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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2018. Contact your State for more information on eligibility –

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

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: https://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since January 31, 2018, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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

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

(Lubrizol EPO, CDHP and OOA group medical programs)
Women's Health and Cancer Rights Act

Your health plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from a mastectomy, including lymphedema. For more information about WHCRA required coverage, please call UnitedHealthcare at 1-877-706-1735.

(Lubrizol EPO, CDHP and OOA group medical programs)
Newborns' and Mothers' Health Protection Act

Your health plan, as required by the Newborns' and Mothers' Health Protection Act of 1996, provides benefits for a hospital length of stay in connection with childbirth for the mother or newborn child of no less than 48 hours following vaginal delivery, or no less than 96 hours following a delivery by cesarean section. The plan may pay for a shorter stay if the attending physician or other provider, after consultation with the mother, discharges the mother or newborn earlier. The plan does not require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). For more information, please call UnitedHealthcare at 1-877-706-1735.

(Lubrizol group health plans/HIPAA)
Notice Regarding Privacy of Protected Health Information

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

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

Protected Health Information

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

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

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

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

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

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

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

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

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

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

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

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

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

Uses and Disclosures Permitted with an Opportunity to Object

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

may determine if the disclosure is in your best interests and, if that determination is made, may only disclose information directly relevant to your health care.

Uses and Disclosures Authorized by You

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

Your Rights

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

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

In addition, you may not inspect or copy certain records by law, including:

1) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and
2) protected health information that is subject to a law that prohibits access to protected health information.

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

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

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

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

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

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

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

The Plan's Duties

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

Complaints

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

Contact Person

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

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

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

(Lubrizol EPO, CDHP and OOA group medical programs)
Important Notice from The Lubrizol Corporation About Your Prescription Drug Coverage and Medicare

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

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

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

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

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

When Can You Join A Medicare Drug Plan? You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

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

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

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

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

NOTE: You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if the coverage through The Lubrizol Corporation changes. You also may request a copy of this notice at any time.

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

For more information about Medicare prescription drug coverage:

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

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

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

The Lubrizol Corporation Employee Benefits Plan
Summary of Material Modifications

The following is a Summary of Material Modifications (SMM) and amends the Summary Plan Description (SPD) for The Lubrizol Corporation Employee Benefits Plan (the Plan). This is a required communication and you should keep this SMM with your SPD for future reference. Copies of the Plan's SPD may also be found on the Benefits website at http://benefits.lubrizol.com. The changes to the Plan described below are effective January 1, 2018.

The following is only a summary. In the case of a conflict between the information presented below and the Plan, the Plan provisions will govern.

Cessation of Participation in the Plan by LSPI

LiquidPower Specialty Products, Inc. and its subsidiaries are not participating employers in the Plan after December 31, 2017.

New Dental Option: The Lubrizol Network PPO

A new dental option, the Lubrizol Network PPO, replaces the Preventive Dental Option. The network PPO offers reduced provider costs when you use a network dentist.

COMPARISON OF 2018 DENTAL BENEFITS

Feature	Lubrizol Comprehensive Dental Option	Lubrizol Network PPO Dental Option
Annual Deductible	$25/person $75/family	Network: $50/person, $150/family Non-Network: $100/person, $300/family
Annual Maximum Benefit	$1,500	$1,000
	PLAN PAYS	PLAN PAYS
Preventive Care • Oral exams (two per year) • Cleanings • X-rays	100% (annual deductible does not apply)	100% (annual deductible does not apply)
Basic • Fillings • Extractions	80% after annual deductible	Network: 80% after annual deductible Non-Network: 50% after annual deductible
Major Restorative • Crowns • Inlays • Dentures	50% after annual deductible	50% after annual deductible
Orthodontia • Children under age 26	50%	50%
Orthodontia Lifetime Maximum Benefit	$1,500/child	$1,000/child

Assignment of Benefits

You may not assign your benefits except by consent of Lubrizol or its designee. Direct payment to a provider will not be deemed to constitute consent by the Plan to an assignment or to a waiver of the consent requirements for the assignment of benefits. The Plan may make a direct payment to a provider. However, if it does, you, and not the provider, will be deemed to be the beneficiary of the direct payment.

