The Lubrizol Corporation
Retiree Health Reimbursement Arrangement
Summary Plan Description

January 1, 2024 Restatement

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Introduction

This Health Reimbursement Account (HRA) Summary Plan Description ("SPD") describes The Lubrizol Corporation Retiree Health Reimbursement Arrangement ("HRA Plan" or "Plan") in which you may be able to participate as a retiree of The Lubrizol Corporation ("Company" or "Sponsor") or a participating subsidiary of the Company. This summary is intended to meet the requirements for a Summary Plan Description (SPD) under the Employee Retirement Income Security Act (ERISA) of 1974, as amended (ERISA).

The purpose of the HRA Plan is to reimburse eligible retirees for certain health care expenses which are not otherwise reimbursed. The HRA Plan is intended to qualify as a self-insured health care reimbursement plan for purposes of Sections 105 and 106 of the Internal Revenue Code, as amended ("Code"), as well as a health reimbursement arrangement as defined in IRS Notice 2002-45. This Plan is also intended to be exempt from the Patient Protection and Affordable Care Act ("ACA") as a separate "retiree-only" plan pursuant to ERISA Section 732(a) and IRC Section 9831(a)(2).

Read this Summary carefully so you understand the provisions of the HRA and how you can use the HRA Plan to your advantage.

This Summary describes the current provisions of the HRA Plan which is designed to comply with applicable legal requirements. The HRA Plan is subject to federal laws, such as the Internal Revenue Code (IRC), the Employee Retirement Income Security Act (ERISA) and other federal and state laws which may affect your rights. The provisions of the HRA Plan are subject to revision due to changes in laws or due to pronouncements by the Internal Revenue Service (IRS) or other federal agencies.

Note that this booklet and the incorporated documents are only a summary. If there are any differences between the information in this SPD and in the official legal plan document, the official legal plan document will govern, with one exception. If there is language in the SPD regarding a topic the official legal plan document is silent on, the language in this SPD will govern.

Note that terms used in this SPD are defined the first time they are used. Please note that "you," "your" and "my" when used in this SPD refer to you, the retiree, or your enrolled dependent as the context indicates.

The Company's Right to Amend or Terminate the Plan

Although the Company expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time for any reason, including the right to change the classes of persons eligible for participation, to change the amount credited to HRA accounts or to reduce or eliminate any amounts currently credited to a Participant's HRA account. If the provisions of the Plan described in this SPD change, you will be notified.

Employers participating in the Plan other than the Sponsor (such as a related affiliate of the Sponsor) may terminate their participation in the Plan at any time upon 60 days written notice to the Sponsor and Plan Administrator.

How the HRA Works

A Health Reimbursement Arrangement (HRA) is a recordkeeping reimbursement account the Company establishes on your behalf. Each year, the Company credits a specific dollar amount to your HRA to help cover the cost of eligible health care expenses for you and your covered dependents as described in this SPD. You can use the HRA to reimburse yourself for eligible expenses you and your eligible dependents incur. This SPD describes the eligible expenses that are reimbursable from your HRA.

Only the Company can contribute to your HRA. The HRA is a bookkeeping account on your employer's records only, with all reimbursements being paid from your employer's general assets. The IRS does not permit you to contribute your own money to an HRA.

The HRA is not funded and cannot earn interest or earnings of any kind. Reimbursements under the HRA are paid from the Company's general assets.

You do not pay taxes on the HRA contributions or the amounts you are reimbursed from the HRA for eligible health care expenses.

Your Eligibility

The HRA Plan provides for a benefit for Pre-Medicare Retirees (and their eligible spouses) and a separate benefit for Medicare Retirees (and their eligible dependents). To be an eligible Pre-Medicare Retiree, you must have been employed by The Lubrizol Corporation or a participating subsidiary and satisfy the following criteria:

- Hired or rehired on or before December 31, 2017
- Completed 15 years of qualifying service as of retirement date
- Attained age 55 as of retirement date
- Retired on or before December 31, 2024
- Not be eligible for Medicare
- Not be covered by disqualifying coverage
- Has timely opted in to participate and thereafter continuously participates in the Plan
- Has completed any enrollment forms or procedures required by the Plan Administrator

To be an eligible Medicare Retiree, you must have been employed by The Lubrizol Corporation or a participating subsidiary and satisfy the following criteria:

- Completed 15 years of qualifying service as of retirement date
- Attained age 55 as of retirement date
- Eligible for Medicare

- Was eligible for subsidized retiree Medicare coverage at the time of your retirement (retired prior to January 1, 2008, and Noveon employees who were eligible for retiree medical and retired prior to January 1, 2006)
- Has completed any enrollment forms or procedures required by the Plan Administrator.

Pre-Medicare Retirees and Pre-Medicare Retiree Spouses must timely opt in to the Plan to receive Benefit Credits.

- Pre-Medicare Retirees who retired before 2024 and their Pre-Medicare Retiree Spouses who opted in to the Plan prior to 2024 do not need to take additional action to opt in to the Plan.
- Pre-Medicare Retirees who retired before 2024 and their Pre-Medicare Retiree Spouses who did not opt in to the Plan before 2024 must opt in to the Plan not later than March 31, 2024 in order to continue participating and receiving Benefit Credits.
- Pre-Medicare Retirees who retire in 2024 and their Pre-Medicare Retiree Spouses must opt in to the HRA Plan during their "opt-in window," which is the three-month period starting on the first day of the month following the Pre-Medicare Retiree's retirement date.

> *Example:* Pre-Medicare Retiree retires March 31, 2024. The opt-in window for the Pre-Medicare Retiree and the Pre-Medicare Retiree Spouse (if any) is April 1, 2024 – June 30, 2024.
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> *Example:* Pre-Medicare Retiree retires April 1, 2024. The opt-in window for the Pre-Medicare Retiree and the Pre-Medicare Retiree Spouse (if any) is May 1, 2024 – July 31, 2024.

Pre-Medicare Retirees and Pre-Medicare Retiree Spouses can enroll in the HRA Plan by contacting Via Benefits at 866 356-8150.

Important: A Pre-Medicare Retiree or a Pre-Medicare Retiree Spouse who does not timely opt in to the Plan will not be eligible to opt in to the Plan at a later date, unless the individual's failure to opt in was to enable the individual to take advantage of the Federal Advance Premium Tax Credit for the year. In that case, the individual, if otherwise eligible for Pre-Medicare Benefit Credits under the HRA Plan, will be permitted to opt in in a later year for which the individual does not intend to use the Federal Premium Tax Credit. If you are non-Medicare eligible, you cannot receive both the FAPTC and Benefit Credits under this HRA Plan.

