF EMPLOYMENT**

For Flexible Spending Account benefits, if You are a former Participant who is rehired within 30 days or less of the date of a termination of employment, You will be reinstated with the same elections that You had before termination; however, Your coverage will not be reinstated retroactively and Your Salary Reductions will be prorated based on the remaining pay periods in the Plan Year. If You are a former Participant who is rehired more than 30 days following termination of employment and are otherwise eligible to participate in the Plan, You may make a new election as a new hire under this Plan. For any other benefits elected under this Plan, Your participation will be reinstated to the extent provided under the component benefit plan, if permitted by law.

## CHANGE IN STATUS
### (Permitted Election Changes)

The IRS irrevocability rule generally prohibits mid-year changes to Your elections. However, there are exceptions to this general rule. Because Your contribution is deducted from Your paycheck on a pre-tax basis, the Code regulates when You may enroll, cancel coverage, or make changes to Your elections. Therefore, unless You experience a Change in Status as defined in this SPD, You may not enroll or revoke an election until the next annual open enrollment period.

The change You make must be consistent with the Change in Status rules. The Plan Administrator (in its sole discretion) will determine whether or not a requested change is on account of and corresponds with a Change in Status. The general rule is that a desired election change will be found to be consistent with a Change in Status if the event affects coverage eligibility.

Unless otherwise stated in this SPD, changes to an election must be made within 30 days following the Change in Status event and will become effective the pay period following the date You make the election.

The events that qualify as Changes in Status include those events described below and any other events that the Plan Administrator determines are permitted under subsequent IRS regulations and other guidance. Determinations will be on a uniform and consistent basis in accordance with IRS or other applicable regulations and in accordance with other terms and conditions contained in this SPD.

Unless specifically stated otherwise below, the following permitted events will apply to the component benefit plans offered under this Cafeteria Plan.

In addition, there are laws that give you rights to change health coverage for You or for Your Dependents. If you change coverage due to rights you have under the law, then you can make a corresponding change in your elections under the Plan. For information regarding your rights under these laws, see "Special Enrollment Provision Under the Health Insurance and Accountability Act" in The Lubrizol Group Health Plan Summary Plan Description, the provisions of which are incorporated herein by reference. If you have questions, please submit a MyHR Benefits request using the following link Benefits – MyHR (service-now.com).

An election to make a contribution to an HSA may be increased, decreased, or revoked at any time on a prospective basis in accordance with IRS rules and contribution limits.

**CHANGE IN STATUS, INCLUDING LEGAL MARITAL STATUS, NUMBER OF DEPENDENTS, AND DEPENDENT SATISFYING OR CEASING TO SATISFY DEPENDENT REQUIREMENTS**

You may revoke an election for the Plan Year and make a new election if You experience any of the following Change in Status events: an event that changes Your marital status (marriage, divorce, annulment or legal separation from a Spouse, or the death of a Spouse), an event that changes the number of Your Dependents (the death, birth, adoption, or Placement for Adoption of a Dependent), or an event that causes Your Dependent to begin to satisfy or cease to satisfy the eligibility requirements for coverage. You may elect to change only an election for the affected person that corresponds with the permitted event. For example:

- the Spouse involved in the divorce, annulment, or legal separation;
- the deceased Spouse or Dependent;
- the Dependent that ceased to satisfy the eligibility requirements; or
- the Dependent that begins to satisfy the eligibility requirements.

Adding or canceling coverage for an individual who is not affected by the permitted event would fail to correspond with that Change in Status.

**CHANGE IN EMPLOYMENT STATUS AND GAIN OF COVERAGE ELIGIBILITY UNDER ANOTHER EMPLOYER'S PLAN**

You may revoke an election for the Plan Year and make a new election if You or Your Dependent(s) experience an event that results in a change in the employment status of You, Your Spouse, or Your Dependent, including termination or commencement of employment, a strike or lockout, or the commencement of or return from an unpaid leave of absence. If Your request is to cease or decrease coverage as a result of gaining eligibility for coverage under a Cafeteria Plan or qualified benefit plan of Your employer or a Dependent's employer, the Plan Administrator may rely on Your certification that You or Your Dependent(s) have obtained or will obtain coverage under another plan, unless the Plan Administrator has reason to believe that Your certification is incorrect. The Plan Administrator may ask You to provide documentation to confirm Your eligibility for coverage under another plan.

**CHANGE IN COVERAGE**

- Transfers. You may revoke an election for the Plan Year for group health coverage and make a new election if You are transferred to another location that results in a change in your medical and/or dental plans in which you are eligible. You must make the election within 30 days of Your transfer. If you enroll Yourself and Your Dependent(s) in coverage, coverage will begin on the date of transfer.

- *Loss of Coverage Under Another Employer's Plan*. You may prospectively change Your election and add group health coverage for a Dependent, if such individual loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a state children's health insurance program ("SCHIP") under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code §7701 (a)(40)), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group Health Plan, subject to the terms and limitations of the applicable benefit package option(s).

- *Eligibility for Medicare or Medicaid.* You may prospectively revoke your election for group health coverage if You become eligible for coverage under Medicare or Medicaid.

- Change in Coverage Under Another Employer's Plan. You may make a prospective election change that is on account of and corresponds with a change made under another employer's plan (including a plan of the employer or a plan of the Dependent's employer), as long as:

  - The other Cafeteria Plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations, or

  - The other plan permits its participants to make an election for a Period of Coverage that is different from the Plan Year under this Cafeteria Plan or a qualified benefits plan offered by Your employer. For example, if an election is made by Your Spouse to drop coverage during their employer's open enrollment period, You may add coverage for the Dependent to replace the Dependent's dropped coverage. The Plan Administrator will determine, based on prevailing IRS guidance, whether or not a requested change is on account of and corresponds with a change made under the other employer's plan.

