

Vision Plan

Summary Plan Description

January 1, 2025

This document is the Summary Plan Description ("SPD") for this benefit. This SPD is required by federal law called the Employee Retirement Income Security Act of 1974 ("ERISA"). This SPD reflects the terms of the benefit in effect as of January 1, 2025. Ecolab has the right to amend or terminate all or part of the Plan at any time.

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ECOLAB HEALTH AND WELFARE BENEFITS PLAN: MEDICAL, PRESCRIPTION DRUG, DENTAL, VISION, EAP AND FLEXIBLE BENEFIT OPTIONS

ADMINISTRATIVE INFORMATION SUMMARY PLAN DESCRIPTION

EFFECTIVE JANUARY 1, 2025

Plan Name and Description

The name of the Plan is the Ecolab Health and Welfare Benefits Plan ("Plan"). The Plan provides health and other welfare benefits to Eligible Employees of Ecolab Inc. and subsidiaries of Ecolab Inc. that have adopted the Plan ("Participating Employers" or "Employers") and their Eligible Dependents.

This Administrative Information Summary Plan Description ("Administrative Information SPD") describes the medical, prescription drug, dental, vision and EAP options under the Plan.

This Administrative Information SPD and the attached Vendor Benefit Description together make up the ERISA-required Summary Plan Description. The list of options covered under this Administrative Information SPD and the title of the Vendor Benefit Description for each option is below in the *Benefit Options Chart.* The SPD is part of the Plan Document.

Benefit Options Chart

Benefit Type	Insured or Self-Insured	Insurer/ Claims Administrator Name and Contact Information	Vendor Benefit Description
Medical	Self-Insured	Cigna PO Box 182223 Chattanooga, TN 37422-7223 1-800-900-3791 www.mycigna.com	Health Savings Account Medical Plan Option (for Employees Residing in US Other than Alaska, Wyoming and Hawaii) Benefit Description
Medical	Self-Insured	Cigna PO Box 182223 Chattanooga, TN 37422-7223 1-800-900-3791 www.mycigna.com	Traditional Medical Plan Option (for Employees Residing in US Other Than Alaska, Wyoming and Hawaii) Benefit Description
Medical	Insured	HMSA PO Box 1958 Honolulu, HI 96805-1958 1-800-810-2583 www.hmsa.com	Hawaii Medical Plan Option Benefit Description

Benefit Type	Insured or Self-Insured	Insurer/ Claims Administrator Name and Contact Information	Vendor Benefit Description
Medical	Self-Insured	Cigna PO Box 182223 Chattanooga, TN 37422-7223 1-800-900-3791 www.mycigna.com	Health Savings Account Medical Plan Option (for Employees Residing in Alaska and Wyoming) Benefit Description
Medical	Self-Insured	Cigna PO Box 182223 Chattanooga, TN 37422-7223 1-800-900-3791 www.mycigna.com	Traditional Medical Plan Option (for Employees Residing in Alaska and Wyoming) Benefit Description
Medical, Prescription Drug, Dental and Vision and EAP	Insured	Cigna Global PO Box 15050 Wilmington DE 19850-5050 1-800-441-2668 www.cignaenvoy.com	International Benefits Plan Option Benefit Description
Prescription Drug	Self-Insured	CVS/caremark PO Box 52136 Phoenix, AZ 85072-2136 1-866-490-0021 www.caremark.com (See Benefit Description for addresses for out-of-network claim reimbursement, appeals and mail order prescriptions.)	Health Savings Account Prescription Drug Plan Option Benefit Description
Prescription Drug	Self-Insured	CVS/caremark PO Box 52136 Phoenix, AZ 85072-2136 1-866-490-0021 www.caremark.com (See Benefit Description for addresses for out-of-network claim reimbursement, appeals and mail order prescriptions.)	Traditional Prescription Drug Plan Option Benefit Description
Dental	Insured	MetLife Dental Claims PO Box 981282 El Paso, TX 79998-1282 1-800-942-0854 www.mybenefits.metlife.com	Premier Dental Plan Option Benefit Description

Benefit Type	Insured or Self-Insured	Insurer/ Claims Administrator Name and Contact Information	Vendor Benefit Description
Dental	Insured	MetLife Dental Claims PO Box 981282 El Paso, TX 79998-1282 1-800-942-0854 www.mybenefits.metlife.com	Standard Dental Plan Option Benefit Description
Vision	Insured	EyeMed Fidelity Security Life Insurance Company 3130 Broadway Kansas City, MO 64111-2406 1-833-918-1259 member.eyemedvisioncare.com/ecolab/en	Vision Plan Option Group Vision Insurance Certificate / Benefit Description
EAP	Insured	Cigna Behavioral Health 11095 Viking Drive Suite 350 Eden Prairie, MN 55344 Member Services at: 1-800-900-3791 www.mycigna.com	Employee Assistance Plan (EAP) Option Benefit Description
Flexible Benefit	Self-Insured	ThrivePass 1-866-855-2844 mybenefits.us.ecolab.com	Flexible Benefit Plan Option Benefit Description

Eligible Employees

You are eligible to participate in the Plan if you are an Eligible Employee. If you and your family member are both employed by Ecolab or another Participating Employer ("Employer"), you cannot be enrolled as both an employee and a dependent (you and your family member will both be enrolled as employees, provided you are Eligible Employees). To enroll for coverage under an Insurance Policy, you must also satisfy the eligibility requirements for coverage as set forth in the Policy.

Eligible Employee. You are an Eligible Employee if you are:

1. employed by the Employer;
2. in a budgeted position;
3. regularly scheduled to work at least 20 hours per week; and
4. not excluded from the definition of Eligible Employee.

Not Eligible Employee (Excluded). You are not an Eligible Employee (excluded from the definition of Eligible Employee) if you are:

1. classified by the Employer as a temporary employee, a leased employee, or independent contractor;
2. covered by a collective bargaining agreement or contract that does not provide for your participation; or

3. employed by an Ecolab subsidiary that has not adopted the Plan.

Foreign Service for Eligible Employees. If you are a U.S. citizen or resident alien who is transferred to a full-time position with Ecolab or an Ecolab subsidiary in a foreign country (outside of the United States) on a temporary basis for 6 months or more, you will be eligible for coverage under the Ecolab Expatriate option.

Union Employees. If you are covered by a collective bargaining agreement, you are eligible for coverage only if your union agreement provides for your Plan participation.

Reclassification as an Eligible Employee. If you are reclassified as an Eligible Employee by a court, an administrative body or the Employer on a retroactive basis, you will be eligible for coverage only during periods that follow the reclassification. No Plan coverage will be retroactive.

Eligible Dependents

Eligible Dependents are: (1) your Spouse or your Domestic Partner; and (2) your Dependent Child(ren).

You must enroll your Eligible Dependents within the period required by the Plan. Refer to the "Enrollment Periods and Coverage Effective Dates" section below. You must be enrolled in an option to enroll your Eligible Dependents in that option.

Proof of Dependent Status. You must provide documents supporting Eligible Dependent status when you first enroll your Spouse or Domestic Partner or your Dependent Child, such as a birth certificate, marriage certificate or domestic partner affidavit.

If you fail to provide the required documentation by the deadline imposed by the Plan Administrator, your dependent will not be enrolled and cannot enroll until the next Open Enrollment Period (unless you experience a qualifying election change event before then).

You may periodically be required to provide proof of Eligible Dependent status after initial enrollment as well.

Spouse. Spouse means your spouse through marriage recognized as valid under U.S. federal law.

Domestic Partner. To be a Domestic Partner, your partner must be:

1. of the same gender as you and the two of you must be in a civil union, in a registered domestic partnership or a similar arrangement that is legally recognized under the laws of a state in the United States or under the laws of a jurisdiction outside of the United States; or

2. of the same or opposite gender as you and the two of you must:

    a. be at least 18 years old and legally competent to enter into a contract;

    b. not be married to or the domestic partner of anyone else;

    c. be jointly responsible for each other's well-being and financial obligations;

    d. not be related to you by blood to a degree that would prohibit your marriage in your state of residence;

    e. have an ongoing and committed spouse-like relationship and intend to do so indefinitely;

    f. live together in the same principal residence and intend to do so indefinitely; and

g. be jointly responsible for the direction and financial management of your household and take joint financial responsibility for each other's financial obligations.

You must submit your certificate of civil union or registered domestic partnership, or a domestic partner affidavit signed by you and your Domestic Partner. Domestic Partner benefits are only available for an option if provided in the Vendor Benefit Description. Federal tax rules generally require your contribution for coverage for a Domestic Partner and his or her children to be paid on an after-tax basis and the value of employer-paid coverage for the Domestic Partner and his or her children to be imputed to you as income.

Dependent Child. Dependent Child means a child who:

1. has one of the following relationships to you or to your Spouse or Domestic Partner:
    a. biological child;
    b. legally adopted child;
    c. child placed for legal adoption;
    d. foster child; or
    e. legal ward (child for whom you or your Spouse or Domestic Partner are legal guardian); and
2. is either:
    a. under the Limiting Age; or
    b. is eligible for Extended Disabled Dependent Coverage.

Limiting Age. The Limiting Age is age 26, regardless of marital, support, or student status.

Extended Disabled Dependent Coverage. To be eligible for Extended Disabled Dependent Coverage, a child must: (1) provide proof of eligibility for Extended Disabled Dependent Coverage when requested; and (2) not be self-supporting due to physical, mental or intellectual disability.

Enrollment Periods and Coverage Effective Dates

You must enroll in the manner directed by Human Resources.

Initial Enrollment. If you are a new Eligible Employee (a new hire or newly eligible for coverage), you must make your benefit elections within 31 days of your hire date or date of initial eligibility, and must be an Eligible Employee on the date of your enrollment. Your coverage will be retroactive to your hire date.

Annual Open Enrollment. All Eligible Employees can make new elections or changes for the next Plan Year during the Open Enrollment Period that occurs in the fall. Open enrollment elections are effective on January 1 following the Open Enrollment Period.

Mid-Year Special Enrollment. Mid-year special enrollment is provided for medical and prescription drug options pursuant to HIPAA for birth or adoption of a child, marriage, loss of other health plan coverage, losing a child's health insurance coverage through the state or becoming eligible for a premium subsidy from the state to obtain coverage for a child under this Plan. Additional details are provided in the medical Vendor Benefit Description.