Effective January 1, 2024, Pre-Medicare Retirees and their spouses are not eligible to receive Benefit Credits in the HRA Plan if covered by a group health plan or by COBRA coverage. Pre-Medicare Retirees and their spouses who were enrolled in the Plan prior to 2024, and are covered by disqualifying coverage, should contact Via Benefits at 866 356-8150 to opt out of receiving Benefit Credits. Even if no longer eligible for Benefit Credits, Pre-Medicare Retirees and Pre-Medicare Retiree Spouses who had an unused accumulated balance of Benefit Credits as of December 31, 2023, will be permitted to incur eligible health care expenses against that balance

through December 31, 2024, and receive reimbursement. See “Special Rule for Accumulated Unused Benefits Credits from 2023 and Earlier.”

You are not eligible to participate in the HRA Plan unless you are classified by the Company as a former employee who satisfies the eligibility requirements, even if you are later determined by a court or governmental agency to be or to have been a former employee of the Company. If you return to employment with the Company, you will be ineligible to participate in the HRA Plan as of the time your employment starts, and you will be unable to re-enter the HRA Plan at any point thereafter.

Dependent Eligibility

The Company allocates separate Benefit Credits for your covered dependents.

If your covered dependents meet all the eligibility requirements as described below, they may become participants in the HRA. A Medicare Retiree does not have to be a qualified participant in the HRA Plan for the Medicare Retiree’s eligible dependents to be a Participant. A Pre-Medicare Retiree must be a qualified participant (or, prior to 2025, have been a qualified participant before reaching Medicare eligibility) for the Pre-Medicare Retiree Spouse to be an eligible dependent.

If the dependent participates in another group health plan sponsored by the Company, that dependent will not be eligible for the HRA Plan. Important: A dependent enrolled in the HRA Plan who is or becomes enrolled in other Company coverage must promptly notify the HRA Plan of the dependent’s enrollment in other Company coverage.

For Medicare Retirees, your eligible dependents are your Medicare-eligible Spouse and your Medicare-eligible dependent child.

For Pre-Medicare Retirees, your eligible dependent is your Spouse.

Your Spouse is defined as the following:

- If you are an eligible retiree whose retirement date occurred in 2023 or earlier, your Spouse is:
  - Your legally married husband or wife as of December 31, 2023, if Benefit Credits were made to your HRA Account for that husband or wife in 2023 or earlier.
  - Your legally married husband or wife as of March 31, 2024, if that husband or wife was a Pre-Medicare Retiree Spouse who opted in to the HRA Plan for Benefit Credits during the January 1, 2024 – March 31, 2024 opt-in window (or would have been eligible to make an election, but did not do so in order to take advantage of the Federal Advance Tax Premium Credit).

If you are an eligible retiree whose retirement date occurred in 2024, your Spouse is your legally married husband or wife at the time of your retirement who timely made an election for Benefit Credits during the applicable election window (or would have been eligible to make such election, but did not do so in order to take advantage of the Federal Advance Tax Premium Credit).

If you were not married as of the above dates, or you were married but your husband or wife did not timely enroll in the HRA Plan, you will not be able to add a spouse to the HRA Plan later. You are required to provide proof of dependent status upon request by the Plan Administrator (or its designee). Failure to provide such proof may result in a delay in benefits provided under the Plan.

If the Retiree Dies

If an eligible retiree with an HRA account in the Plan dies, the retiree's eligible dependents will continue their participation in the Plan as follows:

- *Medicare Retiree Dependents:* The Medicare Retiree Spouse or Medicare-eligible Dependent child will continue to participate in the HRA Plan. However, the Medicare-eligible Dependent child's participation will continue only for so long as the Medicare Retiree Spouse participates in the HRA Plan.
- *Pre-Medicare Retiree Spouse:* The Pre-Medicare Retiree Spouse will continue to receive Benefit Credits for the Plan Year next following the Plan Year in which the Pre-Medicare Retiree's death occurs (such later Plan Year, the "Post-Death Plan Year"), and no Benefit Credits thereafter. However, if either of the following conditions applies, the Pre-Medicare Retiree Spouse will receive no further Benefit Credits after the Plan Year of the Pre-Medicare Retiree's Death:
- The Pre-Medicare Retiree or Pre-Medicare Retiree Spouse attained, or would have attained, eligibility for Medicare in the Plan Year of the Pre-Medicare Retiree's death.
- The Pre-Medicare Retiree Spouse is Medicare-eligible on the first day of the Post-Death Plan Year.

Survivor Benefits. If an eligible retiree dies with no eligible dependents who are participants in the HRA Plan, the retiree's HRA account is immediately forfeited upon death, but the deceased retiree's estate or representatives may submit claims for eligible medical expenses incurred by the eligible retiree and the retiree's eligible dependents before the retiree's death. Claims must be submitted within the earlier of March 31st of the Plan Year following the eligible retiree's death, or six months after the eligible retiree's death.

When Participation Begins

A Pre-Medicare Retiree or Pre-Medicare Retiree Spouse will be eligible for the Pre-Medicare Retiree Benefit Credits if they have timely opted in to the HRA Plan beginning the month following retirement (or as soon thereafter as administratively practicable).

A Medicare Retiree or a Medicare Retiree Dependent will be eligible for the Medicare Benefit Credits if they have satisfied all of the following requirements:

- They have become eligible for Medicare. If you are a Pre-Medicare Retiree or Pre-Medicare Retiree Spouse who will become eligible for Medicare Benefit Credits under the HRA Plan once you reach Medicare eligibility, your first Medicare Benefit Credits will not be made until the January 1st (or as soon thereafter as administratively practicable) coinciding with or following your Medicare eligibility date. You will receive a full (non-prorated) allocation for the year in which you reach Medicare eligibility.
- They have completed any enrollment forms or procedures required by the Plan Administrator.

Note: Medicare Retirees and their eligible Dependents are a closed group. As of January 1, 2024, there are no current Pre-Medicare Retirees who will become eligible for Medicare Benefit Credits when they attain Medicare eligibility.

Benefit Credits

One HRA account will be established for all participants in your family. Benefit credits for all participants in your family will be made to that one HRA account.