**CHANGE IN COST**

You may prospectively change Your election for Medical, Dental, or Vision coverage under the Plan if You experience a significant premium cost change upon changing employment status from full-time to part-time or from part-time to full-time, and in the case of the Dependent Care FSA, You experience a significant change in the cost of dependent care imposed by the dependent care provider who is not Your relative.

**FAMILY MEDICAL LEAVE ACT (FMLA) LEAVES OF ABSENCE (Does not apply to the Dependent Care Spending Account)**

*Non-Health Benefits.* If a Participant goes on a qualifying leave under the FMLA, entitlement to non-health benefits such as the Dependent Care Spending Account is to be determined by the Employer's policy for providing such Benefits when the Participant is on non-FMLA leave.

**NON-FMLA LEAVES OF ABSENCES**

If a Participant goes on an unpaid leave of absence that does not affect Eligibility, then the Participant will continue to participate and the premium due for the Participant will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Plan Administrator.

If a Participant goes on an unpaid leave that affects eligibility, the election change rules set forth by this Plan will apply.

## DEPENDENT CARE SPENDING ACCOUNT

The Dependent Care Spending Account is provided to allow You to receive benefits in the form of reimbursements for Eligible Employment-Related Expenses Incurred on behalf of a Dependent. The Dependent Care Expenses reimbursed are intended to be eligible for exclusion from gross income under Code §129(a).

### ACCOUNT MINIMUMS

The minimum annual contribution is $0.

### ACCOUNT MAXIMUM

You may contribute up to $5,000, subject to the limitations set forth under "Maximum Reimbursement Available."

You may not be reimbursed in excess of the contributions You have made at any point in time. Once You incur Covered Expenses, You may file a claim and be reimbursed for up to the maximum amount of Your account balance.

### MAXIMUM REIMBURSEMENT AVAILABLE (Calculated on a per-taxable-year basis)

You may contribute up to the *least* of the following amounts:

- The year-to-date amount that has been withheld from Your Compensation for the Dependent Care Spending Account for the Period of Coverage, less any prior reimbursements for Dependent Care Expenses during the Period of Coverage;
- Your Earned Income for the applicable month;
- Your Spouse's Earned Income for the applicable month;
- The following annual amount:
  - $5,000, if one of the following applies:
    - You are married and file a joint return;
    - You are married, but furnish more than one-half of the cost of maintaining the Dependent for whom You are eligible to receive reimbursements under the Dependent Care Spending Account, Your Spouse maintains a separate residence for the last six months of the calendar year, and You file a separate tax return; or
    - You are single or the head of the household for federal tax purposes.
  - $2,500, if You are married but You and Your Spouse file separate tax returns.
  - Your taxable Compensation (after Your Salary Reduction under the applicable benefit Plan).
  - Your Spouse's actual or deemed Earned Income.

If You are married, but Your Spouse has no Earned Income, then You are deemed to have an Earned Income of $250 per month ($500 per month if You have two or more Dependents) in each month during which Your Spouse was:

- a Full-Time Student at an educational organization during at least part of five calendar months during the calendar year; or

- incapable of self-care due to a mental or physical condition.

If Your Spouse has a Dependent Care Spending Account through their employer, Your combined contribution may not be more than $5,000. If You and Your Spouse both work for the same employer You may both contribute to the account, but may not contribute more than $5,000 combined.

**TAX CONSIDERATIONS**

The monies that You receive as Dependent Care Expenses under this flexible spending account generally are not subject to Social Security (FICA) taxes, federal taxes, or, where applicable, state or local income taxes. However, they are reported on Your W-2 form. This reporting is required by the IRS in order to ensure that taxpayers do not claim the same expenses in two places. If You are using both the tax credit and the Dependent Care Spending Account, You must reduce the amount of Dependent Care Expenses that qualify for the tax credit by the amount You received from the pre-tax Dependent Care Spending Account.

Determine whether it is more beneficial for You to use the Dependent Care Spending Account or the federal income tax credit for these expenses. You may wish to consult Your personal tax advisor. The actual determination of the preferable method for treating benefit payments depends upon a number of factors such as Your tax filing status (e.g., married, single, head of household) and the number of Dependents. You will have to determine Your individual tax position in order to make a decision between taxable and tax-free benefits.

You may not claim any other tax benefit for the pre-tax amounts You receive under this Dependent Care Spending Account, although the balance of Your Dependent Care Expenses may be eligible for the Dependent care credit.

**IRREVOCABILITY RULE**

Your election to participate in the account(s) is irrevocable for the duration of the Plan Year except as permitted when You experience a Change in Status. In the event of a Change in Status:

> You are not allowed to reduce Your election for Dependent Care Spending Account benefits to a point where the annualized contribution for such benefit is less than the amount already reimbursed.

In addition, any change in an election affecting the Dependent Care Spending Account pursuant to this section will also change the maximum reimbursement benefit for the Period of Coverage remaining in the Plan Year. The maximum reimbursement benefit following an election change is calculated as follows:

> Balance (if any) remaining in Your reimbursement account as of the end of the portion of the Plan Year immediately preceding the change in election
>
> \+ Total contributions You scheduled to make for the remainder of the Plan Year as affected by the election change
>
> ---
>
> Maximum reimbursement benefit for Period of Coverage remaining in the Plan Year

**DEPENDENT CARE EXPENSES IN GENERAL**

These expenses must meet all of the following conditions in order for them to be Eligible Dependent Care Expenses that qualify under Code §21:

- The expenses are Incurred for services rendered after the date of Your election to receive reimbursements for Dependent Care Expenses, and during the coverage period to which they apply.
- Each individual for whom You incur the expenses is a Dependent under the age of 13 for whom You are entitled to a personal tax exemption as a Dependent, or a Spouse or other tax Dependent who is physically or mentally incapable of caring for himself or herself.
- The expenses are Incurred for the care of a Dependent, or for related household services, and are Incurred to enable You to be gainfully employed.
- If the expenses are Incurred for services outside Your household and for the care of a Spouse or other Dependent age 13 or older who is Incapable of Self-Care, such individual regularly spends at least eight hours per day in Your home.
- If the expenses are Incurred for services provided by a Dependent Care center (i.e., a facility that provides care for more than six individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.
- The expenses are not paid or payable to a child of Yours who is under age 19 at the end of the year in which the expenses are Incurred or an individual for whom You or Your Spouse is entitled to a personal tax exemption as a Dependent.