Mid-Year Election Changes. Mid-year election changes can only be made if you have experienced a qualifying Mid-Year Election Change Event (see the list below) and make new elections within 31 days of the event. You must make the election in the manner directed by the Plan Administrator. You are required to provide documents supporting your qualifying Mid-Year Election Change Event when you submit your election change form (for example, birth certificate, marriage certificate, divorce decree).

The Plan Administrator will determine whether you have experienced a qualifying Mid-Year Election Change Event and whether the change you are requesting is consistent with that event in accordance with IRS regulations.

An election change will generally be effective on the date of the Mid-Year Election Change Event. Adjusted premium contributions will begin the first pay period after the effective date of your election change. Premium payments will be made for any period of retroactive coverage. Refunds or retroactive adjustments will be made to your premium contributions.

Mid-Year Election Change Events

The following are qualifying Mid-Year Election Change Events for purposes of the Plan:

1. Change in Status Events. The following are change in status events. An election change will be consistent with a change in status only if the change in status: affects eligibility for coverage under an employer plan, or some other plan such as for medical coverage, or coverage under this Plan; and the election change is on account of, and corresponds with, the change in status.

    a. Gain or loss of a Spouse or Domestic Partner;

    b. A change in the number of your Dependent Children, such as through birth or adoption;

    c. A change in your employment or the employment of your Spouse, Domestic Partner or Dependent Child, including:

        i. starting or losing a job;

        ii. a reduction or increase in the hours of employment (including going on and returning from unpaid leave),

        iii. gain or loss of eligibility for benefits under another employer's plan.

    d. Your child satisfying or ceasing to satisfy eligibility requirements for coverage, such as reaching the limiting age.

2. Change in Cost or Coverage Events. The change in cost or coverage events, and the election changes that are permitted as a result, are:

    a. An insignificant cost change in your contribution for Plan coverage will result in an automatic adjustment to your pre-tax contribution.

    b. A significant increase in the cost of a coverage option will permit you to switch to a similar coverage option or, if one is not available, to cancel coverage.

    c. A significant decrease in the cost of a coverage option will permit you to elect that coverage option, even if you are not currently a participant.

    d. The loss of a coverage option will permit you to change to a similar coverage option if any or, if one is not available, to cancel coverage.

e. The reduction of coverage within a coverage option will permit you to switch to a similar coverage option.

f. The addition or significant improvement of a coverage option will permit you to switch to the new or improved coverage option.

3. Election Lock Events. An election change made under another employer's plan, such as the plan of your Spouse's employer, will permit a corresponding change under this Plan if the other plan permits its participants to make an election change in accordance with the IRS cafeteria plan regulations or the other employer's plan and this Plan have different plan years.

4. QMCSO Events. You may change your election for Plan coverage in a manner that is consistent with a judgment, decree or order (including a Qualified Medical Child Support Order) resulting from a divorce, legal separation, annulment or change in legal custody ("Order") that requires health coverage to be provided for your child by you or another individual, such as your ex-Spouse. You may only elect to cancel coverage for your child under this Plan if the Order requires another individual to provide health coverage for your child and that coverage is actually provided.

> The Plan is not obligated to comply with any order requiring you to add your ex-spouse to coverage. The Plan does not cover ex-spouses other than under COBRA continuation coverage. You must notify the Plan of a divorce for your ex-spouse to be eligible for COBRA. See the *COBRA Continuation Coverage* section of this SPD for details. You may be in violation of a court order if you drop your Spouse from coverage prior to divorce or fail to notify the Plan of the divorce and elect COBRA Continuation Coverage for your ex-spouse. You should consult with your divorce attorney.

5. Gain or Loss of Other Health Coverage Events. You may change your election for Plan coverage in a manner that is consistent with the gain or loss by you or your Spouse, Domestic Partner or Dependent Child of entitlement to Medicare or Medicaid. If you or your Spouse, Domestic Partner or Dependent Child loses group health plan coverage under a state children's health insurance program under Title XXI of the Social Security Act (“SCHIPS”), a tribal plan, a state health benefits risk pool, or a foreign governmental plan, you may enroll the individual(s) losing the coverage in corresponding Plan coverage.

6. Mid-Year Special Enrollment Events. If you exercise HIPAA special enrollment rights for medical Plan coverage because you gained an Eligible Dependent through marriage, birth, adoption or placement for adoption or lost other health coverage, pre-tax contributions for premiums for the coverage will be changed automatically.

7. FMLA Events. You may change your elections for Plan coverage when going on or returning from FMLA leave in a manner that is consistent with FMLA requirements and Plan rules.

8. Other Approved Leaves of Absence. Refer to the section entitled “Impact of Leaves of Absence on Benefits.”

Coverage and Benefits Information in Benefits Description

The terms and conditions of coverage and benefits for an option are in the Benefit Description, including:

1. additional eligibility requirements for coverage (if any);

2. commencement and termination of coverage;

3. type and amount of benefits provided;

4. deductibles, co-insurance, co-payments, and benefit maximums;

5. restrictions, limitations and conditions of coverage and benefits;

6. procedure for filing a benefit claim, including the period within which claims must be filed, and the appeal procedure for a denied benefit claim; and

7. the Plan's reimbursement and subrogation rights (for a self-insured option, the *Subrogation and Reimbursement* section of this SPD below will apply to the extent that it is not inconsistent with the subrogation and reimbursement language in the Benefit Description).

Benefit Payments

Benefits do not vest under this Plan. Benefit payments are limited to the amount due under the Plan and late benefit payments will not include interest or penalties.

If a benefit overpayment is made, you are required to promptly repay it. If you do not, the overpayment may be offset from future benefit payments.

Impact of Leaves of Absence on Benefits

Your participation in the Plan during leave of absence depends on whether it is paid or unpaid and the type of leave (for example, FMLA).

Type of Leave	Going on Approved Leave	Returning from Approved Leave (before or at expiration of Approved Leave)
Paid/Partially Paid Leave	Your participation in Plan benefit options (at the active employee premium rates) will continue while you receive pay (health & safe time, vacation time, parental leave or short-term disability). Premiums will be deducted, in whole or in part, from the pay you receive during your leave. If your pay does not cover them in full, they will be deducted in the order determined by the Plan Administrator (e.g., medical premiums will be deducted first, then dental premiums, etc.) and any premiums that are not deducted will be deducted from future pay. If you experience a qualifying Mid-Year Election Change Event, refer to the Mid-Year Election Change Events section of this SPD.	Your Plan benefit options, and pre-tax premium contribution elections remain in place. You will not be able to make a benefit election change on your return from leave unless you experience a qualifying Mid-Year Election Change Event. Refer to the Mid-Year Election Change Events section of this SPD.
Unpaid Leave, FMLA	Your participation in Plan benefit options will continue at the active employee premium rates. Your premium contributions will be put in arrears and deducted from future pay. You may elect to discontinue your benefits options within 31 days from the start of your FMLA leave. Your coverage under the pre-tax benefit options will end as specified in the various	Your Plan benefit options and pre-tax contribution elections that were in place during your leave will continue, but you can change your elections within 31 days from the date of your return. You will be required to reimburse the Employer for unpaid premium contributions during your FMLA leave.

	SPDs for those benefits, and expenses that you incur during your period of non-participation will not be eligible for reimbursement. If you continue coverage during your leave, but do not return to work at the end of your leave, you may be eligible to continue coverage through COBRA. Refer to the COBRA Continuation Coverage section of this SPD for details.	
Unpaid/Partially Paid Leave, Military	If your military leave is unpaid or partially paid, your Plan benefit options continue at the active employee premium rates through the end of the month following the month in which your military leave begins. If your military leave is partially paid, your premiums will be deducted, in whole or in part, from the pay you receive during your leave. If your pay does not cover them in full, they will be deducted in the order determined by the Plan Administrator (e.g., medical premiums, then dental premiums, etc.) and any premiums that are not deducted will be deducted from future pay. You may elect to continue your Plan benefit options under COBRA beyond the end of the month following the month in which your leave began to the extent required by USERRA. If you elect to continue your Plan benefits options, you will pay the active employee premium rates for the first 12 months of COBRA.	If you did not continue your coverage during the entire period of your leave, coverage (and pre-tax premiums for the coverage) will be offered upon your re-employment in accordance with Plan rules and to the extent required by USERRA. You will be required to reimburse the Employer for unpaid premium contributions during your Military leave.
Unpaid Leave, Special	Your participation in Plan benefit options will continue at the active employee premium rates. Your premium contributions will be put in arrears and deducted from future pay. You may elect to discontinue your benefit options within 31 days from the start of your special leave. Your coverage under the pre-tax benefit options will end as specified in the various SPDs for those benefits, and expenses that you incur during your period of non-participation will not be eligible for reimbursement. If you continue coverage during your leave, but do not return to work at the end of your leave, you may be eligible to continue coverage through COBRA. Refer to the COBRA Continuation Coverage section of this SPD for details.	Your Plan benefit options and pre-tax contribution elections that were in place during your leave will continue, but you can change your elections within 31 days from the date of your return. You will be required to reimburse the Employer for unpaid premium contributions during your Special leave.
Long-Term Disability Leave	When you transition to Long-Term Disability leave, your participation in Plan benefit options will continue at the active	Your Plan benefit options will continue, and the pre-tax premium contributions will resume the first of the month following your return to work

	employee premium rates. Your premium contributions will be paid on an after-tax basis to Ecolab's direct bill vendor. You may elect to discontinue your benefit options within 31 days from the start of your Long-Term Disability leave. Your coverage under the benefit options will end as specified in the various SPDs for those benefits, and expenses that you incur during your period of non-participation will not be eligible for reimbursement. If you continue coverage during your leave, but do not return to work at the end of your leave, you may be eligible to continue coverage through COBRA. Refer to the COBRA Continuation Coverage section of this SPD for details.	date. You can change your benefit elections within 31 days from the date of your return.

Benefit Claims and Appeals

Benefit claims must be filed with the Insurer or Claims Administrator in the period and in the manner provided in the Benefit Description.