Benefit Credits to your HRA are made annually in the following amounts:

- Medicare Retiree: $1,200.00
- Medicare Retiree Spouse or Medicare Eligible Dependent: $1,200.00
- Pre-Medicare Retiree: $6,000.00 (subject to proration)
- Pre-Medicare Retiree Spouse: $3,000.00 (subject to proration)

Benefit Credits for eligible Medicare Retirees and their Medicare Retiree Dependents are made soon as soon as administratively practicable for the first year of eligibility, and in January for following years of eligibility. Benefit Credits for eligible Pre-Medicare Retirees and Pre-Medicare Retiree Spouses are made as soon as administratively practicable following the individual's opting in to the HRA Plan, and in January for following years of eligibility.

Benefit Credits in the HRA account will be reduced from time to time by the amount of any eligible health care expenses for which the participant is reimbursed under the HRA Plan. At any time, the participant may receive reimbursement for eligible health care expenses up to the amount in the HRA.

Benefit Credits for a Plan Year may be used to reimburse eligible health care expenses incurred only in the same Plan Year in which the Benefit Credits were allocated. The deadline for submitting eligible health expenses incurred in a Plan Year is the following March 31st, after which any unused amounts from the prior Plan Year will be forfeited.

There is a special rule for pre-2024 unused HRA amounts; see "Special Rule for Accumulated Unused Benefits Credits from 2023 and Earlier" immediately below. Note that remaining HRA contributions cannot be paid in cash or other form of distribution, other than through reimbursement of actual eligible health care expenses incurred while you are eligible.

Proration of Benefit Credits for Pre-Medicare Retirees and Pre-Medicare Retiree Spouses. Benefit credits for Pre-Medicare Retirees and Pre-Medicare Retiree Spouses are prorated based on retirement date and on attainment of Medicare eligibility.

Proration based on Retirement Date. If a Pre-Medicare Retiree retires after January 1st, Benefit Credits for the Pre-Medicare Retiree and their Pre-Medicare Retiree Spouse, as applicable, will be prorated for the year of retirement.

> *Example:* A Pre-Medicare Retiree who retires on March 31, 2024, is eligible for the HRA on April 1, 2024, the first day of the month following the retirement date. If they timely opt in to the HRA Plan, the Pre-Medicare Retiree and the Pre-Medicare Retiree Spouse will be eligible for prorated contributions of $4,500.00/$2,250.00 (9/12 multiplied by $6,000.00/$3,000.00) in Benefit Credits, respectively, for 2024.

Proration based on Medicare Eligibility Date. Benefit Credits for Pre-Medicare Retirees and Pre-Medicare Retiree Spouses will also be prorated based on the date of attainment of Medicare eligibility.

> For the Pre-Medicare Retiree, Benefit Credits will be prorated for the year in which the Pre-Medicare Retiree reaches Medicare eligibility, based on the Pre-Medicare Retiree's Medicare-eligibility date. Once a Pre-Medicare Retiree is eligible for Medicare on January 1st of the year, the Pre-Medicare Retiree will no longer be eligible for Benefit Credits for that year or any year thereafter.
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> > *Example:* Pre-Medicare Retiree becomes eligible for Medicare on July 1, 2026. The Pre-Medicare Retiree will receive a prorated contribution of $3,000.00 (6/12 multiplied by $6,000) in Benefit Credits for 2026. No Pre-Medicare contributions will be made for the Pre-Medicare Retiree for 2027 or any later year.
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> For the Pre-Medicare Retiree Spouse, proration for Medicare eligibility will apply starting in 2025. Benefit Credits for the Pre-Medicare Retiree Spouse will be prorated based on the Pre-Medicare Retiree's Medicare eligibility date or the Pre-Medicare Retiree Spouse's Medicare eligibility date, whichever occurs first. Once the Pre-Medicare Retiree or the Pre-Medicare Retiree Spouse is eligible for Medicare on January 1st of the year, no contributions will be made for the Pre-Medicare Retiree Spouse for that year or any year thereafter.
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> > *Example:* Pre-Medicare Retiree becomes eligible for Medicare on July 1, 2026. Pre-Medicare Retiree Spouse becomes eligible for Medicare on November 1, 2026. For 2026, Benefit Credits will be allocated as follows: (i) the Pre-Medicare Retiree will receive a prorated contribution of $3,000.00 (6/12 multiplied by $6,000.00), and (ii) the Pre-Medicare Retiree Spouse will receive a prorated

contribution of $1,500.00 (6/12 multiplied by $3,000.00), based on the Pre-Medicare Retiree's earlier Medicare eligibility date. No Pre-Medicare contributions will be made for the Pre-Medicare Retiree or the Pre-Medicare Retiree Spouse for 2027 or any year thereafter.

Example: Pre-Medicare Retiree becomes eligible for Medicare on July 1, 2026. Pre-Medicare Retiree Spouse becomes eligible for Medicare on February 1, 2025. The Pre-Medicare Retiree will receive a full allocation of $6,000.00 in Benefit Credits for 2025, a prorated contribution of $3,000.00 in Benefit Credits for 2026, and no contribution for 2027 or thereafter. The Pre-Medicare Retiree Spouse will receive a prorated contribution of $250.00 (1/12 multiplied by $3,000.00) in Benefit Credits for 2025 based upon the Pre-Medicare Retiree Spouse's earlier Medicare eligibility date, and no Pre-Medicare contribution for 2026 or thereafter.

Example: Pre-Medicare Retiree becomes eligible for Medicare on October 1, 2024. Pre-Medicare Retiree Spouse becomes eligible for Medicare on April 1, 2025. The Pre-Medicare Retiree will receive a prorated allocation of $4,500.00 (9/12 multiplied by $6,000.00) in Benefits Credits for 2024, and no contribution for 2025 or thereafter. Pre-Medicare Retiree Spouse will receive a full allocation of $3,000.00 for 2024 (proration does not apply to the Pre-Medicare Retiree Spouse's Benefit Credits until 2025), and no Pre-Medicare allocation for 2025 or thereafter due to Pre-Medicare Retiree's attainment of Medicare eligibility in 2024.

If a Pre-Medicare Retiree or a Pre-Medicare Retiree Spouse is also eligible for the Medicare HRA, Medicare HRA Benefit Credits for the applicable individual will commence as of the January 1 coinciding with or immediately following that individual's attainment of Medicare eligibility. Benefit Credits for the year of Medicare eligibility are not prorated. A Pre-Medicare Spouse who is eligible for Medicare Benefit Credits and who reaches Medicare eligibility after the Pre-Medicare Retiree will continue to receive Pre-Medicare Benefit Credits until the Pre-Medicare Retiree Spouse is eligible for Medicare Benefit Credits. Note: As of January 1, 2024, the group eligible for Medicare Benefit Credits is closed. No current or future Pre-Medicare Retiree will become a Medicare Retiree upon attainment of Medicare eligibility.