Here are some examples of Dependent Care Expenses:

- Nursery schools. (The entire cost may be treated as Dependent Care Expenses only if the amount paid for schooling is incidental to, and cannot be separated from, the cost of care.)
- Day care centers.
- Day care in Your home.
- Licensed day care centers for children or adults.
- Before- or after-school programs.

**EXCLUSIONS**

The following are examples of expenses that do not qualify for reimbursement from Your Dependent Care Spending Account:

- Payments to Your child who is under age 19 and who is caring for a younger child.
- Tuition expenses for schooling in kindergarten or higher grade levels.
- Food or clothing expenses.
- Overnight camp expenses.
- Summer school.
- Tutoring programs.
- Expenses in excess of Your taxable income or that of Your Spouse, whichever is less.
- Expenses Incurred when You are not working.
- Expenses Incurred prior to the coverage date or after the Plan Year ends.
- Expenses claimed as a deduction or credit for federal or state tax purposes.
- Other expenses that do not fall within IRS guidelines.
- Expenses Incurred if Your Spouse is not engaged in gainful employment during the hours Dependent Care is needed and the Spouse is not physically or mentally disabled or otherwise incapable of caring for a Dependent(s).
- Any expenses that do not qualify under Code §21.

**FUNDING**

When You complete the Salary Reduction agreement, You specify the amount of Dependent Care Spending Account benefits for which You wish to pay with Your Salary Reduction. Thereafter, Your Dependent Care Spending Account will be credited with the portion of Your gross income that You have elected to forgo through Salary Reduction. These portions will be credited each pay period. The amount that is available for reimbursements at any particular time will be whatever has been credited to Your Dependent Care Spending Account as of the date of processing of the request for reimbursement, less any reimbursements already paid.

For example, You have elected to be reimbursed for $2,600 per year for Dependent Care Expenses. Your Dependent Care Spending Account would be credited (and funded) with a total of $2,600 during the Plan Year. Thus, if You are paid biweekly, You would have a total of $100 credited to Your Dependent Care Spending Account each payday to pay reimbursements under this Plan.

You may not be reimbursed for any expenses arising before the Dependent Care Spending Account becomes effective, before Your Salary Reduction agreement becomes effective, after the close of the Plan Year, or after a separation from service, unless otherwise specified within this SPD.

## CLAIMS AND APPEAL PROCEDURES FOR DEPENDENT CARE SPENDING ACCOUNTS (Dependent Care FSAs)

### REASONABLE AND CONSISTENT CLAIMS PROCEDURES

The Plan's claims procedures include administrative safeguards and processes that are designed to ensure and verify that benefit claim determinations are made in accordance with the applicable legal requirements. The Plan provisions will be applied consistently with respect to similarly situated individuals.

### TIMELY FILING

You will have 90 days after the end of the Plan Year or 90 days following termination to submit a claim for reimbursement for a Covered Expense Incurred during the previous Plan Year. You will be notified in writing if any claim for benefits is denied.

### PERSONAL REPRESENTATIVE

**Personal Representative** means a person (or provider) who may contact the Plan on the Covered Person's behalf to help with claims, appeals, or other benefit issues. A minor Dependent must have the signature of a parent or Legal Guardian in order to appoint a third party as a Personal Representative.

If a Covered Person chooses to use a Personal Representative, the Covered Person must submit proper documentation to the Plan stating the following: the name of the Personal Representative, the date and duration of the appointment, and any other pertinent information. In addition, the Covered Person must agree to grant their Personal Representative access to their Protected Health Information. The Covered Person should contact the Plan Administrator to obtain the proper forms. All forms must be signed by the Covered Person in order to be considered official. When dependent care claims are submitted to the Plan by a Personal Representative, it will be assumed that the Personal Representative is acting as the Personal Representative of the Participant.

### SUBMITTING DEPENDENT CARE CLAIMS

When You incur an expense that is eligible for Payment, submit a claim to UMR through Your Plan Sponsors healthcare website, through the FSA mobile application, or on a paper claim form supplied to You. Dependent care account claim forms are available at www.umr.com, through Your Human Resources Department, or by calling 1-800-826-9781. You must submit a claim form for each claim You submit.

You must submit a written statement from an independent third party (the qualified caregiver) indicating their tax identification number or Social Security number, the date the services were provided, and the amount of the expense. This documentation will fulfill the claims substantiation requirements by the IRS.

If enough contributions have been made to the Dependent Care Spending Account, You will be reimbursed for Your Covered Expenses within 30 days.

If Your claim is for an amount that exceeds Your current account balance, the excess part of the claim will be carried over into following months, to be paid as Your balance becomes adequate to cover the unpaid portion of the expense. Please note that it is not necessary for You to have actually paid an amount due for a Covered Expense. You need only to have Incurred the expense. You must also attest to the fact that the expense is not being paid for or reimbursed from any other source. Claim forms will contain this information.