The Insurer or Claims Administrator is the named fiduciary for benefit claims and appeals and has complete discretionary power and authority to make benefit determinations. A benefit is not payable unless the Insurer or Claims Administrator says that it is.

You are required to complete the claims and appeal procedure outlined in the Benefit Description before you can bring a claim in a court. After you have completed the claims and appeal procedure, you have a limited time to bring a claim in court. See the "Limitation of Legal Action" section below for more information.

Participation Claims and Appeals

If you believe that you have been improperly denied eligibility to participate in the Plan, enroll dependents, make election changes or correct premium contributions, you may file a Participation Claim with the Plan Administrator. Direct your Participation Claim to the attention of the Human Resources Benefits Department.

Definitions.

1. "Participation Claim" is a claim that relates to anything other than a claim for the payment of benefits that is made by a Claimant in accordance with the Plan's procedures for filing a Participation Claim. Participation Claim includes claims of eligibility to participate in the Plan, enroll dependents, make coverage changes, and to correct Employee contributions. A Participation Claim does not include an eligibility claim arising out of a request for a Plan benefit (such a claim is subject to the benefit claim and appeal procedures in the Vendor Benefit Description).

2. "Claimant" means an individual who, individually or through a Representative, has made a Participation Claim.

3. A “Representative” is an individual who can act on behalf of the Claimant. A parent or guardian will generally be considered the Representative of a child. In all other situations, the Claimant must notify the Plan in writing of a Representative.

Claim Submission.

1. A Participation Claim must be submitted to the Plan Administrator in writing and include the reason why the Claimant believes that the Participation Claim is valid. Completion and submission of enrollment, coverage change or other forms required by the Plan Administrator satisfies these requirements.

2. A Participation Claim must be made in the manner required by the Plan Administrator and within the period applicable to the type of Claim at issue:

    a. An Employee’s request to enroll himself or herself or a Spouse, Dependent, Domestic Partner or Domestic Partner's Child in Plan coverage must be made within the enrollment or coverage change period required by the Plan (for example, during open enrollment, within 31 days of an Employee’s hire or becoming eligible for coverage, within 31 days of the acquisition of a new Dependent or the date of loss of coverage for special enrollment or within 31 days of an event that permits a coverage change).

    b. A request to correct the amount of an Employee coverage contribution must be made within 60 days of the date of the improper contribution. A contribution is made on the date that it is deducted from the Employee’s pay.

Initial Review.

1. The Plan Administrator will provide its initial review determination to the Claimant within 90 days of receiving the Participation Claim. This period can be extended by up to 90 days in special circumstances, provided notice is given to the Claimant.

2. If a Participation Claim is denied in whole or part, the Plan will provide a written notice to the Claimant that includes:

    a. the reason(s) for the denial;

    b. a description of any additional material or information necessary for the Claimant to perfect the Participation Claim and an explanation as to why the information or material is necessary; and

    c. an explanation of the Plan’s appeal review procedure for the Participation Claim, including the applicable time limits.

Appeal Review.

1. The Claimant must appeal an initial Participation Claim denial within 30 days of his or her receipt of the denial. The appeal must be in writing and include the reason why the Claimant believes that the Participation Claim is valid.

2. The Claimant may submit written comments, documents, records, and other information to the Plan Administrator and the information will be considered on review regardless of whether it was submitted or considered in the initial review.

3. The Plan will provide to the Claimant reasonable access to documents, records, and other information which are, in the judgment of the Plan Administrator, relevant to the Participation Claim.

4. The Plan Administrator will provide its appeal review determination to the Claimant within 60 days of receiving the appeal of the denial of the Participation Claim. This period can be extended by up to 60 days in special circumstances, provided notice is given to the Claimant.

5. If the Participation Claim is denied on appeal review, the Plan will provide written notice to the Claimant that includes the reason(s) for the continued denial.

Qualified Medical Child Support Orders

The Plan Administrator will determine whether an order requiring the Plan to provide group health coverage to a child is a Qualified Medical Child Support Order. You can obtain a copy of the QMCSO procedures on request and free of charge from the Plan Administrator. If you are not enrolled, you will be required to enroll in order to enroll your child pursuant to a QMCSO. You must pay the premium required for your coverage and your child's coverage.

The Plan is not obligated to comply with any order requiring you to add your ex-spouse to coverage. The Plan does not cover ex-spouses other than under COBRA continuation coverage. You must notify the Plan of a divorce for your ex-spouse to be eligible for COBRA. See the COBRA Continuation Coverage section of this SPD for details. You may be in violation of a court order if you drop your Spouse from coverage prior to divorce or fail to notify the Plan of the divorce allowing your ex-spouse to elect COBRA Continuation Coverage. You should consult with your divorce attorney.

Post Retirement Benefits

The Ecolab Post Retirement Benefits Plan and certain other Ecolab plans currently provide eligible retirees with medical, dental and vision benefits, in addition to a small death benefit. For eligibility information, refer to the Ecolab Post Retirement Benefit Plan Summary Plan Description (SPD).

Under the terms of the plans applicable to Nalco Company retirees, you will lose eligibility for retiree medical and dental benefits if (i) you directly or indirectly in any manner or under any circumstances or conditions, engage in, as a partner, principal, agent, employee, stockholder, officer, director, trustee, consultant, or in any other capacity whatsoever, except as a nominal owner of stock of a public corporation, any business that in any way competes with the Company within any geographic area in which you had direct or indirect responsibility during the last two (2) years of your employment; or (ii) you, at any time, solicit any employee of the Company, or any person who served as an employee of the Company during the six (6) months immediately before your termination from employment, for employment or service or retain, hire or encourage any other person to solicit employees of the Company. You will forfeit eligibility under the retiree plans effective as of the last day of the month in which the Plan sponsor reasonably determines you are in competition with the Company, and you will not become eligible to participate in the retiree plans again.

COBRA Continuation Coverage

If you or your dependent loses coverage due to a COBRA qualifying event (reduction of hours, termination of employment, death, divorce or loss of dependent status), COBRA continuation coverage may be elected to temporarily continue your coverage as provided in this section. You must notify Ecolab Human Resources in writing within 60 days of a death, divorce or loss of Eligible Dependent status. If you do not notify Ecolab within 60 days, COBRA continuation coverage rights will be lost.

Any covered Eligible Employee or Eligible Dependent who loses Plan coverage as a result of a "qualifying event" will be eligible to elect to temporarily continue Plan coverage under a federal law called COBRA as described below.

For employees, the qualifying events are: (1) termination of employment for any reason other than gross misconduct; and (2) a reduction in hours.

For dependents, the qualifying events are: (1) the employee's termination of employment for any reason other than gross misconduct; (2) the employee's loss of eligibility for coverage due to a reduction in work hours; (3) the employee's death; (4) the employee's divorce, legal separation or termination of domestic partnership; or (5) loss of Eligible Dependent status under the Plan.

"You" or "your" refers to an Eligible Employee who is eligible for (and when required, has elected) COBRA continuation coverage. Your "dependent" means your Eligible Dependent who is eligible for (and when required, has elected) COBRA continuation coverage.

"Employer" means Ecolab Inc. or a Participating Employer.

Maximum COBRA Coverage Period

If your qualifying event was termination of employment or reduction of hours, your coverage and the coverage of your dependents can generally be continued for up to 18 months from the date of the employment termination or hours reduction. The coverage period can be extended to up to 29 months if you or your dependent is determined to be disabled for Social Security purposes at any time during the first 60 days of coverage continuation and you satisfy the notice requirement stated in "Disability Determination" below.

The continuation coverage period for your dependent can be extended to up to 36 months if, within the initial 18-month period (or 29-month extended period), coverage under the Plan would otherwise terminate because you die, your dependent ceases to meet the eligibility requirements of the Plan, you and your Spouse become legally separated or divorced, or you and your Domestic Partner end your domestic partnership. This is called a "second qualifying event."

If you enrolled in Medicare benefits before you lost coverage because of a reduction in hours or termination of employment, coverage for your dependents can be extended until up to 18 months after the reduction or termination or up to 36 months after the date of Medicare enrollment, whichever is later.

If the qualifying event was your death, legal separation, divorce, termination of domestic partnership or your dependent's ceasing to meet the eligibility requirements of the Plan, the continuation period would be up to 36 months from the date of the event.

The maximum COBRA coverage periods described above will not be extended even though coverage under the Plan is continued unintentionally, resulting in a delay in termination of coverage, or the Employer reduces or subsidizes, in whole or in part, the premium an individual is required to pay for COBRA coverage. The continuation coverage periods described above are maximum periods that will be reduced as described below.

You Must Provide Notice to the Plan Administrator of Certain Events

There are four instances in which you are required to notify the Plan Administrator or COBRA Administrator of an event. They are below. If you fail to provide the required notice within the period noted below, the right to elect to continue coverage will be lost. The notice must be in writing, must contain the information described below, and must be mailed by first class mail, postage prepaid.

1. *Divorce, Legal Separation, Termination of Domestic Partnership or Loss of Dependent Child Status.* You or your dependent must notify the COBRA Administrator of your divorce, legal separation, termination of domestic partnership or your child's ceasing to qualify as a dependent under the Plan within 60 days of the date of the qualifying event. If the COBRA Administrator is not given the required notice within 60 days, the right to continue coverage will be lost. The notice must contain the following information:

    a. The name, address and Social Security Number of the employee;

b. The name, address and Social Security Number of each dependent covered by the Plan;

c. A description of the qualifying event;

d. The date of the qualifying event; and

e. A list of the health plan options under which the affected individuals are covered.

2. *Disability Determination.* If you or any of your dependents were eligible for COBRA coverage as a result of your termination of employment or reduction in hours and elected COBRA coverage, and you or any dependent was determined to be disabled by the Social Security Administration at any time within the first 60 days of COBRA continuation coverage (whether or not the disabled person elected COBRA coverage), you and your dependents who elected COBRA coverage will be eligible for an additional 11 months of COBRA continuation coverage if you notify the COBRA Administrator of such determination within 60 days after the Social Security Administration determination and prior to the expiration of 18 months following the qualifying event. If the COBRA Administrator is not given the required notice within 60 days after the Social Security Administration determination and within the 18 month continuation period, the right to the disability extension will be lost. The notice must contain the following information:

a. The name, address and Social Security Number of the employee;

b. The name, address and Social Security Number of each dependent covered by the Plan; and

c. A copy of the Social Security Administration notice of determination.