Special Rule for Accumulated Unused Benefit Credits from 2023 and Earlier

If you had unused Benefit Credits in your HRA account as of December 31, 2023, you have until December 31, 2024 to incur eligible health care expenses for which you can claim reimbursement from your pre-2024 balance. You may incur claims in 2024 against your pre-2024 balance even if you are no longer eligible for Benefit Credits.

Due to systems limitations, reimbursement of expenses incurred in 2024 will involve an "exception process" at Via Benefits. When you go online to submit an eligible health care expense that you incurred in 2024, you may receive a message that your 2024 claims are not eligible for reimbursement. If you receive that message, you should contact Via Benefits at 866 356-8150 and request an exception. The Via Benefits representative will help get you started

with the exception process. You must complete the exception process in order to obtain reimbursement. If you complete that process and your 2024 health care expense is otherwise an eligible health care expense, it will be approved for reimbursement.

If you have unreimbursed eligible health care expenses you incurred before 2024 but during your participation in the HRA, you may also submit those expenses from your pre-2024 balance.

Eligible health care expenses to be reimbursed from pre-January 1, 2024 unused balances must be submitted no later than March 31, 2025. Any unused amounts will be forfeited after that date.

Eligible and Ineligible Expenses

You may submit an eligible health care expense for reimbursement from your HRA. *Benefit Credits contributed to your HRA in 2024 or a later plan year* may be used solely to reimburse individual after-tax medical, prescription drug, dental, vision and long-term care coverage premiums. COBRA premiums are excluded. No other health care expense will be eligible for reimbursement from Benefit Credits allocated to an HRA account in 2024 or a later year.

Special rule for unused Benefit Credits accumulated prior to 2024: If you had unused accumulated Benefit Credits in your HRA as of December 31, 2023, those Benefit Credits may be used to reimburse the individual premiums described above, as well as COBRA premiums and other eligible expenses paid for care as described in Section 213 (d) of the Internal Revenue Code. For more detailed information regarding eligible health care expenses, please refer to IRS Publication 502 titled, “Medical and Dental Expenses.” If tax advice is required, you should seek the services of a competent professional. Note that prescription drug copays are not eligible for reimbursement from the HRA Plan.

Only eligible health care expenses incurred while you are a Participant in the HRA Plan may be reimbursed from your HRA.

Eligible health care expenses are incurred when the covered individual is provided the health care that gives rise to the expense, and not when the amount is billed or paid. An expense that has been paid but not incurred (e.g., pre-payment to a physician or for premiums) will not be reimbursed until the services or treatment giving rise to the expense has been provided.

Health insurance premiums are incurred on the first day of each month of coverage on a pro rata basis, the first day of the period of coverage, or the date the premium is paid even if the covered individual paid the premium for the coverage prior to the first day of the Plan Year. The federal government permits you to take a deduction on your income tax return for certain health care expenses. You should remember that you cannot claim the same expense twice, once through the HRA and also as a tax deduction. For specific advice about your situation, you may want to consult a tax advisor. The Company cannot advise you regarding tax, investment or legal considerations relating to the HRA.

You may not submit a claim for an amount that was incurred prior to the time your HRA became effective. If you are a Pre-Medicare Retiree or Pre-Medicare Retiree Spouse entering the HRA Plan in 2024, and you timely opt in to the Plan during the applicable three-month opt in window,

your HRA participation is effective the first day of the opt in window. You also cannot submit a claim for any expenses that have been paid in-full through any other health insurance plan, Section 125 "cafeteria" plan or other similar health care expense reimbursement arrangement.

Note that the following expenses are not reimbursed from an HRA:

- Expenses incurred *prior to the date* that you became a participant in the HRA.
- Expenses incurred *after the date* that you cease to be a participant in the HRA.
- Expenses that have been reimbursed by another plan or for which you intend to seek reimbursement under another health plan.

If you need more information regarding whether an expense is an eligible health care expense under the HRA Plan, contact the Third-Party Administrator listed in the Plan Information Appendix of this SPD. The Plan Administrator (and its delegates) solely determine what qualifies as an eligible health care expense.

When Your Participation Ends

If you are an eligible retiree, you will cease being a Participant in the Plan on the earliest of:

Pre-Medicare Retiree:

- The date you cease to be eligible for the Plan for any reason.
- The date you are rehired by the Company or an affiliate of the Company as an active employee.
- The date you become eligible for Medicare, unless you are also eligible for Medicare Benefit Credits.
- Your date of death.
- The effective date of any amendment terminating your eligibility under the Plan.
- The date the Plan is terminated.

Medicare Retiree:

- The date you cease to be eligible for the Plan for any reason.
- The date you are rehired by the Company or an affiliate of the Company as an active employee.
- The date you cease to be eligible for Medicare.
- Your date of death.
- The effective date of any amendment terminating your eligibility under the Plan.
- The date the Plan is terminated.

If you are an eligible dependent, you will cease being a Participant in the Plan on the earliest of:

Pre-Medicare Spouse:

- The date you cease to be an eligible dependent for any reason.
- The date the Retiree to whom you are married is rehired by the Company or an affiliate of the Company as an active employee.

- The date you become eligible for Medicare, unless you are also eligible for Medicare Benefit Credits.
- Starting in 2025, the earlier of the date you or the Pre-Medicare Retiree to whom you are married becomes eligible for Medicare, unless you will also be eligible for Medicare Benefit Credits when you reach Medicare eligibility.
- The date you divorce the Pre-Medicare Retiree.
- The last day of the year following the year of the Pre-Medicare Retiree's death.
- Your date of death.
- The effective date of any amendment terminating your eligibility under the Plan.
- The date the Plan is terminated.

Medicare Dependent:

- The date you cease to be an eligible dependent for any reason.
- The date the Retiree to whom you are married is rehired by the Company or an affiliate of the Company as an active employee.
- The date you cease to be eligible for Medicare.
- In the case of a Medicare Retiree Spouse, the date you divorce the eligible retiree.
- In the case of an eligible dependent child, the date you cease to have a parent participating in the Plan.
- Your date of death.
- The effective date of any amendment terminating your eligibility under the Plan.
- The date the Plan is terminated.

You generally have until March 31st of the year following termination of participation to submit any claims you incurred during the year prior to your participation ending. See "If the Retiree Dies" above for information on the deadline for submission of claims a deceased participant.