**Debit Card**

The debit card provides You with an automated way to pay for Your qualified expenses. You may access the pre-tax contributions You set aside in Your FSA electronically. Each time You incur a qualified expense at an eligible location as defined by the eligible services on Your debit card and that location accepts MasterCard®, You may use Your debit card. The amount of Your qualified purchases will be deducted from Your FSA automatically.

Do not use Your debit card at locations that are not related to dependent care, such as restaurants, gas stations, or bookstores.

You must repay any improper payments that are made with Your debit card. Improper payments may be recouped in accordance with applicable IRS guidance.

**NOTIFICATION OF BENEFIT DETERMINATION**

Each time You submit a claim, You will receive a written Explanation of Benefits (EOB) form that will explain how much was paid toward the claim or that the claim was denied. If You have any questions or concerns about the EOB, call UMR at the number listed on the form.

**TIMELINES FOR INITIAL BENEFIT DETERMINATION**

The Plan will process Your claim within 30 calendar days following receipt of a claim request, but the Plan may have an additional 15-day extension when necessary for reasons beyond control of the Plan, if written notice is provided to You within the original 30-day period.

A claim is considered to be filed when a complete claim for benefits has been submitted to UMR for formal consideration under the terms of this Plan.

**CIRCUMSTANCES CAUSING LOSS OR DENIAL OF PLAN BENEFITS**

Claims may be denied for any of the following reasons:

- Termination of Your employment.
- Your loss of eligibility for coverage under the Plan.
- Charges are Incurred prior to Your Effective Date or following termination of coverage.
- You or Your Dependents reached the maximum benefits under the dependent care Plan.
- Amendment of the group flexible benefits Plan.
- Termination of the group flexible benefits Plan.
- You did not respond to a request for additional information needed to process the claim or appeal.
- Services are not covered under this Plan.
- Misuse of the Plan or other fraud.
- Failure to pay required contributions.
- Your claim submission was incomplete.
- Other reasons as stated elsewhere in this SPD.

**ADVERSE BENEFIT DETERMINATION (DENIED CLAIMS)**

**Adverse Benefit Determination** means a denial, reduction, or termination of a benefit, or a failure to provide or make Payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, or failure to provide or make Payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

If a claim is being denied, in whole or in part, You will receive an initial claim denial notice within the timelines described above. A claim denial notice, usually referred to as an EOB, will:

- Explain the specific reasons for the denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the Covered Person to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.
- Provide appropriate information as to the steps the Covered Person may take to submit the claim for appeal (review).

**APPEALS PROCEDURE FOR ADVERSE BENEFIT DETERMINATIONS**

If a Covered Person disagrees with the denial of a claim or a rescission of coverage determination, the Covered Person or their Personal Representative may request that the Plan review its initial determination by submitting a written request to the Plan as described below. An appeal filed by a provider on the Covered Person's behalf is not considered an appeal under the Plan unless the provider is a Personal Representative.

**First Level of Appeal**: This is a **mandatory** appeal level. The Covered Person must exhaust the following internal procedures before taking any outside legal action.

- The Covered Person must file the appeal within 180 days of the date they received the EOB form from the Plan showing that the claim was denied. The Plan will assume the Covered Person received the EOB form seven days after the Plan mailed the EOB form.
- The Covered Person or their Personal Representative will be allowed reasonable access to review or copy pertinent documents, at no charge.
- The Covered Person may submit written comments, documents, records, and other information related to the claim to explain why they believe denial should be overturned. This information should be submitted at the same time the written request for a review is submitted.
- The Covered Person has the right to submit evidence that their claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The review will take into account all comments, documents, records, and other information submitted that relates to the claim. This will include comments, documents, records, and other information that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision and are not under the supervision of the person who originally denied the claim.
- After the claim has been reviewed, the Covered Person will receive written notification letting them know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to the Covered Person. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above.

**Second Level of Appeal**: This is a **mandatory** appeal level. The Covered Person is required to follow this internal procedure before taking outside legal action.

- A Covered Person who is not satisfied with the decision following the first appeal has the right to appeal the denial a second time.
- The Covered Person or their Personal Representative must submit a written request for a second review within 60 calendar days following the date they received the Plan's decision regarding the first appeal. The Plan will assume the Covered Person received the determination letter regarding the first appeal seven days after the Plan sent the determination letter.
- The Covered Person may submit written comments, documents, records, and other pertinent information to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a second review is submitted.

- The Covered Person has the right to submit evidence that their claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The second review will take into account all comments, documents, records, and other information submitted that relates to the claim that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision or the first appeal, and are not under the supervision of those individuals.
- After the claim has been reviewed, the Covered Person will receive written notification letting them know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to the Covered Person. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above.

**Appeals should be sent within the prescribed time period as stated above to the following address(es).**

Note: Appeal Request forms are available at www.umr.com to assist You in providing all the recommended information to ensure a full and fair review of Your Adverse Benefit Determination. You are not required to use this form.

UMR
CLAIMS APPEAL UNIT
PO BOX 30546
SALT LAKE CITY UT 84130-0546

**TIME PERIODS FOR MAKING DECISIONS ON APPEALS**

After reviewing a claim that has been appealed, the Plan will notify the Covered Person of its decision within the following timeframes, although Covered Persons may voluntarily extend these timelines. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the Plan will provide such evidence to You free of charge and sufficiently in advance of the due date of the response to the Adverse Benefit Determination. If such evidence is received at a point in the process where the Plan is unable to provide You with a reasonable opportunity to respond prior to the end of the period stated below, the time period will be tolled to allow You a reasonable opportunity to respond to the new or additional evidence.

- Within a reasonable period of time, but no later than 60 calendar days after the Plan receives the request for review.