3. *End of Disability.* If the Social Security Administration determines that the person has ceased to be disabled, you or your dependent must notify the COBRA Administrator within 30 days. The notice must contain the following information:

1. The name, address and Social Security Number of the employee;

2. The name, address and Social Security Number of each dependent covered by the Plan;

3. A copy of the Social Security Administration notice of determination; and

4. A list of the group health plan options under which the affected individuals are covered.

4. *Second Qualifying Event.* If during an 18-month or 29-month period of continuation coverage your dependent would otherwise lose coverage because of a second qualifying event which is the employee's divorce, legal separation, or termination of domestic partnership or the child's ceasing to qualify as a dependent under the Plan, you or your dependent must notify the COBRA Administrator within 60 days of the date of the second qualifying event. If the COBRA Administrator is not given the required notice within 60 days, the right to extend continuation coverage to a maximum of 36 months will be lost. The notice must contain the following information:

a. The name, address and Social Security Number of the employee;

b. The name, address and Social Security Number of each dependent covered by the Plan;

c. A description of the second qualifying event;

d. The date of the second qualifying event; and

e. A list of the group health plan options under which the affected individuals are covered.

Type of COBRA Coverage Available

An individual electing COBRA continuation coverage may elect to continue the Plan coverage in effect immediately before the qualifying event. If, however, the coverage provided to similarly situated employees is eliminated and the Employer continues to maintain other medical coverage, the individual will have the right to elect that coverage.

While the individual can only elect to continue health care coverage he or she had at the time of the qualifying event, as long as he or she continues the coverage, he or she will have the same coverage options that he or she would have had if the qualifying event had not occurred. For example, he or she may be able to change to a different option offered by the Employer during an open enrollment period or add coverage for newly acquired Eligible Dependents. (Dependents who are added during coverage continuation (after the qualifying event) will not have any independent continuation rights, except for children born to, placed for adoption with or adopted by the employee during the employee's continuation coverage period.)

Who May Elect COBRA Coverage

If you are eligible for COBRA coverage, you can make the election for yourself and for any one or more of your dependents who are eligible for COBRA coverage. If you do not make the election, your Spouse or Domestic Partner can make the election for himself or herself and any covered Dependent Child. Finally, if neither you nor your Spouse or Domestic Partner make the election for a covered Dependent Child, the dependent may make the election for himself or herself. (A child who is born to, or placed for adoption with, the employee while the employee is continuing coverage under COBRA and who becomes covered by the Plan will have independent COBRA election rights as if he or she were covered at the time of the qualifying event.)

Impact of COBRA on other Federal Law Rights

In considering whether to elect continuation coverage, you should take into account that a failure to continue group health plan coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of a qualifying event. You will also have the same special enrollment right at the end of the continuation coverage period if you get continuation coverage for the maximum time available to you.

COBRA Election Period

After a qualifying event or receiving notice of a qualifying event (if notice is required), the COBRA Administrator will send a notice regarding COBRA election rights to individuals eligible for COBRA. The individuals will have 60 days from the date of such notice (or from the date coverage would otherwise terminate because of the qualifying event, if the coverage would stop after the notice is sent) in which to file a written election to continue your coverage. If the individual does not file the required election form within this 60-day period, he or she will lose the right to continue coverage under the Plan. The election form must be submitted to the address specified in the election form.

The Trade Act of 2004 created a tax credit for certain individuals who become eligible for trade adjustment assistance ("eligible individuals"). Under the tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. An eligible individual who did not elect COBRA coverage will have a second 60-day COBRA election period beginning on the first day of the month in which he or she is determined to be

an eligible individual, but only if the election is made within six months after the original termination of employment. Any COBRA coverage elected during the second election period will begin with the first day of the second election period, rather than on the date coverage terminated.

COBRA Premium

You (or your dependent) must pay the full premium (both the employee and employer contribution), plus a 2% administration fee, for any coverage you continue. (The charge will be higher for coverage extended on account of disability.) The premium will be the same premium that would be paid for a person in your situation with respect to whom no qualifying event had occurred (but will include any portion the Employer normally pays for active employees). The first premium payment, covering the period between the date coverage would otherwise stop and the date of the payment, must be made within 45 days after the date you file the election to continue coverage. Subsequent premiums are due monthly on the day of the month coverage would have stopped if COBRA continuation had not been elected, and coverage will end if your or your dependent fails to pay the premium for any month within 30 days after the due date.

Under its current practice, if you die while actively employed by Ecolab or its subsidiary, Ecolab will subsidize the first 6 months of COBRA premiums for your dependents enrolled in medical coverage at the time of your death. Each dependent can elect to continue coverage at the full COBRA premium cost for the remaining 30 months of the continuation period.

No COBRA Coverage Pending Election or Payment

You will not have COBRA coverage until you have elected the coverage and made the required premium payment. Once you make the election and pay the premium, coverage will be reinstated retroactively to the date you lost your coverage.

Termination of Coverage

The continuation coverage will terminate when the first of the following events occurs.

1. The 18-, 29- or 36-month maximum continuation period ends.

2. You fail or your dependent fails to pay the initial premium within 45 days after your election, in which case you will be treated as not having elected to continue your coverage.

3. You fail or your dependent fails to pay any other premium within 30 days after it is due, in which case your coverage will end as of the end of the last period for which you made a timely premium payment.

4. After electing continuation coverage, you become or your dependent enrolls in Medicare benefits or becomes covered by any other group health plan that does not limit or exclude coverage because of a preexisting condition. Coverage already in place at the time of the continuation coverage election will not cause termination of continuation coverage.

5. The Employer ceases to provide group health benefits to any of its employees.

6. For coverage that is continued beyond 18 months because of disability, the disabled person ceases to be disabled, in which case the coverage will terminate as of the first day of the month that begins at least 30 days after date of the Social Security Administration’s determination that the person is no longer disabled.

7. The continuation coverage is terminated for cause (for example, you commit fraud against the Plan).

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator (see contact information below) or the COBRA Administrator. 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 the Plan and COBRA Administrator Informed of Address Changes

To protect your family's COBRA continuation rights, you should keep the Plan and COBRA Administrator informed of any changes in the addresses of family members.

Keep Copies of Any Notices You Send to the Plan or COBRA Administrator

You should also keep a copy, for your records, of any notices you send to the Plan and COBRA Administrator.

Plan Administrator Contact Information

Ecolab Inc.
Attn: Benefits Department – EGH3
1 Ecolab Place
St. Paul, MN 55102
If you have questions, call: (800) 964-0265

COBRA Administrator Contact Information:

ThrivePass
PO Box 220
Minneapolis, MN 55440-0220
(866) 855-2844

USERRA Continuation Coverage

If you leave your job with a Participating Employer to go on a qualifying military leave of absence as defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), you may elect to continue your coverage as provided in this section.

You will have the right to elect to continue Plan coverage for yourself and your Eligible Dependents during a period of Uniformed Service for up to 24 months, or the date on which you fail to return to work following your period of Uniformed Service, whichever is earlier. USERRA Continuation Coverage will begin on the first day of your leave of absence due to Uniformed Service.

Definitions

1. "Uniformed Service" includes service by an Employee in the Armed Forces, Reserves, federally activated National Guard and volunteers in the National Disaster Medical System.

2. "Service" means the performance of duty on a voluntary or involuntary basis in the Uniformed Services, including active and inactive duty training or service, examination to determine fitness for duty, certain funeral honors duties, and certain service by intermittent disaster-response personnel of the National Disaster Medical System.

3. "USERRA Continuation Coverage" means continuation of Plan coverage pursuant to USERRA.

Election of USERRA Continuation Coverage

You will be required to elect USERRA coverage. COBRA election procedures as set forth in COBRA Continuation Coverage Rights section will apply, except that an election for USERRA Continuation Coverage is not required if advance notice of leave is excused under USERRA. If you elect COBRA, you will be considered to have elected USERRA continuation coverage as well.

Cost of USERRA Continuation Coverage

The COBRA rate will apply. You will only be required to pay the active employee rate, however, for a USERRA leave of less than 31 days if you notify the Plan that your Uniformed Service is scheduled to last less than 31 days.

Termination of USERRA Continuation Coverage

USERRA Continuation Coverage will end when the earliest of the following occurs:

1. The 24-month USERRA Continuation Coverage period ends;

2. You fail to report back to work or apply for reemployment within the period required under USERRA after completing Service;

3. The Employer ceases to offer any group health plan to any of its employees; or

4. You fail to pay the required premium contribution within 30 days of the due date.

Coordination of COBRA Coverage and USERRA Coverage

The maximum USERRA Continuation Coverage period is 24 months. The maximum COBRA continuation coverage period may be 18 months, 29 months or 36 months depending on the qualifying event. The USERRA Continuation Coverage period and the COBRA continuation coverage period will run concurrently.

Covered dependents do have independent election rights under COBRA but not under USERRA. You must elect continuation coverage for yourself in order for your Spouse or Domestic Partner or Dependent Child to be eligible for any USERRA Continuation Coverage period that extends beyond the COBRA continuation coverage period.

Reinstatement of Coverage on Return from Service

To the extent required by USERRA, Plan coverage will be reinstated after you return to work even if you do not elect USERRA Continuation Coverage or your USERRA Continuation Coverage terminates for failure to pay a premium. No waiting period will be imposed.

Other Notices

Conditions of Participation

Participation in the Plan by an Eligible Employee is voluntary. Participation in the Plan does not give any Employee the right to continued employment.

As a condition of participation, each Eligible Employee and Eligible Dependent agrees to:

1. be bound by all of the terms and conditions of the Plan and, for an insured option, the Insurance Policy;

2. make the contributions required; and

3. furnish such information and execute such instruments and forms as the Plan Administrator and Insurer or Claims Administrator may request.

Committing Fraud or Intentional Misrepresentation Against the Plan

If you commit fraud or intentional misrepresentation of a material fact against the Plan (which may include enrolling someone in coverage who you know or should know does not qualify as your Eligible Dependent, continuing enrollment of someone in coverage who you know or should know has lost eligibility or filing a false claim) the Plan (or your Participating Employer) may take action, which may include the following:

1. Termination of Plan Coverage. Your coverage may be terminated. Coverage for the person you enrolled may be terminated. If you have committed fraud or made an intentional misrepresentation of a material fact, coverage may be terminated retroactively.