How to Use Your HRA Account

Via Benefits gives you several options for using your HRA account.

Using Your Smartphone or Mobile Device

Using the Via Benefits mobile app, you can submit claims, upload and submit receipts, and check your account balance any time.

To use the Via Benefits mobile app:

- Visit iTunes or Google Play Store to download the Via Benefits Accounts mobile app.
- Log in to your account.
- Check your balance, request reimbursement, upload receipts, and check claim status, among other activities. All activities are easily accessible from the app home screen.

Using the Via Benefits Website

Using the Via Benefits website is quick, easy, secure, and available at any time.

Once you've logged in, you'll be asked to provide details about the claim, and you'll upload/attach your receipt or EOB.

For Pre-Medicare Retirees and Pre-Medicare Retiree Spouses with pre-2024 HRA account balances submitting a health care expense incurred in 2024 for reimbursement, you must contact Via Benefits and request a paper form to file a claim.

Paper Claim

You can also request a reimbursement from your HRA account using a paper claim form. You can obtain a paper claim form by contacting the Via Benefits Service Center. Your paper form will be mailed to you. Fax or mail your claim to the address on the form to submit your request for reimbursement.

What to Include in a Claim

Regardless of the method you choose to submit a claim, make sure your documentation includes the required information.

For premium expenses, make sure your supporting documents show the following items:

- Insurance carrier (the name of your medical insurance provider)
- Premium type (e.g., medical, dental)
- Premium amount (proof of total amount you paid for premiums)
- Individual covered (e.g., your name or your spouse's name)
- Premium coverage period (e.g., January 1-January 31 for monthly premiums)

For non-premium expenses, make sure your documents have the five following pieces of information required by the IRS:

- Date of service or purchase
- Patient name
- Detailed description
- Patient portion or amount owed
- Provider or merchant name

You may submit a claim for reimbursement for an eligible health care expense arising during the plan year at any time during the year. Most claims are processed within one to two business days after they are received, and payments are sent shortly thereafter.

More About Claims

Via Benefits will process your claim, and if the request is for eligible health care expenses, Via Benefits will deduct the money from your HRA and pay you via direct deposit or such other method as may be available under current administrative procedures. If your claim request is denied, you will be notified of this denial under procedures described below.

The Company does not allow amounts to be carried over to the next Plan Year.

You should submit requests for reimbursement of eligible health care expenses by March 31st following the Plan Year in which the expense is incurred. Any claims submitted after that date will not be reimbursed.

Initial Claims Process and Timing

If you make a claim for health care expenses under the HRA, the following timetable for claims decisions applies (references to "days" below indicate calendar days):

Notification of whether claim is denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information to process the claim	15 days
Notification to Participant	15 days
Response by Participant	45 days
Response to claim	15 days

If a claim under the HRA is denied in whole or in part, the Participant will receive electronic or written notification based on the Participant's setting. The notification will include:

- The specific reason(s) for the denial.
- Reference to the specific plan provisions on which the denial was based.
- A description of any additional material or information needed to further process the claim, and an explanation of why such material or information is necessary.
- A description of the Plan's internal review procedures, and time limits applicable to such procedures, available external review procedures, as well as your right to bring a civil action under Section 502 of ERISA following a final appeal.
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.
- A description of any internal rule, guideline, protocol, or similar criteria used in the decision OR statement that if the denial was based on an internal rule, guideline, protocol, or similar criteria, a copy of such rule, guideline, protocol, or other similar criteria will be provided, free of charge, upon request.
- An explanation of the scientific or clinical judgment used in the decision in the case of a decision regarding medical necessity, experimental treatment or similar exclusion or limit, applying the terms of the plan to your medical circumstances, OR a statement that such explanation will be provided upon request, free of charge.

- The availability of and contact information for an applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793.

Claims Appeals Process

If you receive a claim denial, you will have 180 days following the receipt of the notification in which to appeal the decision, by making a written request for consideration to Via Benefits. You have the right to:

- Submit written comments, documents, records, and other information relating to the reimbursement claim for benefits.
- Request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits. For this purpose, a document, record, or other information is treated as "relevant" to your claim request if it:
  - Was relied upon in making the benefit determination.
  - Was submitted, considered, or generated in the course of making the benefit determination, regardless of whether such document, record, or other information was relied upon in making the benefit determination.
  - Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination.
  - Constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination.
- A review that takes into account, all comments, documents, records, and other information related to the claim that you submitted, regardless of whether the information was submitted or considered in the initial benefit determination.
- A review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination nor by that person's subordinate.
- If the appeal involves a denial based on a medical judgment, a review in which the named fiduciary consults with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse benefit determination, nor the subordinate of any such individual. This applies only if the appeal involves an adverse benefit determination based in whole or in part on a medical judgment (including whether a particular treatment, drug or other item is experimental).
- The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, regardless of whether the advice was relied upon in making the decision.

If sufficient information is available to decide the first level appeal, Via Benefits will resolve your first level appeal within a reasonable period of time but not later than 30 days from receipt of the first level appeal request. If, for reasons beyond Via Benefits' control, more time is needed to review a request, Via Benefits may extend the time period up to an additional 15 days.

If more information is needed to make a decision on your appeal, Via Benefits shall send a written request for the information after receipt of the appeal. If the additional information requested is not received within 45 days of the appeal request, Via Benefits shall conduct its review based upon the available information.

The first and second level of appeal will not take more than 60 days combined to resolve, from the receipt of each written appeal to the notice of decision for each appeal.

Notice of an adverse benefit determination on appeals will contain all of the following information:

- The specific reasons for the denial.
- Information sufficient to identify the claim involved, including the date of the service, the health care provider, and the claim amount (if applicable).
- The specific HRA Plan provisions on which the decision is based, including the denial code and its corresponding meaning, a description of the plan's standard, if any, used in denying the claim, and in the case of a final adverse determination, a discussion of the decision.
- A description of any additional material or information necessary for the claim to be completed and an explanation of why such material or information is necessary.
- A description of the HRA Plan's external review procedures and a statement describing any voluntary appeal procedures offered by the HRA Plan and your right to obtain the information about such procedures; including your right to bring a civil action in federal court following a claims denial on review.
- A description of any internal rules, guidelines, protocols, or other similar criteria that were relied upon in the decision-making, OR a statement that the decision was based on the applicable items mentioned above, and that copies of the applicable material, will be provided upon request, free of charge.
- An explanation of the scientific or clinical judgment used in the decision in the case of a decision regarding medical necessity, experimental treatment or similar exclusion or limit, applying the terms of the plan to your medical circumstances, OR a statement that such explanation will be provided upon request, free of charge.
- The availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

If you have any questions about a denied claim, you should contact Via Benefits. Via Benefits' decisions are conclusive and binding.