## PARKING AND TRANSPORTATION SPENDING ACCOUNT
**(also referred to as a Commuter Reimbursement Account – New Jersey site only)**

Parking and transportation benefits are separate from Code §125 benefits. This section is intended to qualify as a "qualified transportation fringe" benefit plan under Code§132(f) and applicable regulations. You may have up to $315 per month for parking and/or $315 per month for vanpooling and transit pass expenses credited to Your Parking and Transportation Spending Account. These allowed expenses total a maximum annual Salary Reduction of $7,560. The covered parking and transportation expenses may be adjusted each year for inflation. Your Plan Sponsor establishes a monthly coverage period and reserves the right to change the maximum election amounts as needed.

Plan the amount of Your Salary Reduction carefully because elections are irrevocable. You may not receive any refund of unused Salary Reductions from Your transportation account upon loss of eligibility under this Plan.

### WHAT IS COVERED

IRS guidelines currently determine the types of parking and transportation expenses that are eligible for reimbursement through the Parking and Transportation Spending Account. Covered Expenses are:

- Expenses for parking on or near Your work location that You incur for Your own vehicle or as a member of a car pool.
- Expenses for parking on or near a location from which You commute to work by mass transit or a Commuter Highway Vehicle.
- Expenses for purchase of a mass transit pass or voucher (e.g., for a bus or commuter train).
- Expenses for transportation in a Commuter Highway Vehicle.

### NOTE FOR TRANSIT PASS BENEFITS

A cash reimbursement or a debit card program may be provided for Your transit expenses only if no voucher is readily available for direct distribution by the employer, as defined under IRS rules.

### NOTE FOR CAR POOLERS

Only <u>one</u> member of a car pool may collect pre-tax reimbursement for parking or transportation expenses from this Plan or any other employer's parking and transportation spending account program. If You are a member of a car pool, You will need to agree with the other members on which person will participate in a plan of this type.

### WHAT IS NOT COVERED

According to current guidelines, expenses that are not eligible for reimbursement from a Parking and Transportation Spending Account include:

- Gasoline and mileage expenses for Your personal vehicle or a vehicle used in a car pool.
- Parking and/or transportation expenses for a Spouse or other Dependent.

***Guidelines governing eligible and ineligible expenses for pre-tax spending accounts have changed in the past and may change again in the future. If IRS regulations change any provisions in the current guidelines, the administration of the Plan provisions must also change accordingly.***

## SUBMITTING PARKING AND TRANSPORTATION ACCOUNT CLAIMS

In order to submit a claim, complete a Parking and Transportation Spending Account claim form online, through the Consumer Account with UMR mobile application, or on paper and send it to the address listed on the form. Claim forms can be obtained through Your Plan Sponsors healthcare website or Your Human Resources Department.

Claims must be submitted no later than March 31 following the end of the calendar year in which the expenses were Incurred or 180 days following the date on which the expenses were Incurred, if earlier. Claims submitted after that date will not be considered for reimbursement.

An eligible expense is "Incurred" on the date a service is rendered, not on the date You receive or pay the bill. Any claim You submit for reimbursement must be for at least $25, although Your last claim for any month or the end of the Plan Year may be for less.

## PROPER DOCUMENTS

You will need documentation of Your eligible parking and transportation expenses (a receipt, invoice, or payment voucher that shows the date, provider, and type of service).

## RECEIVING YOUR REIMBURSEMENT

You may be reimbursed only up to the amount already credited to Your Parking and Transportation Spending Account at the time You submit an expense. Any eligible expense that exceeds Your account balance will be reimbursed to You when Your account balance meets or exceeds the expense**.**

An explanation of the Parking and Transportation Spending Account Payment will be included with Your reimbursement check.

Your claim will not be reimbursed if:

- Charges are Incurred prior to Your Effective Date or following termination of coverage.
- The service is for Your Dependent.
- The service claimed is not an eligible expense.
- The required documentation is not provided.
- The claim is not submitted by the appropriate deadline.
- The claim form is improperly completed.

## YOUR CERTIFICATION

The benefit of using a flexible spending account is that You receive pre-tax dollars for qualified expenses. In this way, a flexible spending account alters Your income tax liability, for which You are solely responsible. UMR and this Plan are not liable for any penalties or damages as a result of an inappropriate claim being filed.

There are rules that You must follow under the terms of this Plan, which are set forth in the following certification. This certification can be found on the claim form so that each time You submit a claim, You can refer to the rules that You must follow when submitting claims to Your flexible spending account.

I certify that the expenses for which I am requesting reimbursement meet all of the conditions listed below:

- They were Incurred for services or supplies received by me or my eligible Dependents under the Plan.
- They were for services and/or supplies furnished on or after the Effective Date of my Dependent Care Spending Account.
- I have not been reimbursed for these expenses in any other way or from any other source.

I understand that reimbursement of these expenses should be requested and made only after I have collected all benefit payments available from all Plans under which my eligible Dependents and I are covered.

I further certify that I have not deducted, nor will I deduct, on my individual income tax return any of the expenses reimbursed through my Dependent Care Spending Account. I understand that reimbursement will be made in accordance with the provisions of the Dependent Care Spending Account plan. I accept responsibility for the proper treatment of benefits paid under this Plan with respect to eligibility, income tax reporting, and liability.

## FRAUD

Fraud is a crime for which an individual may be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a Covered Person to file a claim containing any false, incomplete, or misleading information with intent to injure, defraud, or deceive the Plan. In addition, it is a fraudulent act when a Covered Person willfully and knowingly fails to notify the Plan regarding an event that affects eligibility for a Covered Person. Notification requirements are outlined in this SPD and other Plan materials. Please read them carefully and refer to all Plan materials that You receive (e.g., COBRA notices). A few examples of events that require Plan notification are divorce, a Dependent aging out of the Plan, and enrollment in other group health coverage while on COBRA. (Please note that the examples listed are not all-inclusive.)