Subrogation Rights of the Plan

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

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

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

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

The following persons and entities are considered third parties (this list is not exclusive):

- a person or entity alleged to have caused you to suffer a sickness, injury or damages, or who is legally responsible for the sickness, injury or damages;
- any insurer or other indemnifier of any person or entity alleged to have caused or who caused the sickness, injury or damages;
- your employer in a workers' compensation case or other matter alleging liability;
- any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators;
- any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a sickness or injury you allege or could have alleged was the responsibility of any third party; and
- any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including but not limited to:
    - notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused benefits to be paid or become payable;
    - providing any relevant information requested by the Plan;
    - signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim;
    - responding to requests for information about any accident or injuries;
    - making court appearances;

- obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses; and
- complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your benefits, deny future benefits, take legal action against you, and/or set off from any future benefits the value of benefits the Plan has paid relating to any sickness or injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and your beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries, and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered benefits advanced.
- If you receive any payment from any party as a result of sickness or injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting benefits from the plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets to the extent of the amount of Plan benefits provided on behalf of the covered person, (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- By participating in and accepting benefits from the Plan, you agree to assign to the Plan any benefits, claims or rights of recovery you have under any automobile policy (including no-fault benefits, PIP benefits and/or medical payment benefits) or other coverage or against any third party to the full extent of the benefits the Plan has paid for the sickness or injury. By agreeing to provide this assignment in exchange for participating in and accepting benefits, you acknowledge and recognize the Plan's right to assert, pursue, and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.

- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party and filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits paid on your behalf out of any settlement, judgment or other recovery from any third party considered responsible; and filing suit in your name or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund benefits as required under the terms of the Plan is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a dependent child who incurs a sickness or injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's sickness or injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a sickness or injury while you are covered under the Plan, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate benefits to you, your dependents or the participant, deny future benefits, take legal action against you, and or set off from any future benefits the value of benefits the Plan has paid relating to a sickness or injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan and all administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to 1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and 2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

The Lubrizol Corporation Long Term Disability Plan
Summary of Material Modifications

The following is a Summary of Material Modifications (SMM) and amends the Summary Plan Description (SPD) for The Lubrizol Corporation Long Term Disability Plan (the Plan) contained in your Employee Resource Guide. This is a required communication and you should keep this SMM with your SPD for future reference. Copies of the Plan's SPD may also be found on the Benefits website at http://benefits.lubrizol.com. Except as noted below, the changes to the Plan described below are effective January 1, 2018.

The following is only a summary. In the case of a conflict between the information presented below and the Plan, the Plan provisions will govern.

Cessation of Participation in the Plan by LSPI

The Plan is being amended to reflect that LiquidPower Specialty Products, Inc. and its subsidiaries are not participating employers in the Plan after December 31, 2017. Employees of LiquidPower Specialty Products, Inc. (LSPI) or its subsidiaries are not eligible to participate in the plan after December 31, 2017.

When Benefits Begin

The Plan has required an Employee applying for benefits to deliver as part of the application a consent to a third-party investigation under the Fair Credit Reporting Act. Employees will no longer be required to deliver the consent as part of the application process unless requested by the Plan. Lubrizol may suspend LTD benefits if the Employee fails to cooperate with an investigation of fraud, including the failure to provide a consent to a third-party investigation upon Lubrizol's request.

How to Apply for Benefits – Translation Services (Effective April 1, 2018)

You may request translation services to assist you in applying for your benefits by contacting the plan administrator at (440) 347-6108.

How to Apply for Benefits — If Your Claim is Denied (Effective April 1, 2018)

If your claim is denied in whole or in part, you will receive a notice explaining the reason for the denial including specific plan provisions on which the decision was made. The notice will also include the following information:

- a description of any additional information needed to complete the claim and why the information is necessary;
- a discussion of the decision, including an explanation of the basis for the plan's disagreeing with any of the following:
    - the views of the health care professionals who treated you and vocational professionals who evaluated you, if you presented those views to the plan;
    - the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the denial, even if the plan did not rely on that advice in denying the claim;
    - a determination of your disability made by the Social Security Administration;
- if an internal rule, guideline, protocol, or other similar criterion was relied on in denying your claim, the specific rule, guideline, protocol, or other similar criterion will be provided, or else the notice will indicate that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist; and
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- a description of the Plan's review procedures and time limits, including a statement of your right to bring suit under ERISA following a denial of your appeal, and the deadline for bringing suit.

If you speak a language other than English, you may request a translation of the notice of denial by contacting the plan administrator at (440) 347-6108.

How to Apply for Benefits — Claims Review Procedures (Effective April 1, 2018)

You may request a review of the denial. The request should be submitted to the Employee Benefits Administrative Committee in writing, within 180 days after the claim for benefits was first denied or reduced, and should include your reason for requesting the review. Your request for review may include written comments, documents, records and other information relating to your claim. During the review, you may represent yourself or appoint a representative, and will have the right to inspect all documents and information that was relevant to your claim. You may request translation services to assist you in submitting your request for review by contacting the plan administrator at (440) 347-6108. If no request for review is received within the time limit, the denial or reduction of benefits will be final. If you make a timely appeal, you will remain an employee on an unpaid leave of absence for the duration of the appeal process.

