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AGILENT TECHNOLOGIES, INC.

RETIREE MEDICAL ACCOUNT PLAN

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

As Amended and Restated Effective January 1, 2020

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As Amended and Restated Effective January 1, 2020

1. INTRODUCTION

This document serves as the Plan Document and Summary Plan Description (the "SPD") of the Agilent Technologies, Inc. Retiree Medical Account Plan (the "Plan"). The Plan was amended and restated to read as set forth herein effective January 1, 2020. The Plan was previously amended and restated effective January 1, 2009, and then again on January 1, 2012, January 1, 2014, April 1, 2014, August 1, 2014, November 1, 2014, April 30, 2016 and January 1, 2017. The Plan was originally established effective January 1, 2005 (the "Effective Date"). The purpose of the Plan is to provide eligible individuals with reimbursements for eligible medical, Medicare Part A, Medicare Part B, prescription drug, dental and vision plan premiums. Reimbursements will be made up to a maximum amount established by the Company. There is no right under the Plan to receive cash or any benefit other than reimbursement for eligible health plan premiums.

The Plan applies to certain Eligible Retirees of Agilent Technologies, Inc. (the "Company") and their eligible Spouses (and when applicable an Eligible Retiree's surviving Spouse); and certain Totally Disabled Former Employees who first became disabled before January 1, 2016, their eligible Spouses and their eligible Dependent Children (and when applicable a Totally Disabled Former Employee's surviving Spouse and surviving eligible Dependent Children). Same- or opposite-sex domestic partners are not eligible to receive reimbursements under the Plan.

The Plan's eligibility and participation rules for Eligible Retirees are contained in the main body of this Plan Document and SPD. If you are not an Eligible Retiree, you might be eligible for benefits under the Plan if you are a Totally Disabled Former Employee who first became disabled before January 1, 2016 and met certain other requirements. The Plan's eligibility and participation rules for Totally Disabled Former Employees are contained in Appendix A of this Plan Document and SPD (titled "Eligibility, Participation and Benefits For Totally Disabled Former Employees").

The Plan is intended to be an ERISA group health plan as described in Sections 105(b) and 106 of the Internal Revenue Code ("Code") and a Health Reimbursement Arrangement as described in Internal Revenue Service Notice 2002-45 (as amplified by Revenue Ruling 2006-36). The Plan is also intended to be a retiree-only health plan that is exempt from the group market reform requirements of the Patient Protection and Affordable Care Act.

Many sections of this Plan Document and SPD are interrelated, so you may not have all of the information you need by reading just one section. Therefore, we encourage you to read this document carefully and share it with your Spouse.

If you have any questions about your eligibility for the Plan, please contact the Agilent Service Center at Fidelity, P.O. Box 770003, Cincinnati, OH 45277-0071. The telephone number is 1-877-989-2727. If you have any questions about your benefits under the Plan, please contact Willis Towers Watson's Via Benefits at 1-888-232-3855. ***No legal action may be taken to gain benefits from the Plan after two years from when the premium for which a claim was made was paid by the Member.***

2. INFORMATION ABOUT DEFINED TERMS

Certain capitalized words used in this Plan Document and SPD have special meanings. These words are defined in the Glossary.

The words "we," "us," and "our" in this document refer to Agilent Technologies, Inc., the Plan Sponsor. When we use the words "you" and "your" we are referring to people who are Covered Persons as the term is defined in the Glossary.

3. OVERVIEW OF THE RETIREE MEDICAL ACCOUNT PLAN

A. Who is Eligible?

To be eligible for the Plan upon your termination of employment, you must meet certain requirements and be an Eligible Retiree; or, if you are not an Eligible Retiree, you must be a Totally Disabled Former Employee who first became disabled prior to January 1, 2016 and met certain other requirements.

Where to Find the Relevant Plan Document and SPD Provisions

- This Section 3 contains a brief summary of the rules governing eligibility, participation, and benefits for Eligible Retirees.
- Sections 4 through 6 of the main body of this Plan Document and SPD contain the official rules governing eligibility, participation, and benefits for Eligible Retirees.
- *Appendix* A ("Eligibility, Participation, and Benefits for Totally Disabled Former Employees") contains the rules governing eligibility, participation, and benefit amounts for Totally Disabled Former Employees.
- Sections 7 through 14 of the main body of the Plan Document and SPD contain various rules that apply to both Eligible Retirees and Totally Disabled Former Employees (e.g., claims and appeals).