These actions will result in denial of the Covered Person's claim or in termination of the Covered Person's coverage under the Plan, and are subject to prosecution and punishment to the full extent under state and/or federal law.

Each Covered Person must:

- File accurate claims. If someone else, such as the Covered Person's Spouse or another family member, files claims on the Covered Person's behalf, the Covered Person should review the claim form before signing it;
- Review the Explanation of Benefits (EOB) form. The Covered Person should make certain that benefits have been paid correctly based on their knowledge of the expenses Incurred and the services rendered;
- Provide complete and accurate information on claim forms and any other forms. They should answer all questions to the best of their knowledge; and
- Notify the Plan when an event occurs that affects a Covered Person's eligibility.

Covered Persons concerned about any of the charges that appear on a bill or EOB form, or who know of or suspect any illegal activity, should call the toll-free hotline at 1-800-356-5803. All calls are strictly confidential.

# RECORDKEEPING AND ADMINISTRATION

## PLAN ADMINISTRATOR

The administration of this Plan is under the supervision of the Plan Administrator. It is the principal duty of the Plan Administrator to see that this Plan is administered, in accordance with its terms, for the exclusive benefit of persons entitled to participate in this Plan without discrimination among them.

## POWERS OF THE PLAN ADMINISTRATOR

The Plan Administrator has such duties and powers as it considers necessary or appropriate to discharge its duties. It has the exclusive right to interpret the Plan and to decide all matters thereunder, and all determinations of the Plan Administrator with respect to any matter hereunder will be conclusive and binding upon all persons. Without limiting the generality of the foregoing, the Plan Administrator has the following discretionary authority:

- To construe and interpret this Plan, including all possible ambiguities, inconsistencies, and omissions in the Plan and related documents, and to decide all questions of fact, questions related to eligibility and participation, and questions of benefits under this Plan to prescribe procedures to be followed and the forms to be used to make elections pursuant to this Plan;
- To prepare and distribute information explaining this Plan and the benefits under this Plan in such a manner as the Plan Administrator determines to be appropriate;
- To request and receive such information as the Plan Administrator, from time to time, determines to be necessary for the proper administration of this Plan, including information to confirm a person's eligibility for or entitlement to benefit under any benefit program of the Plan;
- To furnish each Participant with such reports with respect to the administration of this Plan as the Plan Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's Compensation has been reduced in order to provide benefits under this Plan;
- To receive, review, and keep on file such reports and information concerning the benefits covered by this Plan as the Plan Administrator determines to be necessary and proper;
- To appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary and advisable, including legal counsel and benefit consultants;
- To sign documents for the purpose of administering this Plan, or to designate an individual or individuals to sign documents for the purpose of administering this Plan;
- To secure independent medical or other advice and require such evidence as it deems necessary to decide upon any claim or appeal; and
- To maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable Disclosure and reporting requirements.

## RELIANCE

The Plan Administrator may rely upon the direction, information, or election of a Participant as being proper under the Plan and will not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Plan Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions, and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Plan Administrator.

## COMPENSATION OF PLAN ADMINISTRATOR

Unless otherwise determined by the employer and permitted by law, any Plan Administrator who is also an Employee of the employer will serve without Compensation for services rendered in such capacity, but all reasonable expenses Incurred in the performance of their duties will be paid by the employer.

**INABILITY TO LOCATE PAYEE**

The Plan Administrator will make reasonable efforts to locate Participants. In the event that the Plan Administrator is unable to make benefit Payment to a Participant, the Plan Administrator will hold benefit Payment until the location of the Participant is known or until one year after the end of the Plan Year in which the benefit was payable.

**EFFECT OF MISTAKE**

In the event of a mistake as to eligibility, allocation of elected contribution amounts, or the Payment of benefits under the Plan, the Plan Administrator reserves the right to correct the mistake, to the extent possible, using any available legal means.

# GENERAL PROVISIONS

## EXPENSES

All reasonable expenses Incurred in administering the Plan are currently paid by forfeitures to the extent provided by the Plan, and then by the employer.

## NO CONTRACT OF EMPLOYMENT

Nothing herein is intended to be or will be construed as constituting a contract or other arrangement between any eligible Employee and the employer to the effect that such Employee will be employed for any specific period of time. All Employees are considered to be employed at the will of the employer.

The Plan Sponsor fully intends to maintain this Plan indefinitely; however, the employer reserves the right to terminate, suspend, or amend this Plan at any time, in whole or in part, including making modifications to the benefits under this Plan. No person or entity has any authority to make any oral change or amendments to this Plan.

The Plan Administrator will provide written notice to You within 60 days following an adopted formal action that makes material changes to the Plan.

## AUTHORIZED AGENT TO SIGN AND AUTHORIZE AMENDMENT

Any amendment that is signed and acknowledged by the employer will be deemed to be a valid amendment.

## YOUR RIGHTS IF PLAN IS AMENDED OR TERMINATED

If this Plan is amended, Your rights are limited to Plan benefits in force at the time expenses are Incurred, whether or not You have received written notification from the Plan Administrator that the Plan has been amended.

If this Plan is terminated, Your rights are limited to Covered Expenses Incurred before You receive notice of termination.

The Plan will assume that You receive the written amendment or termination letter from the Plan three days after the Plan mails the letter to You regarding the changes.

No person will become entitled to any vested rights under this Plan.