2. Repayment of Plan Benefits. You may be responsible for all benefits paid for a person who was not eligible for coverage or as a result of a false claim.

3. Discipline. You may be subject to discipline, including termination of your employment.

4. Notification of Law Enforcement. Law enforcement may be notified that you have committed intentional misrepresentation or fraud against the Plan.

Limitation of Legal Action

For insured options, the limitation of actions provision contained in the Policy will apply.

For self-insured options (and insured options if the Policy does not contain a limitation of action provision), the following will apply:

No action with respect to eligibility to participate or for any benefit under this Plan may be brought more than six months following the final decision in the final appeal review brought pursuant to the claim and appeal procedure set forth in the Vendor Benefit Description, or for eligibility claims, the participation and claims procedure described in this SPD. In no event can any action with respect to eligibility to participate or with respect to any benefit under this Plan be brought more than three years after the date the event giving rise to the claim occurred.

No Guarantee of Tax Consequences

Although Ecolab intends to provide certain Plan benefits on a tax-free basis, Ecolab does not guarantee that the benefits are tax-free or the tax consequences to you. You are responsible to pay any local, state or federal taxes that you owe as a result of your Plan participation or receipt of Plan benefits.

Availability of the Plan's HIPAA Notice of Privacy Practices

You can obtain a copy of the Plan's HIPAA Notice of Privacy Practices, which describes your privacy rights under the Health Insurance Portability and Accountability Act of 1996, from the Plan Administrator or from the Insurer for an insured option.

The separate HIPAA Plan amendment is part of the Plan document.

Health Care Providers

You are responsible for choosing your own health care provider. You must decide if any provider treating you (including an in-network provider) is right for you. You must decide with your health care provider which care you will receive. Your health care provider, whether in- or out-of-network, is responsible for the care provided to you.

The Plan pays for certain health care expenses. It does not provide health care. Determinations that health care services or supplies are not Covered Expenses (including that they are not medically necessary) are for payment purposes only.

The Insurer or Claims Administrator pays network providers through various types of contractual arrangements, which may include financial incentives to promote the delivery of care in a cost- effective manner (for example, bonuses based on quality, member satisfaction and cost-effectiveness). The financial incentives are not intended to affect your access to health care. If you have questions about whether your network provider's contract includes any financial incentives, you should discuss them with your provider and the Insurer or Claims Administrator.

Wellness Program Incentives

The Insurer, Claims Administrator or Plan may offer incentives to encourage you to participate in wellness programs or disease management programs. The decision whether to participate is yours alone and will not impact your eligibility to participate in the Plan or your employment at Ecolab.

Subrogation and Reimbursement

Insured vs. Self-insured. Subrogation and reimbursement under a fully insured Option will be as provided in the Policy. This section applies to self-insured medical options to the extent not inconsistent with the Vendor Benefit Description. If it is inconsistent with the Vendor Benefit Description, the Vendor Benefit Description controls.

Subrogation and Reimbursement Rights. Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any benefit, the Plan shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and benefits the Plan provided to Eligible Employees or Eligible Dependents ("Covered Persons"), from any or all the following listed below. In addition to any subrogation rights and in consideration of the coverage provided by this Summary Plan Description, the Plan shall also have an independent right to be reimbursed by Covered Persons for the reasonable value of any services and benefits the Plan provides to Covered Persons, from any or all of the following listed below.

1. Third parties, including any person alleged to have caused a Covered Person to suffer injuries or damages.

2. Any person or entity who is or may be obligated to provide benefits or payments to a Covered Person, 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.

3. Any person or entity who is liable for payment to a Covered Person on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties".

Responsibilities of Covered Persons. Covered Persons agree as follows:

1. The Covered Person will cooperate with the Plan in a timely manner in protecting the Plan's legal and equitable rights to subrogation and reimbursement, including, but not limited to:

    a. providing any relevant information requested by the Plan;

    b. signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim;

    c. responding to requests for information about any accident or injuries;

    d. appearing at depositions and in court; and

    e. obtaining the consent of the Plan or its agents before releasing any party from liability or payment of medical expenses.

2. Failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits and/or the institution of legal action against a Covered Person.

3. The Plan has the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

4. No court costs or attorneys' fees may be deducted from the Plan's recovery without the Plan's express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and the Plan is not required to participate in or pay court costs or attorneys' fees to the attorney hired by a Covered Person to pursue his or her damage/personal injury claim.

5. Regardless of whether a Covered Person has been fully compensated or made whole, the Plan may collect from Covered Persons the proceeds of any full or partial recovery that a Covered Person or his or her legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment. The proceeds available for collection shall include, but not be limited to, any and all amounts earmarked as non-economic damage settlement or judgment.

6. Benefits paid by the Plan may also be considered to be benefits advanced.

7. Covered Persons agree that if they receive any payment from any potentially responsible party as a result of an Injury or Sickness, whether by settlement (either before or after any determination of liability), or judgment, the Covered Person will serve as a constructive trustee over the funds and failure to hold such funds in trust will be deemed as a breach of the Covered Person's duties hereunder.

8. Covered Persons or an authorized agent, such as the Covered Person's attorney, must hold any funds received from any potentially responsible party that are due and owed to the Plan, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the institution of legal action against the Covered Person.

9. The Plan shall be entitled to recover reasonable attorney fees from Covered Persons incurred in collecting from the Covered Person any funds held by the Covered Person that he or she recovered from any Third Party.

10. The Plan may set off from any future benefits otherwise allowed by the Plan the value of benefits paid or advanced under this section to the extent not recovered by the Plan.

11. Covered Persons will neither accept any settlement that does not fully compensate or reimburse the Plan without the Plan's written approval, nor will the Covered Person do anything to prejudice the Plan's rights under this section.

12. Covered Persons will assign to the Plan all rights of recovery against Third Parties, to the extent of the reasonable value of services and benefits the Plan provided, plus reasonable costs of collection.

13. The Plan's rights will be considered as the first priority claim against Third Parties, including tortfeasors for whom Covered Persons are seeking recovery, to be paid before any other of the Covered Person's claims are paid.

14. The Plan' rights will not be reduced due to the Covered Person's own negligence.

15. The Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including filing suit in the Covered Person's name, which does not obligate the Plan in any way to pay the Covered Person part of any recovery the Plan might obtain.

16. The Plan shall not be obligated in any way to pursue this right independently or on behalf of the Covered Person.

17. If the injury or condition giving rise to subrogation or reimbursement involves a minor child, this section applies to the parents or guardian of the minor child.

18. If the injury or condition giving rise to subrogation or reimbursement involves the wrongful death of a Plan beneficiary, this section applies to the personal representative of the deceased Plan beneficiary.

<u>Refund of Overpayments.</u>

1. If the Plan pays benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if either of the following apply:

   a. all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person; or

   b. all or some of the payment we made exceeded the benefits under the Plan.

2. The refund equals the amount we paid in excess of the amount we should have paid under the Plan.

3. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

4. If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future benefits that are payable under the Plan. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

ERISA Plan Information

Plan Name and Type: Ecolab Health and Welfare Benefits Plan. The Plan provides health and other welfare benefits to Eligible Employees of Ecolab Inc. and other Participating Employers.

Participating Employers: Ecolab Inc. and subsidiaries of Ecolab Inc. that have adopted the Plan. If you have questions about whether your employer is a Participating Employer, contact the Plan Administrator.

Plan Number: The Plan number is 501.

Plan Year: The Plan Year is the 12-month period beginning each January 1 and ending the following December 31.

Plan Sponsor Taxpayer Identification Number: Ecolab's Taxpayer Identification Number is 41-0231510.

Plan Sponsor and Plan Administrator: Ecolab Inc. is the Plan Sponsor and Plan Administrator of the Plan.

Ecolab Inc.
Attn: Benefits Department - EGH3
1 Ecolab Place
St. Paul, MN 55102
(800) 964-0265

Plan Administrator Discretionary Authority: The Plan Administrator's determinations regarding coverage, claims and all other aspects of the Plan are binding. The Plan Administrator has complete discretionary power and authority with respect to all Plan matters, including eligibility and benefits, factual determinations and Plan interpretation. A benefit is not payable unless the Plan Administrator determines that it is. The Plan Administrator may delegate its authority to Plan service providers, such as the Insurer or Claims Administrator.

Right to Amend or Terminate Plan: Ecolab reserves the right to amend or terminate all or part of this Plan and will do so by written instrument signed by an authorized Ecolab officer. Plan terms cannot be modified by oral statements made by anyone. Misinformation or a mistake does not create a right to eligibility or benefits.

Insurer or Claims Administrator: The name, address and contact information for the Insurer or Claims Administrator for each option is listed in the *Benefits Options Chart* at the front of this SPD.

Premium Contributions and Plan Funding: Premiums for the Plan benefits you elect are paid through your contributions and contributions by your Participating Employer, if any. The Plan Administrator will inform you what Premium amount you will be required to pay for your coverage. To the extent permitted by federal law, your Premium contributions will automatically be paid on a pre-tax basis. Benefits for insured options are paid by the Insurer. Ecolab has no responsibility to pay any benefits under this Plan for insured options. Benefits for self-insured options are paid from Ecolab's general corporate assets.

Legal Process: Legal process may be served on the Plan Administrator at the following address:

Ecolab Inc.
Attn: General Counsel's Office
1 Ecolab Place
St. Paul, MN 55102

Collective Bargaining Agreements:

A copy of any collective bargaining agreement that provides for participation in this Plan is available for examination.

Provider Lists: Provider lists are furnished automatically, without charge, upon request.

Statement of ERISA Rights

As a participant in this 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

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the 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 collective bargaining agreements, and copies of the latest Form 5500 and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report, if applicable. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You have the right to continue health care coverage for yourself, spouse or dependents if there is a loss of group health plan coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review *COBRA Continuation Coverage and USERRA Continuation Coverage* on the rules governing your COBRA continuation coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of this 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, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit provided under this Plan or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a 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.