If you are not satisfied with the decision made on the first level appeal, you may request in writing, within 90 days of receipt of the notice of the decision, a second level appeal. A second level appeal may be initiated by you or your authorized representative (e.g., physician) to the plan Fiduciary. To initiate a second level appeal, you can provide all information from the first level of appeal, and additional information or statements that you feel are relevant, to the plan Fiduciary. You have the same rights with the second level appeal as you do with the first level appeal and all responses will follow the same time period. Instructions for contacting your plan Fiduciary will be included in the notice of adverse benefit determination.

You and the HRA Plan may also have the right to other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office, and your state insurance regulatory agency.

You cannot bring any legal action relating to this HRA against the HRA Plan, Plan Administrator, or Claims Administrator, for any reason unless you first complete all non-voluntary steps in the appeal process as described in this "Claims Appeals Process" section. (However, you may be treated as having completed all these steps with respect to a claim if the HRA Plan fails to comply with its obligations at any point in the claims and appeals process, unless the HRA Plan's failure to comply is de minimis, non-prejudicial, attributable to good cause, or matters beyond the HRA Plan's control, in the context of an ongoing, good-faith exchange of information, and not reflective of a pattern or practice of non-compliance). After completing the claims and appeals process, if you want to bring such a legal action you must do so within 18 months of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action.

Overpayments

If it is later determined that you and/or your covered eligible dependent(s) received an overpayment or a payment was made in error, you (or your covered eligible dependents) will be required to refund the overpayment or erroneous reimbursement to the HRA Plan. An example of an overpayment is being reimbursed for an expense under the HRA Plan that is later determined to be ineligible or paid for by some other health care plan.

If you do not refund the overpayment or erroneous payment, the HRA Plan reserves the right to offset future reimbursements from the HRA equal to the overpayment or erroneous payment, or to pursue other methods of recovery. If all other attempts to recoup the overpayment/erroneous payment are unsuccessful, the Plan Administrator may include the amount on an IRS Form 1099 as income. In addition, if the Plan Administrator determines that you have submitted a fraudulent claim, the Plan Administrator may terminate your coverage under the HRA Plan.

Unclaimed Payments

Any HRA payments that are unclaimed (e.g., uncashed benefit checks or unclaimed electronic transfers) will automatically forfeit 18 months from the date set forth on the check or from the date the payment was otherwise approved.

If the participant or other authorized person does not contact Via Benefits prior to the 18-month forfeiture time frame, the unclaimed reimbursement will be forfeited.

If the Participant or other authorized person contacts Via Benefits within six months, Via Benefits may cancel and void the original check or payment and re-issue a new check or as otherwise determined by Via Benefits.

If the Participant or other authorized person contacts Via Benefits after six months, Via Benefits will cancel and void the original check or payment and shall re-issue the payment by direct deposit, or as otherwise determined by Via Benefits.

Plan Accounting

You may access your HRA balance and a list of your reimbursements through the Via Benefits website so you can track your account balance during the year. This will also help you budget for expense reimbursement needs in future plan years. You may also submit a written request to the plan administrator to receive a copy of your account information at any time.

Your Rights

As a participant in the HRA Plan, 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:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations such as work sites, all documents governing the plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The 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.

Continue Group Health Plan Coverage

- Continue group health coverage for yourself, your spouse, or your dependents if there is 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 for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits that is denied, or ignored, in whole or in part, you may file a suit in a state or federal court but only after you have exhausted the Plan's claims and appeals procedure as described in this SPD or the claim and appeals sections in the materials prepared by your Plan carrier. In addition, if you disagree with the Plan's decision, or lack thereof, concerning the qualified status of a medical child support order, you may file suit in a federal court. Any action at law or in equity must begin within three years after the denial of any appeal from an initial adverse benefit determination, regardless of any state or federal statutes establishing procedures relating to limitations of actions.

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 fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The HRA Plan is intended to comply with the privacy and security requirements of the Health Insurance Portability and Accountability Act (HIPAA). The Company is required to provide notice of the ways that Protected Health Information (PHI) may be used in accordance with HIPAA. A copy of the HIPAA notice of privacy practices accompanies this SPD. A paper copy can be obtained by contacting The Lubrizol Corporation, Attn: HIPAA Privacy Officer, 29400 Lakeland Boulevard, Wickliffe, OH 44092.

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 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, U.S. Department of Labor, 200 Constitution Ave. N.W. 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 at 1-866-EBSA (1-866-444-3272), logging on to www.dol.gov or by contacting the EBSA Field office nearest you.

Plan Information Appendix

Details About Plan Administration	
Plan Sponsor/Plan Administrator	Name: The Lubrizol Corporation Address: 29400 Lakeland Boulevard, Wickliffe, OH 44092 Phone Number: 440-934-4200
Participating Subsidiaries	Lubrizol Advanced Materials, Inc. Lipotec USA, Inc.
COBRA Administrator	Name: National Benefit Services COBRA Address: 430 W 7th Street, Suite 219893Kansas City, MO 64105-1407 Phone Number: 800-274-0503, option 4
Employer Identification Number	34-0367600
Official Plan Name and Number	The Lubrizol Corporation Retiree Health Reimbursement Arrangement 508
Plan Year	January 1 through December 31
Type of Plan	Welfare benefit plan providing health care reimbursements under ERISA.
Agent for Service of Legal Process	Name: The Lubrizol Corporation Address: 29400 Lakeland Boulevard, Wickliffe, OH 44092 Phone Number: 440-934-4200 Legal process can also be served on the plan administrator
Third Party Administrator	Via Benefits 38 East Scenic Pointe Drive, Suite 200 Draper, UT 84020 Medicare Eligible: 1-855-241-5724 Medicare Eligible: https://my.viabenefits.com/Lubrizol Pre-65 Eligible: 1-866-356-8150 Pre-65 Eligible: https://marketplace.viabenefits.com/Lubrizol

Claims Submission Information	Name: Via Benefits Mobile App: Search for Via Benefits Accounts where you download apps Online: Medicare Eligible: https://my.viabenefits.com/Lubrizol Pre-65 Eligible: https://marketplace.viabenefits.com/LubrizolMail: Via Benefits, PO Box 981155, El Paso, TX 79998-1155 Fax: 1-866-886-0879
Plan Funding	The Company contributes to the participants' HRAs as described in this SPD. The HRAs are notional accounts and reimbursements of eligible health care expenses are made from the Company's general assets.