Within 45 days, the committee will render its decision unless special circumstances require an extension of not more than an additional 45 days. You will be notified prior to the end of the first 45 days if more time is needed. The review of the denial of your claim will take into account all comments, documents and information you submit. If the committee denies your claim for benefits based on a new or additional rationale, you must be provided that rationale as soon as possible and sufficiently in advance of the date on which the decision is required to be provided to give you a reasonable opportunity to respond before that date.

All decisions of the committee will be in writing and will provide the following:

- the specific reasons for the action taken;
- the specific plan provisions on which the decision is based.
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim.

If the decision is a denial of your claim, the notification will also include:

- a statement of your right to bring civil action under ERISA;
- a description of the plan deadline to sue, including the calendar date on which the deadline to sue expires for your claim;
- a discussion of the decision, including an explanation of the basis for the plan's disagreeing with any of the following:
    - the views of the health care professionals who treated you and vocational professionals who evaluated you, if you presented those views to the plan;
    - the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the denial, even if the plan did not rely on that advice in denying the claim;
    - a determination of your disability made by the Social Security Administration; and
- if an internal rule, guideline, protocol, or other similar criterion was relied on in making the decision, the specific rule, guideline, protocol, or other similar criterion will be provided, or else the notice will indicate that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist.

If you speak a language other than English, you may request a translation of the letter notifying you of the decision to deny your claim by contacting the plan administrator at (440) 348-6108.

Bringing a Lawsuit Against the Plan (Effective April 1, 2018)

You must exhaust the claims review process before you may bring a lawsuit to obtain benefits under the plan. You may be deemed to have exhausted the claims review process if the plan fails to adhere to the claims procedures. Your lawsuit must be brought within three years of the final appeal denial, and must be brought in the United States District Court for the Southern District of Texas; or if that forum lacks jurisdiction, in the United States District Court for the Northern District of Ohio; or if that court lacks jurisdiction, in any federal or state court that has jurisdiction.

The Lubrizol Corporation Pension Plan
Applicable to Employees Hired Before January 1, 2010
Summary of Material Modifications

The following is a Summary of Material Modifications (SMM) and amends the Summary Plan Description (SPD) for The Lubrizol Corporation Pension Plan (the Plan). This is a required communication and you should keep this SMM with your SPD for future reference. Copies of the Plan's SPD may also be found on the Benefits website at http://benefits.lubrizol.com. The changes to the Plan described below are effective January 1, 2018.

The following is only a summary. In the case of a conflict between the information presented below and the Plan, the Plan provisions will govern.

Lubrizol Employees Who Leave Lubrizol for LSPI Employment

A Lubrizol employee who leaves the employ of Lubrizol or a Lubrizol subsidiary that has adopted the plan, and becomes an employee of LiquidPower Specialty Products, Inc., will cease to be an active participant in the Pension Plan after the termination of his Lubrizol or Lubrizol subsidiary employment.

The Lubrizol Corporation Employees' Profit Sharing and Savings Plan
Summary of Material Modifications

The following is a Summary of Material Modifications (SMM) and amends the Summary Plan Description (SPD) for The Lubrizol Corporation Profit Sharing and Savings Plan (the Plan). This is a required communication and you should keep this SMM with your SPD for future reference. Copies of the Plan's SPD may also be found on the Benefits website at http://benefits.lubrizol.com. Except as noted below, the changes to the Plan described below are effective January 1, 2018.

The following is only a summary. In the case of a conflict between the information presented below and the Plan, the Plan provisions will govern.

Who Is Eligible

Employees of LiquidPower Specialty Products, Inc. (LSPI) or its subsidiaries are not eligible to actively participate in the plan after December 31, 2017.

Distribution of Your Benefit – Disability

You may receive a distribution of your plan benefit if you become totally and permanently disabled as defined by the Internal Revenue Service and you have been determined to be disabled by the Social Security Administration.

Cessation of Participation in the Plan by LSPI and LSPI Subsidiaries

The accounts of employees of LSPI and its subsidiaries have been transferred to the LiquidPower Specialty Products, Inc. 401(k) and Profit Sharing Plan.

Hardship Distributions

Victims of Hurricanes Harvey, Irma and Maria and of the California wildfires are entitled to the relief for hardship distributions, including the 10% penalty for early withdrawals, taken in accordance with the terms and conditions set forth in applicable IRS announcement (IRS Announcements 2017-11, 2017-13 and 2017-15).

The Lubrizol Corporation Age-Weighted Defined Contribution Plan Summary of Material Modifications

The following is a Summary of Material Modifications (SMM) and amends the Summary Plan Description (SPD) for The Lubrizol Corporation Age-Weighted Defined Contribution Plan (the Plan). This is a required communication and you should keep this SMM with your SPD for future reference. Copies of the Plan's SPD may also be found on the Benefits website at http://benefits.lubrizol.com. Except as noted below, the changes to the Plan described below are effective January 1, 2018.