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. 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 Plan Administrator's control. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

If the Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about this 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, 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 Avenue N.W., Washington, D.C. 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.

FIDELITY SECURITY LIFE INSURANCE COMPANY®

3130 Broadway
Kansas City, Missouri 64111-2406
Phone 800-648-8624
A STOCK COMPANY
(Herein Called "the Company")

POLICY NUMBER: VC-146

POLICYHOLDER: Ecolab Inc.

POLICY EFFECTIVE DATE: January 1, 2025

POLICY ANNIVERSARY DATE: January 1 of the following year and each January 1 thereafter

Fidelity Security Life Insurance Company represents that the Insured Person is insured for the benefits described in the following pages, subject to and in accordance with the terms and conditions of the Policy.

The Policy may be amended, changed, cancelled or discontinued without the consent of any Insured Person.

The Certificate explains the plan of insurance. An individual identification card will be issued to the Insured containing the group name, group number, and Insured's effective date. The Certificate replaces all certificates previously issued to the Insured under the Policy.

All periods of time under the Policy will begin and end at 12:01 A.M. Local Time at the Policyholder's business address.

The Policy is issued by Fidelity Security Life Insurance Company at Kansas City, Missouri on the Policy Effective Date.

FIDELITY SECURITY LIFE INSURANCE COMPANY

Bryson T. Jones — Bradford R. James

President — Secretary

GROUP VISION INSURANCE CERTIFICATE
THIS IS A LIMITED BENEFIT CERTIFICATE
Non-Qualified
Please read the Certificate carefully.

THIS PLAN IS NOT MEDICARE SUPPLEMENT. If you are eligible for Medicare, please review "Choosing a Medigap Policy: A Guide to Health Insurance for People With Medicare," available from the Company.

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SCHEDULE OF BENEFITS ..... Attached (1A)

DEFINITIONS

Allowance means the benefit amount shown in the Schedule of Benefits that is the maximum amount payable by the Company, subject to the expenses incurred. The Insured Person is responsible for any amounts due above the Allowance. The Allowance cannot be used to satisfy a Copayment.

Benefit Frequency means the period of time in which a benefit is payable as shown in the Schedule of Benefits.

The Benefit Frequency begins on January 1. Each new Benefit Frequency begins at the expiration of the previous Benefit Frequency.

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

Comprehensive Eye Examination means a general evaluation of the complete visual system. The examination includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields, basic sensorimotor examination and Refraction. It always includes initiation of diagnostic and treatment programs. It may include biomicroscopy, examination with cycloplegia or mydriasis and tonometry, as determined by the Provider. These services may be performed at different sessions, but comprise only one Comprehensive Eye Examination.

Dependent means any of the following persons whose coverage under the Policy is in force and has not ended:

1. the Insured's lawful spouse or Domestic Partner;
2. each child of the Insured or the Insured's spouse who is under 26 years of age; or
3. each unmarried child at least 26 years of age who is primarily dependent upon the Insured or the Insured's spouse for support and maintenance because the child is incapable of self-sustaining employment by reason of a developmental disability, mental illness or disorder, or physical disability.

Dependent includes a step-child, foster child, grandchild, legally adopted child, child for whom the Insured is a party to a suit for adoption, child who has been placed in the Insured's home for adoption and child under the Insured's legal guardianship, if such child depends primarily on the Insured for support. Dependent will also include a child for whom the Insured is legally required to support due to court order or divorce decree.

Domestic Partner means a same-sex or an opposite-sex adult who is in a committed relationship with the Insured and the Insured and the Domestic Partner are mutually responsible for one another financially and otherwise. The term "spouse," wherever used, will include a Domestic Partner.

Formulary means a list, provided by the Company, of Vision Materials by tier, that are covered under the Policy as shown in the Schedule of Benefits.

Insured means an employee of the Policyholder who meets the eligibility requirements as shown in the Policyholder's application, and whose coverage under the Policy is in force and has not ended.

Insured Person means the Insured. Insured Person will also include the Insured's Dependents, if enrolled.

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

Low Vision means a severe visual loss that is not correctable with standard lenses and:

1. when the best-corrected acuity is 20/200 or less in the better eye with best conventional spectacle or contact lenses prescription; or
2. when there can be a demonstrated constriction of the peripheral fields in the better eye to 10 degrees or less from the fixation point or the widest diameter subtends an angle less than 20 degrees in the better eye.

Low Vision Aids are classified as follows:

1. *Spectacle-mounted magnifiers* - A magnifying lens is mounted in spectacles (this type of system is called a microscope) or on a special headband. This allows use of both hands to complete the close-up task, such as reading;
2. *Handheld or spectacle-mounted telescopes* - These miniature telescopes are useful for seeing longer distances, such as across the room to watch television, and can also be modified for near (reading) tasks;
3. *Handheld and stand magnifiers* - These magnifiers can serve as supplements to other specialized systems and are convenient for short-term reading of such things as price tags, labels and instrument dials. Both types of magnifiers can be equipped with lights; or
4. *Video magnification* - Table-top (closed-circuit television) or head-mounted systems enlarge reading material on a video display. Some systems can be used for distance viewing tasks. These are portable systems and can be used with a computer or Computer Display. Image brightness, image size, contrast, foreground/background color and illumination can be customized.

Low Vision Supplemental Examination means diagnostic evaluation beyond the Comprehensive Eye Examination and includes a history of functional difficulties that involves such things as reading, activities in the kitchen, glare problems, mobility, the workplace, television viewing, school requirements, hobbies and interests. Preliminary tests may include assessment of ocular functions such as color vision and contrast sensitivity. Measurements will be taken for visual acuity using special low vision test charts, which include a larger range of letters or numbers to more accurately determine a starting point for assessing the level of impairment. Visual fields may also be evaluated. A specialized Refraction must be performed with each eye thoroughly examined. The Provider may prescribe various treatment options, including Low Vision Aids, as well as assist with identifying other resources for vision and lifestyle rehabilitation.

Medically Necessary Contact Lenses means that adequate functional vision correction cannot be achieved with spectacles but can be achieved with contact lenses. Conditions that qualify for Medically Necessary Contact Lenses are:

1. Anisometropia of 3D in meridian powers;
2. High Ametropia exceeding -12D or +12D in meridian powers;
3. Keratoconus when vision is not correctable to 20/25 in either eye or both eyes using standard spectacle lenses; or
4. vision impairments, other than Keratoconus, when vision can be improved by two lines on the visual acuity chart when compared to best corrected standard spectacle lenses.

Out-of-Network Provider means a Provider, located within the PPO Service Area, but is not an In-Network Provider.

Policy means the Vision Insurance Policy issued to the Policyholder.

Policyholder means the employer named as the Policyholder in the face page of the Policy.

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

Preferred Provider Agreement means the agreement between the PPO and a Provider who agrees to become an In-Network Provider. The Preferred Provider Agreement contains the rates and reimbursement methods for services and supplies furnished by an In-Network Provider.

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

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

Refraction means a test performed by a Provider to determine the glasses or contact lens prescription due to a refractive error (for example, nearsightedness, farsightedness, astigmatism or presbyopia).

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

Vision Materials means those materials provided for visual health and welfare shown in the Schedule of Benefits.

EFFECTIVE DATES

Effective Date of Insured's Insurance. The Insured's insurance will be effective as follows:

1. if the Policyholder does not require the Insured to contribute toward the premium for this coverage, the Insured's insurance will be effective on the date the Insured becomes eligible;
2. if the Policyholder requires the Insured to contribute toward the premium for this coverage, the Insured's insurance will be effective on the date the Insured becomes eligible, provided;
   a. the Insured has given the Company the Insured's enrollment form (if required) on, prior to, or within 30 days of the date the Insured becomes eligible; and
   b. the Insured has agreed to pay the required premium contributions; and
3. if the Insured fails to meet the requirements of 2 a) and 2 b) within 30 days after becoming eligible, the Insured's coverage will not become effective until the Company has verified that the Insured has met these requirements. The Insured will then be advised of the Insured's effective date.

Effective Date of Dependents' Insurance. Coverage for Dependents becomes effective on the later of:

1. the date Dependent coverage is first included in the Insured's coverage; or
2. the premium due date on or after the date the person first qualifies as the Insured's Dependent. If an enrollment form is required, the Insured must provide such form and agree to pay any premium contribution that may be required prior to coverage becoming effective.

If the Insured and the Insured's spouse are both Insureds, one Insured may request to be a Dependent spouse of the other. A Dependent child may not be covered by more than one Insured.

Newborn Children. A Dependent child born while the Insured's coverage is in force will be covered from the moment of birth. To continue coverage, the Insured must agree to pay any premium contribution that may be required.

Adopted Children. If a Dependent child is placed with the Insured for adoption while the Insured's coverage is in force, this child will be covered from the date of placement. To continue coverage, the Insured must agree to pay any premium contribution that may be required. Coverage will continue unless the placement is disrupted prior to legal adoption and the child is removed from placement.

BENEFITS

Benefits are payable for each Insured Person as shown in the Schedule of Benefits for expenses incurred while this insurance is in force.

In-Network Provider Benefits. The Insured Person must pay any Copayment or any cost above the Allowance shown in the Schedule of Benefits at the time the covered service is provided. Benefits will be paid to the In-Network Provider who will file a claim with the Company on behalf of the Insured Person.

Out-of-Network Provider Benefits. The Insured Person must pay the Out-of-Network Provider the full cost at the time the covered service is provided and file a claim with the Company, unless the Out-of-Network Provider allows assignment of benefits. The Company will pay the Out-of-Network benefits up to the maximum dollar amount shown in the Schedule of Benefits.

LIMITATIONS

Fees charged by a Provider for services other than a covered benefit and any local, state or Federal taxes must be paid in full by the Insured Person to the Provider. Such fees, taxes or materials are not covered under the Policy.

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

EXCLUSIONS

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

1. medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures;
2. Refraction, when not provided as part of a Comprehensive Eye Examination;
3. services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
4. orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
5. any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment;
6. safety eyewear;
7. solutions, cleaning products or frame cases;
8. non-prescription sunglasses;
9. plano (non-prescription) lenses;
10. plano (non-prescription) contact lenses;
11. two pair of glasses in lieu of bifocals;
12. electronic vision devices, except as provided in the Low Vision Aids benefit;
13. services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or
14. lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available.