Plan Administrator's Discretionary Authority to Interpret the Plan

The administration of the HRA Plan will be under the supervision of the Plan Administrator. To the fullest extent permitted by law, the Plan Administrator will have the exclusive discretionary authority to determine all matters relating to the HRA Plan, including eligibility, coverage, and benefits, to the extent permitted under the applicable collective bargaining agreement.

The Plan Administrator will also have the exclusive discretionary authority to determine all matters relating to interpretation and operation of the HRA Plan. The Plan Administrator may delegate any of its duties and responsibilities to one or more persons or entities. Such delegation of authority must be in writing and must identify the delegate and the scope of the delegated responsibilities. Decisions by the Plan Administrator, or any authorized delegate, will be conclusive and legally binding on all parties.

Plan Document

This SPD is intended to help you understand the main features of the HRA Plan. It should not be considered a substitute for the official legal HRA plan document that governs the operation of the HRA Plan. That document sets forth the provisions concerning the HRA Plan and is subject to amendment. If any questions arise that are not covered in this SPD or if this SPD appears to conflict with the official legal HRA Plan document, the text of the official legal plan document will determine how questions will be resolved, with one exception. If this SPD contains provisions regarding an issue on which the official legal HRA plan document is silent, this SPD will determine how that issue will be resolved. To request a copy of the plan document, contact The Lubrizol Corporation, ATTN: Corporate Benefits,29400 Lakeland Avenue, Wickliffe, OH 44092, telephone 440 347-5358.

Employers participating in the Plan other than the Sponsor (such as a related affiliate of the Sponsor) may terminate their participation in the Plan at any time upon 60 days written notice to the Sponsor and Plan Administrator.

Any such action would be taken in writing and maintained with the records of the HRA Plan. Plan amendment, modification, suspension, or termination may be made for any reason, and at any time, and may, in certain circumstances, result in the reduction of or elimination of benefits or other features of the HRA Plan to the extent permitted by law, and to the extent permitted under the applicable collective bargaining agreement.

The Company's rights include the right to obtain coverage and/or administrative services from additional or different insurance carriers, third-party administrators, etc., at any time, and the right to revise the amount of Company contributions. Participants will be notified of any material modification to the HRA Plan.

If the HRA Plan is terminated, there will not be any plan assets that would need to be distributed.

Limitation on Assignment

Your rights under the HRA Plan cannot be assigned, sold, or transferred to your creditors or anyone else. However, you may assign any benefit payments you may be entitled to the health care provider who provided the covered services.

Your Employment

This SPD provides detailed summary of the Company's HRA Plan and how it works. This SPD does not constitute an implied or express contract or guarantee of employment. Similarly, your eligibility or your right to benefits under the HRA Plan should not be interpreted as an implied or express contract or guarantee of employment. The Company's employment decisions are made without regard to benefits to which you are entitled upon employment.

Continuation of Coverage under COBRA

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your covered spouse and dependent children, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose coverage under the Plan. It can also become available to your spouse and dependent children who are covered under the Plan when they would otherwise lose such coverage.

What Is COBRA Continuation Coverage

COBRA continuation coverage is a continuation of HRA Plan coverage when you would otherwise lose such coverage because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You and your covered spouse could become qualified beneficiaries if covered under the Plan at the time of a qualifying event, and such coverage is lost because of the qualifying event. Under the Plan, qualified beneficiaries must pay for the COBRA continuation coverage they elect, as described in the "Paying for COBRA Continuation Coverage" section.

COBRA Qualifying Events

If you are a covered *Medicare Retiree*, you will become a qualified beneficiary if you lose coverage under the HRA Plan because the following qualifying event happens:

- The Company files for Chapter 11 bankruptcy and coverage under the HRA Plan is substantially eliminated within one year before or after the filing.

If you are a covered *Medicare Retiree Spouse*, you will become a qualified beneficiary if you lose coverage under the HRA Plan because any of the following qualifying events happens:

- You become divorced or legally separated from your spouse.
- The Company files for Chapter 11 bankruptcy and coverage under the HRA Plan is substantially eliminated within one year before or after the filing.

If you are a covered *Medicare Retiree Dependent child*, you will become a qualified beneficiary if you lose coverage under the HRA Plan because any of the following qualifying events happens:

- Your Medicare retiree parent dies.
- You no longer meet the definition of dependent child under the HRA Plan.
- The Company files for Chapter 11 bankruptcy and coverage under the HRA Plan is substantially eliminated within one year before or after the filing.

If you are a covered *Pre-Medicare Retiree*, you will become a qualified beneficiary if you lose coverage under the HRA Plan because the following qualifying event happens:

- You age into Medicare.
- The Company files for Chapter 11 bankruptcy and coverage under the HRA Plan is substantially eliminated within one year before or after the filing.

If you are a covered *Pre-Medicare Retiree Spouse*, you will become a qualified beneficiary if you lose coverage under the HRA Plan because the following qualifying event happens:

- You become divorced or legally separated from your spouse.
- Your spouse dies.
- You or your spouse ages into Medicare.
- The Company files for Chapter 11 bankruptcy and coverage under the HRA Plan is substantially eliminated within one year before or after the filing.

For this purpose, "lose coverage" means to cease to be covered under the same terms and conditions as in effect immediately before the qualifying event.

Giving Notice that a COBRA Qualifying Event Has Occurred

The HRA Plan will offer COBRA continuation coverage to qualified beneficiaries only after the plan administrator has been timely notified that a qualifying event has occurred. When the qualifying event is the retiree's death or the employer's bankruptcy filing, the employer must notify the Plan administrator of the qualifying events.

For all other qualifying events (divorce or legal separation), you are responsible for notifying the plan Administrator within 60 days after the later of: 1) the date of qualifying event or 2) the date the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event. You can contact Via Benefits at the phone numbers below or contact Lubrizol directly:

- Via Benefit Medicare Phone Number: 855-241-5724
- Via Benefits Pre-65 Phone Number: 866-356-8150

Once the plan administrator receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered (through a "COBRA Continuation Coverage Election Notice") to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered retirees may elect COBRA continuation on behalf of their covered spouses or covered dependent children, but covered retirees cannot reject COBRA continuation on behalf of their covered spouses or covered dependent children.