## FORUM FOR LAWSUITS

All lawsuits arising under or relating to a component benefit program that is self-insured by the Plan Sponsor must be submitted to the United States District Court for the Southern District of Texas. Lawsuits arising under or relating to a fully insured component benefit program must be submitted to the United States District Court for the Southern District of Texas if they name as a party the Plan Sponsor or an affiliate, an employee of the Sponsor or an affiliate, a Plan committee or a member of such a committee, or the Plan itself. By participating in the Plan, or by asserting an entitlement to any right or benefit under the Plan, each Participant or Beneficiary consents to the exercise of personal jurisdiction over that person by the United States District Court for the Southern District of Texas, and waives any argument that that forum is not a convenient forum in which to resolve the lawsuit. 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 (to which the Participant or Beneficiary likewise consents to the personal jurisdiction over that person), or if that court lacks jurisdiction, then the lawsuit may be brought in any United States federal or state court that does have jurisdiction.

## CODE COMPLIANCE

It is intended that this Plan meet all applicable requirements of the Code and of all regulations issued thereunder. This Plan will be construed, operated, and administered accordingly, and in the event of any conflict between any part, clause, or provision of this Plan and the Code the provisions of the Code will be deemed controlling, and any conflicting part, clause, or provision of this Plan will be deemed superseded to the extent of the conflict.

In the event that the Plan fails a nondiscrimination test, the Plan Administrator reserves the right to decrease contribution levels of Highly Compensated or Key Employees.

## NO GUARANTEE OF TAX CONSEQUENCES

Neither the Plan Administrator nor the employer makes any commitment or guarantee that any amounts paid to or for Your benefits under this Plan will be excludable from gross income for federal, state, or local income tax purposes. It will be Your obligation to determine whether each Payment under this Plan is excludable from Your gross income for federal, state, and local income tax purposes, and to notify the Plan Administrator if there is any reason to believe that such Payment is not excludable.

## INDEMNIFICATION OF EMPLOYER

If You receive one or more Payments or reimbursements that are not for Medical Care Expenses or for Dependent Care Expenses, You must indemnify and reimburse the employer for such amounts, including any liability the employer may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such Payments or reimbursements. Any such amounts may be withheld from an Employee's paycheck to the extent permitted by law. If, at the end of the Plan Year, You have not reimbursed the Plan for the improper Payment, the Plan Sponsor will treat the improper Payment as it would any other business debt.

## NON-ASSIGNABILITY OF RIGHTS

Your right to receive any reimbursement under this Plan will not be alienable by assignment or any other method and will not be subject to claims by Your creditors through any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

## FORFEITURE OF STALE CHECKS

Any checks that you receive for reimbursement of expenses must be cashed on a timely basis. In particular, the Plan may stop payment on any check that has not been deposited or cashed within one year after the close of the Plan Year in which the check was issued. Any such amounts will be forfeited and used to defray the reasonable expenses associated with administering this Plan.

## PLAN HEADINGS

The headings of the various articles and sections (but not subsections) are inserted for convenience of reference and are not to be regarded as part of this Plan or as indicating or controlling the meaning or construction of any provision.

## PLAN PROVISIONS CONTROLLING

In the event that the terms or provisions of any summary or description of this Plan, or of any other instrument, are in any construction interpreted as being in conflict with the provisions of the Plan, the provision of this Plan will be controlling.

## SEVERABILITY

Should any part of this SPD be invalidated by a court of competent jurisdiction, the remainder of the SPD will be given effect to the maximum extent possible.

## GLOSSARY OF TERMS

**Adverse Benefit Determination** means a denial, reduction, or termination of a benefit, or a failure to provide or make Payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, or failure to provide or make Payment that is based on a determination that You are no longer eligible to participate in the Plan.

**Cafeteria Plan** means a written plan in which all participants are Employees who may choose between two or more benefits consisting of cash and "qualified benefits" as permitted by Code §125.

**Change in Cost** means a significant cost increase or a significant cost decrease as determined by the Plan Administrator that applies uniformly to all Covered Persons. A Dependent care provider who is a relative of the Employee may not impose the cost change. A relative is an individual who is related as described in Code §152(d), incorporating the rules of Code §152(f).

**Change in Coverage** means a prospective election change by a Covered Person that is on account of and corresponds with a Plan benefit change by the employer.

**Change in Status** means any of the events described in the Change in Status section of this SPD.

**COBRA** means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time, and applicable regulations. This law gives a Covered Person the right, under certain circumstances, to elect continuation coverage under the Plan when active coverage ends due to a Qualifying Event.

**Code** means the Internal Revenue Code of 1986, as amended.

**Compensation** means the wages or salary paid to an Employee by the employer, determined prior to any Salary Reduction election under this Plan, prior to any Salary Reduction election under any other Code §125 Cafeteria Plan, and prior to any salary deferral election under any Code §401(k), 403(b), or 408(k) arrangement.

**Covered Expense** means any expense, or portion thereof, that is Incurred as a result of receiving an eligible benefit under the Dependent Care Spending Account, whichever is applicable.

**Covered Person** means You and each of Your Dependents who are enrolled in component benefit plans offered by Your employer under this Plan.

**Dependent** means any individual who:

- An individual as defined in Code §21(b)(1) with respect to the Participant
    - A dependent of the taxpayer who is under the age of 13 and with respect to whom the taxpayer is entitled to a deduction under Code section 151(c), or
    - A dependent of the taxpayer who is physically or mentally Incapable of Self Care for himself/herself, or
    - The Spouse of the taxpayer, if he/she is physically or mentally Incapable of Self Care for himself/herself
- In the case of divorced parents, a child will, as provided in Code §21(e)(5), be treated as a Dependent of the custodial parent and will not be treated as a Dependent of the non-custodial parent.

If You are uncertain about the qualifying status of the Qualifying Individual, consult Your local IRS office.

**Dependent Care Expenses** means expenses that are considered to be Eligible Employment-Related Expenses under Code §21(b)(2) (related to expenses for household and Dependent Care Services necessary for gainful employment of the Employee and Spouse, if any), if paid for by the Employee to provide qualifying Dependent Care Services.