The following is only a summary. In the case of a conflict between the information presented below and the Plan, the Plan provisions will govern.

Who Is Eligible

Employees of LiquidPower Specialty Products, Inc. (LSPI) or its subsidiaries are not eligible to actively participate in the plan after December 31, 2017.

Distribution of Your Benefit – Disability

You may receive a distribution of your plan benefit if you become totally and permanently disabled as defined by the Internal Revenue Service and you have been determined to be disabled by the Social Security Administration.

Cessation of Participation in the Plan by LSPI and LSPI Subsidiaries

The accounts of employees of LSPI and its subsidiaries have been spun-off from the plan, and transferred to the LiquidPower Specialty Products, Inc. 401(k) and Profit Sharing Plan.

The Lubrizol Corporation Short Term Disability Plan
Summary of Material Modifications

The following is a Summary of Material Modifications (SMM) and amends the Summary Plan Description (SPD) for The Lubrizol Corporation Short Term Disability Plan (generally, applies to employees in California, Wisconsin and Washington). Copies of the Plan's SPD may also be found on the Benefits website at http://benefits.lubrizol.com. The changes to the Plan described below are effective April 1, 2018.

The following is only a summary. In the case of a conflict between the information presented below and the Plan, the Plan provisions will govern.

How to Apply for Benefits – Translation Services (Effective April 1, 2018)

You may request translation services to assist you in applying for your benefits by contacting the plan administrator at (440) 347-6108.

How to Apply for Benefits – If your Claim is Denied (Effective April 1, 2018)

If your claim is denied in whole or in part, you will receive a notice explaining the reason for the denial including specific plan provisions on which the decision was made. The notice will also include the following information:

- a description of any additional information needed to complete the claim and why the information is necessary;
- a discussion of the decision, including an explanation of the basis for the plan's disagreeing with any of the following:
    - the views of the health care professionals who treated you and vocational professionals who evaluated you, if you presented those views to the plan;
    - the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the denial, even if the plan did not rely on that advice in denying the claim;
    - a determination of your disability made by the Social Security Administration;
- if an internal rule, guideline, protocol, or other similar criterion was relied on in denying your claim, the specific rule, guideline, protocol, or other similar criterion will be provided, or else the notice will indicate that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim; and
- a description of the Plan's review procedures and time limits, including a statement of your right to bring suit under ERISA following a denial of your appeal, and the deadline for bringing suit.

If you speak a language other than English, you may request a translation of the notice of denial by contacting the plan administrator at (440) 347-6108.

How to Apply for Benefits – Claims Review Procedures (Effective April 1, 2018)

You may request a review of the denial. The request should be submitted to the Employee Benefits Administrative Committee in writing, within 180 days after the claim for benefits was first denied or reduced, and should include your reason for requesting the review. Your request for review may include written comments, documents, records and other information relating to your claim. During the review, you may represent yourself or appoint a representative, and will have the right to inspect all documents and information that was relevant to your claim. You may request translation services to assist you in submitting your request for review by contacting the plan administrator at (440) 347-6108. If no request for review is received within the time limit, the denial or reduction of benefits will be final. If you make a timely appeal, you will remain an employee on an unpaid leave of absence for the duration of the appeal process.

Within 45 days, the committee will render its decision unless special circumstances require an extension of not more than an additional 45 days. You will be notified prior to the end of the first 45 days if more time is needed. The review of the denial of your claim will take into account all comments, documents and information you submit. If the committee denies your claim for benefits based on a new or additional rationale, you must be provided that rationale as soon as possible and sufficiently in advance of the date on which the decision is required to be provided to give you a reasonable opportunity to respond before that date.

All decisions of the committee will be in writing and will provide the following:

- the specific reasons for the action taken;
- the specific plan provisions on which the decision is based.
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim.

If the decision is a denial of your claim, the notification will also include:

- a statement of your right to bring civil action under ERISA;
- a description of the plan deadline to sue, including the calendar date on which the deadline to sue expires for your claim;
- a discussion of the decision, including an explanation of the basis for the plan's disagreeing with any of the following:
    - the views of the health care professionals who treated you and vocational professionals who evaluated you, if you presented those views to the plan;
    - the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the denial, even if the plan did not rely on that advice in denying the claim;
    - a determination of your disability made by the Social Security Administration; and
- if an internal rule, guideline, protocol, or other similar criterion was relied on in making the decision, the specific rule, guideline, protocol, or other similar criterion will be provided, or else the notice will indicate that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist.

If you speak a language other than English, you may request a translation of the letter notifying you of the decision to deny your claim by contacting the plan administrator at (440) 347-6108.