If coverage under the HRA Plan is changed for retirees, the same changes will apply to individuals receiving COBRA continuation coverage.

Duration of COBRA Continuation Coverage

COBRA continuation coverage is a temporary continuation of HRA coverage.

When the qualifying event is the death of the retiree or divorce, COBRA continuation coverage for the retiree's covered spouse or covered dependent child(ren) (but not the retiree) under the HRA Plan lasts for up to a total of 36 months from the date of the qualifying event.

When the qualifying event is the bankruptcy of the Company, retiree health coverage under the HRA Plan for you and your covered spouse and/or covered dependent children may be continued for the rest of your (the retiree's) life. After your death (including if you have already died when the bankruptcy proceeding begins), your surviving covered spouse and/or surviving covered dependent children may continue HRA Plan coverage for an additional 36 months after your death.

The table below provides a summary of the COBRA provisions outlined in this section.

	Maximum Continuation Period	
Qualifying Events That Result in Loss of Coverage	**Retiree**	**Spouse/dependent**
Retiree dies	N/A	36 months
Retiree and spouse divorce	N/A	36 months
Retiree or spouse ages into Medicare	36 months	36 months
Medicare-eligible dependent of Medicare Retiree loses Medicare eligibility	N/A	36 months
The Company commences bankruptcy proceedings under Title 11 of the United States Code	Death	36 months[1]

36-month period is counted from the date of retiree's death.

Electing COBRA Continuation Coverage

You, your covered spouse, or your covered dependent child(ren) must choose to continue coverage under the HRA Plan within 60 days after the later of the following dates:

- The date you, your covered spouse or covered dependent child would lose coverage under the HRA Plan as a result of the qualifying event.
- The date the Company notifies you and/or your covered spouse and/or covered dependent child (through a "COBRA Continuation Coverage Election Notice") of your right to choose to continue coverage as a result of the qualifying event.

Paying for COBRA Continuation Coverage

Cost: Generally, each qualified beneficiary is required to pay the entire cost of COBRA continuation coverage. The cost of COBRA continuation coverage is 102% of the cost of HRA Plan coverage.

Premium Due Dates: If you elect COBRA continuation coverage, you must make your initial payment for continuation coverage (including all contributions due but not paid) no later than 45 days after the date of your election. (This is the date the COBRA Election Notice is post-marked, if mailed.) If you do not make your initial payment for COBRA continuation coverage within 45 days after the date of your election, you will lose all COBRA continuation coverage rights under the HRA Plan. Payment is considered made on the date it is sent to the HRA Plan.

After you make your initial payment for COBRA continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The contribution due date and exact amount due each coverage period for each qualified beneficiary will be shown in the COBRA Election Notice you receive. Although periodic payments are due on the dates shown in the COBRA Election Notice, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the HRA Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you elect COBRA continuation coverage but then fail to make an initial or periodic payment before the end of the 45- or 30-day grace period, respectively, for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan, and such coverage will be terminated retroactively to the last day for which timely payment was made (if any).

When COBRA Continuation Coverage Ends

COBRA continuation coverage for any qualified beneficiary will end when the first of the following occurs:

- The applicable 36-month COBRA continuation coverage period ends.
- Any required premium is not paid on time.
- After the date COBRA continuation coverage is elected, a qualified beneficiary first becomes covered (as a retiree or otherwise) under another group health plan (not offered by the Company).
- After the date COBRA continuation coverage is elected, a qualified beneficiary first becomes entitled to (that is, enrolled in) Medicare benefits (under Part A, Part B, or both). This does not apply to other qualified beneficiaries who are not entitled to

Medicare and does not apply at all to end retiree COBRA continuation coverage if bankruptcy is the qualifying event.

- The date the Company ceases to provide any group health plan for its employees and retirees.

COBRA continuation coverage may also be terminated for any reason the HRA Plan would terminate coverage of a participant or beneficiary not receiving COBRA continuation coverage (such as fraud).

Continuing Your Health Reimbursement Account under COBRA

If you elect to continue your HRA under COBRA, the HRA will provide for continuation of the maximum reimbursement available at the time of the qualifying event reduced by any claims reimbursed during the period of coverage.

If you continue your HRA under COBRA, any amounts that would otherwise have been contributed by the Company into the HRA will continue.

More information regarding COBRA coverage is included above and in the COBRA Notices available from the plan administrator. Additional information regarding Public Marketplace coverage is available by visiting www.healthcare.gov and also in the health plans' COBRA Notices.

If You Have Questions

Questions concerning your Plan, or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Website.)

Keep Your Plan Informed of Address and Contact Changes

In order to protect your rights, as well as the rights of your spouse and dependent children, you should keep Via Benefits informed of any changes in the addresses of your spouse and/or dependent children. You should also keep a copy for your records of any notices you send to Via Benefits.

Plan Contact Information

For information about The Lubrizol Corporation Retiree Health Reimbursement Arrangement and COBRA continuation coverage, contact the Plan Sponsor at The Lubrizol Corporation, 29400 Lakeland Boulevard, Wickliffe, OH 44092, 440-934-4200, or the COBRA Administrator National Benefit Services COBRA, 430 W 7th Street, Suite 219893, Kansas City, MO 64105-1407, 800-274-0503, option 4.

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 Treatment, 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. The plan itself does not engage directly in "treatment" under the HIPAA privacy rules. However, the plan may interact with a health care provider in treatment transactions. 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. For example, the plan may tell your doctor whether you are eligible for coverage and the percentage of the bill that is covered.

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 utilization management; disease management program administration; 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, without your authorization, the plan will not 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 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) psychotherapy notes; (2) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and (3) 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 (1) disclosures you requested, (2) disclosures you authorized by signing an authorization form, (3) disclosures 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, and the revised notice will be posted on the plan sponsor's internal website.

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:

HR Director– Employee Benefits
The Lubrizol Corporation
29400 Lakeland Boulevard
Wickliffe OH 44092

Mothers' And Newborns' Health Protection Act

The Plan may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section, or require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

Women's Health And Cancer Rights Act

To the extent the Plan provides benefits with respect to mastectomy, it will provide, in the case of an individual who is receiving benefits in connection with a mastectomy and who elects reconstruction in connection with such mastectomy, coverage for all stages of reconstruction of the breast on which a mastectomy was performed, surgery and reconstruction of the other breast to provide a symmetrical appearance, prostheses, and coverage of physical complications at all stages of the mastectomy, including lymphedemas.