TERMINATION OF INSURANCE

The Policyholder or the Company may terminate or cancel the Policy as shown in the Policy.

For All Insureds. The Insureds' insurance will cease on the earlier of:

1. the date the Policy ends;
2. the end of the last period for which any required premium contribution agreed to in writing has been made;
3. the date the Insured is no longer eligible for insurance; or
4. the date the Insured's employment with the Policyholder ends. The Policyholder may, at the Policyholder's option, continue insurance for individuals whose employment has ended, if the Policyholder:
   a. does so without individual selection between Insureds; and
   b. continues to pay any premium contribution for those individuals.

For Dependents. A Dependent's insurance will cease on the earlier of:

1. the date the Insured's coverage ends;
2. the end of the month in which the Dependent ceases to be an eligible Dependent as defined in the Policyholder's application; or
3. the end of the last period for which any required premium contribution has been made.

A Dependent child will not cease to be a Dependent solely because of age if the child is:

1. not capable of self-sustaining employment due to mental incapacity or physical handicap that began before the age limit was reached; and
2. mainly dependent on the Insured for support.

The Company may ask for proof of the eligible Dependent child's incapacity and dependency two months prior to the date the Dependent child would otherwise cease to be covered.

The Company may require the same proof again, but will not request it more than once a year after this coverage has been continued for two years. This continued coverage will end on the earlier of:

1. on the date the Policy ends;
2. on the date the incapacity or dependency ends;
3. on the end of the last period for which any required premium contribution for the Dependent child has been made; or
4. 60 days following the date the Company requests proof and such proof is not provided to the Company.

Continuation Privilege For Certain Dependents. If coverage terminates as a result of an Insured's death, divorce or eligibility under Title XVIII of the Social Security Act (Medicare), the Dependent's coverage can continue. The coverage will end at the earliest of:

1. the date the Dependent becomes eligible for coverage under any other group plan providing similar benefits;
2. 36 months after continuation was elected if due to the Insured being covered under Title XVIII of the Social Security Act (Medicare);
3. the Dependent fails to make timely premium payments; or
4. the Policy terminates.

Notification Requirements. The Dependent must notify the Policyholder of the Insured's death or divorce. The Policyholder will provide written notice to the Dependent of the right to continue coverage and will send the election form and instructions for premium payments immediately. The Policyholder, upon request, will provide the Dependent with written verification from the Company the cost of this coverage at the time of eligibility. The premium charged will not exceed 102% of the group premium.

If termination is due to the surviving Dependent's failure to make the required premium payment, written notice of cancellation must be mailed to the last known address at least 30 days before the cancellation. Failure of the surviving Dependent to make the premium payment within 90 days after notice of the requirement to pay the premiums will be the basis of termination of coverage without written consent.

PREMIUMS

The Company provides insurance coverage in return for premium payment. Premiums are payable to the Company by the Policyholder on behalf of the Insured Person. The Insured Person's first premium is due on the Insured Person's Effective Date. Premiums must be paid to the Company on or before the due date. The initial premium rates are shown in the Policyholder's application.

Premium Changes. The Company has the right to change the premium rates on any premium due date as allowed in the Policy. The Company will provide written notice to the Policyholder at least 31 days before the date of the change. The premium rates also may be changed at any time the terms of the Policy are changed.

Grace Period. The Policy has a 31-day grace period for the payment of each premium due after the first premium. Coverage will continue in force during the grace period. Coverage will terminate at the end of the grace period if all premiums due are not paid. The Company will require payment of all premiums for the period this coverage continues in force, including the premiums for the grace period. The grace period will not apply if the Company receives written notice of the Policyholder's or the Insured's intent to terminate coverage.

Unpaid Premium. When a claim is paid during the grace period, any premium due and unpaid for the Insured Person will be deducted from the claim payment.

CLAIMS

Notice of Claim. Written notice of claim must be given to the Company within 30 days after the occurrence or commencement of any loss covered by the Policy, or as soon as is reasonably possible. Notice given by or for the Insured Person to the Company at the Company's home office, to the Company's authorized administrator or to any of the Company's authorized agents with sufficient information to identify the Insured Person will be deemed as notice to the Company.

Claim Forms. The Company will furnish claim forms to the Insured Person within 15 days after notice of claim is received. If the Company does not provide the forms within that time, the Insured Person may send written proof of the occurrence, character and extent of loss for which the claim is made within the time stated in the Policy for filing proof of loss.

Proof of Loss. Written proof of loss must be furnished to the Company at the Company's home office within 90 days after the date of the loss. Failure to furnish proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within that time, if the proof is furnished as soon as reasonably possible. In no event, except in the absence of legal capacity, will proof of loss be accepted later than one year from the time proof is required.

Time Payment of Claims. Any benefit payable under the Policy will be paid immediately, but not more than 30 days, upon receipt of due written proof of loss.

Payment of Claims. All claims will be paid to the Insured, unless assigned. Any benefits payable on or after the Insured's death will be paid to the Insured's beneficiary. If there is no designated beneficiary when the Insured dies, the Company will pay the benefits to the Insured's estate.

If any benefit is payable to an estate or to a minor or person not otherwise competent to give a valid release, the Company may pay such benefit, up to $1,000. Such payment will be made to the legal guardian of the minor or incompetent. Any payment made by the Company in good faith under this provision will fully discharge the Company to the extent of the payment.

The Insured may change the beneficiary at any time unless an irrevocable beneficiary is named or the insurance is assigned. The change date is the date the Insured signed the written request. If the Company pays the benefit before the Company receives the request, the Company is released from further liability under the Policy to the extent of the Company's payment.

Assignment. Benefits under the Policy may be assigned.

Right of Recovery. If payment for claims exceeds the amount for which the Insured Person is eligible under any benefit provision or rider of the Policy, the Company has the right to recover the excess of such payment from the Provider or the Insured.

Legal Actions. No Insured Person can bring an action at law or in equity to recover on the Policy until more than 60 days after the date written proof of loss has been furnished according to the Policy. No such action may be brought after the

expiration of three years after the time written proof of loss is required to be furnished. If the time limit of the Policy is less than allowed by the laws of the state where the Insured Person resides, the limit is extended to meet the minimum time allowed by such law.

GENERAL PROVISIONS

Clerical Error. Clerical errors or delays in keeping records for the Policy will not deny insurance that would otherwise have been granted, nor extend insurance that otherwise would have ceased, and call for a fair adjustment of premium and benefits to correct the error.

Conformity to Law. Any provision of the Policy that is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

Entire Contract. The Policy, including any endorsements and riders, the Certificate, the Policyholder's application, which is attached to the Policy when issued, the Insured's individual enrollment form, if any, and the eligibility file, if any, are the entire contract between the parties. A copy of the Policy may be examined at the office of the Policyholder during normal business hours. All statements made by the Policyholder or an Insured will, in the absence of fraud, be deemed representations and not warranties, and no such statement will be used in defense to a claim hereunder unless it is contained in a written instrument signed by the Policyholder, the Insured, the Insured's beneficiary or personal representative, a copy of which has been furnished to the Policyholder, the Insured, the Insured's beneficiary or personal representative.

Amendments and Changes. No agent is authorized to alter or amend the Policy, or to waive any conditions or restrictions herein, or to extend the time for paying any premium. The Policy and the Certificate may be amended at any time by mutual agreement between the Policyholder and the Company without the consent of the Insured, but without prejudice to any loss incurred prior to the effective date of the amendment. No person except an Officer of the Company has authority on behalf of the Company to modify the Policy or to waive or lapse any of the Company's rights or requirements.

Incontestability. No misstatement, except fraudulent misstatements, can be used to void the Policy or deny a claim after the Insured Person's insurance has been in force for two years during the Insured Person's lifetime. No statement an Insured Person makes can be used in a contest unless it is in writing and signed by the Insured Person.

Insurance Data. The Policyholder must give the Company the names and ages of all individuals initially insured. The names of persons who later become eligible (whether or not the person becomes insured), and the names of those who cease to be eligible must also be given. The eligibility dates and any other necessary data must be given to the Company so that the premium can be determined.

The Company has the right to audit the Policyholder's books and records as the books and records relate to this insurance. The Company may authorize someone else to perform this audit. Any such inspection may be done at any reasonable time.

Workers' Compensation. The Policy is not a Workers' Compensation policy. The Policy does not satisfy any requirement for coverage by Workers' Compensation Insurance.

SCHEDULE OF BENEFITS

Ecolab Inc.

BENEFIT FREQUENCY		
Vision Examination	once every plan year	Insured Person
Vision Materials		
Frame	once every plan year	Insured Person
Lenses and Lens Options	once every plan year	Insured Person
Contact Lenses	once every plan year	Insured Person

BENEFIT	*In-Network*		*Out-of-Network Provider* *(Reimbursement up to)*
	Plus In-Network Provider	*In-Network Provider*	
Vision Examination			
Comprehensive Eye Examination	$0 Copayment	$10 Copayment	$45
Low Vision Supplemental Examination	$0 Copayment	$0 Copayment	$125
Vision Materials			
Frame	$0 Copayment, up to $250 Allowance	$0 Copayment, up to $200 Allowance	$100
Contact Lenses Only one of the following Contact Lenses benefits may be used for the Contact Lenses benefit. Contact Lenses are in lieu of Lenses and Lens Options.			
Conventional	$0 Copayment, up to $250 Allowance	$0 Copayment, up to $200 Allowance	$105
Disposable	$0 Copayment, up to $250 Allowance	$0 Copayment, up to $200 Allowance	$105
Medically Necessary	Paid in Full	Paid in Full	$300
Standard Plastic Lenses			
Single Vision	$20 Copayment	$20 Copayment	$30
Bifocal	$20 Copayment	$20 Copayment	$50
Trifocal	$20 Copayment	$20 Copayment	$70
Lenticular	$20 Copayment	$20 Copayment	$70
Progressive – Standard	$20 Copayment	$20 Copayment	$50
Progressive – Premium Tier 1	$20 Copayment	$20 Copayment	$50
Progressive – Premium Tier 2	$20 Copayment	$20 Copayment	$50
Progressive – Premium Tier 3	$20 Copayment	$20 Copayment	$50
Progressive – Premium Tier 4	$20 Copayment	$20 Copayment	$50
Lens Options			
Anti-Reflective Coating – Standard	$45 Copayment	$45 Copayment	$23
Anti-Reflective Coating – Premium Tier 1	$57 Copayment	$57 Copayment	$23
Anti-Reflective Coating – Premium Tier 2	$68 Copayment	$68 Copayment	$23
Anti-Reflective Coating – Premium Tier 3	$100 Copayment	$100 Copayment	$23