**Dependent Care Services** means services related to the care of a Qualifying Individual that enable the Covered Person and Spouse to remain gainfully employed and that are performed inside or outside the Covered Person's home for:

- The care of a Dependent of the Covered Person who is under age 13.
- The care of any other Qualifying Individual that resides at least eight hours per day in the Covered Person's household.

If the expenses are Incurred for services provided by a Dependent care center (i.e., a facility that provides care for more than six individuals not residing at the facility), then the center must comply with all applicable state and local laws and regulations.

**Dependent Care Spending Account** means the Dependent Care Spending Account as described in this Plan.

**Earned Income** means all income derived from wages, salaries, tips, self-employment, and other Employee Compensation (such as disability or wage continuation benefits), but does not include:

- Any amounts received pursuant to any Dependent care assistance program under Code §129.
- Any amounts received as a pension or annuity.
- Any amounts received pursuant to Workers' Compensation.

**Effective Date** means the first day of coverage under this Plan as defined in this SPD.

**Eligible Employment-Related Expenses** means those qualifying Dependent Care Services Incurred incident to maintaining employment after the date of the Employee's participation in the Dependent Care Spending Account of this Plan and during the Plan Year, other than amounts paid to:

- An individual with respect to whom a Dependent deduction is allowable under Code §151(c) to the Participant or their Spouse.
- The Participant's Spouse.
- A child of the Participant (within the meaning of Code §152(f)) who is under 19 years of age at the end of the year in which the expenses were Incurred.

For this purpose, a Dependent Care Expense is Incurred only after the services giving rise to the expense have actually been rendered.

**Employee** - see the Eligibility and Enrollment section of this SPD.

**Full-Time Student or Student** means a Student attending high school or an Accredited Institution of Higher Education. In order to be considered a Full-Time Student, a Dependent must receive at least the minimum number of credits determined by the school to be full-time, or the equivalent if the school operates on an alternative-term basis. Alternatively, the Student must meet the accredited college's or university's definition of Full-Time Student. A Student attending a combination of accredited institutions and whose total combined credits meet the requirements listed in this paragraph will also qualify as a Full-Time Student. With respect to a licensed trade school, the Plan requires enrollment in a six-month or longer training program for at least 20 hours per week that awards a formal certification upon graduation, and the school must be accredited by a national governing body.

**Health Plan** means any individual or group plan, private or governmental, that provides or pays for medical care, to the extent specified in the HIPAA Privacy Regulation, 65 Fed. Reg No. 250 (82463).

**Highly Compensated Employee** means an Employee in whose favor discrimination is prohibited under provisions of the Code that apply to Cafeteria Plans and certain other benefit plans. The specific definition differs depending upon the type of plan and the nondiscrimination requirement at issue.

**Incapable of Self-Care** means incapable of caring for one's hygienic or nutritional needs, or requiring full-time attention of another person for one's own safety or the safety of others.

**Incurred** means the date on which a service or treatment is given, a supply is received, or a facility is used, without regard to when the service, treatment, supply, or facility is billed, charged, or paid.

**Independent Contractor** means someone who signs an agreement with the employer as an Independent Contractor, or an entity or individual who performs services to or on behalf of the employer, who is not an Employee or an officer of the employer, and who retains control over how work is completed. The employer who hires the Independent Contractor controls only the outcome of the work and not the performance of the hired service. Determination as to whether an individual or entity is an Independent Contractor will be made consistent with §530 of the Internal Revenue Code.

**Key Employee** means an Employee who is an officer or shareholder of the employer (as further defined in Code §416) and in whose favor discrimination is prohibited under provisions of the Code that apply to Cafeteria Plans and certain other benefit plans.

**Participant** means a person who is an eligible Employee and who is participating in this Plan in accordance with the applicable provisions of this Plan.

**Period of Coverage** means the Plan Year for Code §213(d) benefits, with the following exceptions: (1) for Employees who first become eligible to participate, it means the portion of the Plan Year following the date participation commences, and (2) for Employees who terminate participation, it means the portion of the Plan Year prior to the date participation terminates.

**Plan Administrator** means THE LUBRIZOL CORPORATION.

**Plan Sponsor** means any employer who sponsors a group Health Plan.

**Plan Year** means the consecutive 12-month period of time, designated in the Plan Information section of this SPD, during which the Plan is maintained.

**Protected Health Information** means Individually Identifiable Health Information that is transmitted by electronic media, maintained in any medium that is considered an electronic medium, or transmitted or maintained in any other form or medium.

**Qualifying Individual** for purposes of the Dependent Care Spending Account, means:

- A Dependent of the Covered Person who is under the age of 13.
- A Dependent of a Covered Person who is mentally or physically Incapable of Self-Care.
- The Spouse of a Covered Person who is mentally or physically Incapable of Self-Care.

**Salary Reduction** means the amount by which the Covered Person's Compensation is reduced and applied by the employer under this Plan to pay for one or more of the benefits provided under this Plan.

**Spouse** means an individual who is legally married to a Participant (and who is treated as a Spouse under the Code). Notwithstanding the above, for purposes of the Dependent Care Spending Account, the term "Spouse" does not include:

- An individual legally separated from the Participant under a divorce or separate maintenance decree.
- An individual who, although married to the Participant, files a separate federal income tax return, maintains a separate principal residence from the Participant during the last six months of the taxable year, and does not furnish more than half of the cost of maintaining the principal place of residence of the Participant.

**Third Party Administrator (TPA)** is a service provider hired by the Plan to process claims and perform other administrative services. The TPA does not assume liability for Payment of benefits under this Plan.

**You / Your** means the Employee.