BENEFIT	***In-Network***		***Out-of-Network Provider*** *(Reimbursement up to)*
	Plus In-Network Provider	***In-Network Provider***	
Photochromic Non-Glass Lens	$0 Copayment	$0 Copayment	$5
Polycarbonate Lenses – Standard Dependent Children under 19 years of age	$0 Copayment	$0 Copayment	$20
Tint (Solid and Gradient) – Standard	$0 Copayment	$0 Copayment	$8
Low Vision Aids	25% Copayment up to $1,000 Allowance	25% Copayment up to $1,000Allowance	25% Copayment up to $1,000 Allowance

FIDELITY SECURITY LIFE INSURANCE COMPANY®

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AMENDATORY RIDER REGARDING REPLACEMENT COVERAGE

The Policy/Certificate to which this Amendment Rider is attached is amended as follows:

The following applies when the Policy serves to replace similar coverage the Policyholder previously obtained through another plan or policy. In this provision, that other plan or policy is referred to as the prior plan. The Policyholder's coverage under the Policy will not be considered as replacement coverage unless the Policyholder's coverage under the Policy takes effect within 60 days after coverage under the prior plan ends.

In the absence of this provision, an Insured Person who was covered by the prior plan at the date of discontinuance might not qualify for coverage under the Policy because the person is not actively at work or is confined in a Hospital.

Each such person will be insured under the Policy if:

1. the person was insured under the prior plan, including coverage under the prior plan's extension of benefits provision, on the date the Policyholder's coverage with the prior plan ended;
2. the prior plan covered more than 15 people; and
3. the person is in a class of persons eligible for coverage under the Policy.

The benefits payable for the persons described above will be the benefits of the Policy less any amount payable under the prior plan pursuant to any extension of benefits provision.

The Policy, in applying any waiting periods, will give credit for the satisfaction or partial satisfaction of the same or similar provisions under the prior policy.

This Rider takes effect on the effective date of the Policy/Certificate to which it is attached. This Rider terminates concurrently with the Policy/Certificate to which it is attached. It is subject to all the terms and conditions of the Policy/Certificate except as stated herein.

FIDELITY SECURITY LIFE INSURANCE COMPANY

Bryson T. Jones — President

Bradford R. James — Secretary

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VISION EXAMINATION BENEFIT RIDER
For Insured Persons with Type 1 or Type 2 Diabetes with Diabetic Retinopathy

By attachment of this Rider, the Policy/Certificate is amended by adding the following benefits:

SCHEDULE OF BENEFITS

BENEFIT FREQUENCY		
Vision Examinations		
Medical Follow-Up Eye Examination	once every 6 months	Insured Person
Fundus Photography Examination	once every 6 months	Insured Person
Extended Ophthalmoscopy, initial and subsequent	once every 6 months	Insured Person
Gonioscopy	once every 6 months	Insured Person
Scanning Laser	once every 6 months	Insured Person

BENEFIT	***In-Network Provider***	***Out-of-Network Provider*** *(Reimbursement up to)*
Vision Examinations		
Medical Follow-Up Eye Examination	$0 Copayment	$77
Fundus Photography Examination	$0 Copayment	$50
Extended Ophthalmoscopy, initial and subsequent	$0 Copayment	$15
Gonioscopy	$0 Copayment	$15
Scanning Laser	$0 Copayment	$33

DEFINITIONS

Diabetes Mellitus or **Diabetes** means a metabolic disease in which a person has high blood sugar, either because the body does not produce enough insulin or because cells do not respond to the insulin that is produced.

Diabetic Retinopathy means damage to the retina caused by complications of Diabetes Mellitus.

Extended Ophthalmoscopy means an examination of the interior of the eye, focusing on the posterior segment of the eye, including the lens, retina, and optic nerve, by direct or indirect ophthalmoscopy, and includes a retinal drawing with interpretation and report.

Gonioscopy means an eye examination of the front part of the eye (anterior chamber) to check the angle where the iris meets the cornea with a gonioscope or with a contact prism lens.

Fundus Photography Examination means photographing portion(s) of or the complete retina surface and structures, with interpretation and report.

Medical Follow-Up Eye Examination means an office visit for diabetic vision care after the initial Comprehensive Eye Examination.

Scanning Laser means a computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report.

Type 1 Diabetes means a condition that results from the body's failure to produce insulin. It is also referred to as insulin-dependent Diabetes Mellitus or juvenile Diabetes.

Type 2 Diabetes means a condition in which cells fail to use insulin properly, sometimes combined with an absolute insulin deficiency.

BENEFITS

Benefits are payable as shown in the Schedule of Benefits for expenses incurred while this Rider is in force for each Insured Person who has Type 1 or Type 2 Diabetes and has been diagnosed with Diabetic Retinopathy.

Extended Ophthalmoscopy. An Insured Person is eligible for one initial Extended Ophthalmoscopy examination and one subsequent Extended Ophthalmoscopy examination for diabetic vision care in each Benefit Frequency. The Extended Ophthalmoscopy must provide information not available from the standard evaluation services and/or information that will demonstrably affect the treatment plan. The Extended Ophthalmoscopy is not covered if Fundus Photography Examination was provided within the previous six-month period.

Gonioscopy. An Insured Person is eligible for one Gonioscopy for diabetic vision care in each Benefit Frequency.

Medical Follow-Up Eye Examination. An Insured Person is eligible for one Medical Follow-Up Eye Examination for diabetic vision care in each Benefit Frequency.

Fundus Photography Examination. An Insured Person is eligible for one Fundus Photography Examination for diabetic vision care in each Benefit Frequency. The Fundus Photography Examination is not covered if an Extended Ophthalmoscopy was provided within the previous six-month period.

Scanning Laser. An Insured Person is eligible for one Scanning Laser in each Benefit Frequency.

EXCLUSIONS

In addition to the Exclusions in the Policy/Certificate, no benefits are payable for services connected with or charges arising from:

1. any Vision Materials;
2. orthoptic or vision training, subnormal vision aids and any associated supplemental testing;
3. medical, pathological and/or surgical treatment of the eye, eyes or supporting structures;
4. any Vision Examination required by a Policyholder as a condition of employment; or
5. services, supplies, prescription medication or treatment for diabetes, except as specifically included in this Rider.

This Rider takes effect on the effective date of the Policy/Certificate to which it is attached. This Rider terminates concurrently with the Policy/Certificate to which it is attached. It is subject to all the definitions, limitations, exclusions and conditions of the Policy/Certificate except as stated.

FIDELITY SECURITY LIFE INSURANCE COMPANY



President Secretary

FIDELITY SECURITY LIFE INSURANCE COMPANY®

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NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN INSOLVENCY UNDER THE MINNESOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION LAW

If the insurer or health maintenance organization that issued your life, annuity or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy or contract from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer or health maintenance organization.

In addition, residents of Minnesota who purchase life insurance, annuities, health insurance, or health maintenance organization coverage from insurance companies authorized to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer or health maintenance organization becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

For purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations.

Minnesota Life & Health Insurance Guaranty Association
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Minneapolis, MN 55402
(612) 322-8713

The maximum amount the guaranty association will pay for all policies or contracts issued on one life by the same insurer or health maintenance organization is limited to $500,000. Subject to this $500,000 limit, the guaranty association will pay up to $500,000 in life insurance death benefits, $130,000 in net cash surrender and net cash withdrawal values for life insurance, $500,000 in health insurance, health maintenance organization, and long-term care benefits, including any net cash surrender and net cash withdrawal values, $500,000 in disability income insurance, $250,000 in annuity net cash surrender and net cash withdrawal values, $410,000 in present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant's lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be $500,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under Section 401, 403(b), or 457 of the Internal Revenue Code of 1986, as amended through December 31, 1992, are covered up to $250,000 in net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the association shall not be responsible for more than $10,000,000 in claims from all Minnesota residents covered by the plan. If total claims exceed $10,000,000, the $10,000,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the guaranty association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the guaranty association's limits, you may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The guaranty association assesses insurers and health maintenance organizations licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment.

Benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY, CONTRACT, OR POLICY, YOU SHOULD NOT RELY ON COVERAGE BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF LIFE, ANNUITY, HEALTH INSURANCE, OR HEALTH MAINTENANCE ORGANIZATION POLICIES AND CONTRACTS OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY IMPAIRED OR INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE, ANNUITY, HEALTH INSURANCE, AND HEALTH MAINTENANCE ORGANIZATION POLICIES AND CONTRACTS ARE REQUIRED TO PROVIDE THIS NOTICE.

FIDELITY SECURITY LIFE INSURANCE COMPANY®

3130 Broadway
Kansas City, Missouri 64111-2406
Phone 800-648-8624
A STOCK COMPANY
(Herein Called "the Company")

NOTICE OF ADMINISTRATOR'S CAPACITY

PLEASE READ: This notice advises insured persons of the identity and relationship among the administrator, the policyholder and the insurer:

1. Fidelity Security Life Insurance Company (FSL) has, by agreement, arranged for First American Administrators, Inc. to provide administrative services for your insurance plan. As administrator, First American Administrators, Inc., is authorized to process claim payments, and perform other services, according to the terms of its agreement with the insurance company. First American Administrators, Inc. is not the insurance company or the policyholder.

2. The policyholder is the entity to whom the insurance policy has been issued. The policyholder is identified on either the face page or schedule page of the policy or certificate.

3. Fidelity Security Life Insurance Company is liable for the funds to pay your insurance claims.

As First American Administrators, Inc. is authorized to process claims for the insurance company, they will do so promptly. In the event there are delays in claims processing, you will have no greater rights to interest or other remedies against First American Administrators, Inc. than would otherwise be afforded to you by law.