B. Eligible Retirees—Brief Overview of Eligibility, Participation, and Benefit Amounts.

The following chart provides a snapshot of the eligibility, participation, and benefits rules for Eligible Retirees. Those rules are described in more detail in other sections of this Plan Document and SPD, and this chart is provided for informational purposes only.

Eligible Retirees Eligibility and Benefits Overview			
Who is an Eligible Retiree?	**Primary Eligibility Requirements**	**Potential Retiree Medical Account Amounts**	**Individuals Eligible for Reimbursement**
A former employee of the Company who terminated employment on the US. dollar Payroll of the Company at age 55 or older and with 15 Years of Full-Time Equivalent Service *See the definition of "Eligible Retiree" in the "Glossary."*	• Age 49 or younger on January 1, 2005 or hired or rehired between January 1, 2005 and November 1, 2014; and • Not hired or rehired on or after November 1, 2014. *See Section 4.A ("Eligible Retirees—Eligibility Requirements")*	• $55,000 • $40,000 • $27,500; or • $20,000 *See Section 4.B ("Eligible Retirees—Retiree Medical Account Amounts")*	• Eligible Retiree • Eligible Spouse *See Section 6 ("Eligible Retirees—Using the Retiree Medical Account")*

C. Eligibility Requirements for Eligible Retirees

In general, an Eligible Retiree is a former employee of the Company who terminated employment on the US. dollar Payroll of the Company at age 55 or older and with 15 Years of Full-Time Equivalent Service. See the "Glossary" for the complete definition of an Eligible Retiree. To be eligible for a Retiree Medical Account under the Plan, an Eligible Retiree must meet certain requirements. Those eligibility requirements, which are described in more detail in Section 4.A ("Eligible Retirees—Eligibility Requirements"), are as follows:

(1) First, you must meet <u>either</u> requirement (A) or requirement (B) below:

(A) On January 1, 2005, you were both an Eligible Employee of the Company and age 49 or under; or

(B) You were hired or rehired as an Eligible Employee after January 1, 2005 and before November 1, 2014.[1]

(2) Second, if you did not terminate employment as an Eligible Retiree prior to November 1, 2014, then you must meet both requirement (C) and requirement (D) below:

(C) You must have been an Eligible Employee on October 31, 2014 (i.e., you were not hired on or after November 1, 2014); and

(D) You must have remained an Eligible Employee from October 31, 2014 through the date you terminated employment with the Company as an Eligible Retiree (i.e., you must not have terminated employment or transferred to an ineligible position between October 31, 2014 and the date you are at least age 55 and have at least 15 Years of Full-Time Equivalent Service).

D. Plan Benefits For Eligible Retirees

The Plan provides a qualifying Eligible Retiree with a "virtual" or "notional" unfunded account (a "Retiree Medical Account") representing amounts available for reimbursement of eligible medical, Medicare Part A, Medicare Part B, prescription drug, dental and vision plan premiums that are paid by the Eligible Retiree for coverage of the Eligible Retiree or his or her or eligible Spouse (see the "Glossary" for the Plan's definition of Spouse). Funds are not actually set aside in an Eligible Retiree's Retiree Medical Account under the Plan.

Section 6 ("Eligible Retirees—Using the Retiree Medical Account") contains the rules regarding what expenses can be reimbursed from an Eligible Retiree's Retiree Medical Account. It is important that you read Section 6 closely to determine what kinds of premiums meet the Plan's reimbursement requirements.

E. Retiree Medical Account Reimbursement Amounts for Eligible Retirees

The amount of reimbursements available for an Eligible Retiree, if eligible for a Retiree Medical Account under the Plan, depends on various factors and is either $55,000, $40,000, $27,500, or $20,000. *The rules regarding how an Eligible Retiree's Retiree Medical Account amount is determined are contained in Section 4.B ("Eligible Retirees—Retiree Medical Account Amounts").*

[1] At a high level, to be an Eligible Employee you must have been on the U.S. Dollar Payroll of the company and in regular employment of not less than 20 hours per week. See the "Glossary" for the complete definition of an Eligible Employee.

4. ELIGIBLE RETIREES—ELIGIBILITY, PARTICIPATION AND REIMBURSEMENT AMOUNTS

A. Eligible Retirees—Eligibility Requirements

To be eligible for the Plan as an Eligible Retiree, you must meet all of the following requirements:

(1) Requirement #1—Eligible Employee on Certain Dates. You must meet either requirement (1)(A) or requirement (1)(B) below:

(A) On January 1, 2005, you were an Eligible Employee and age 49 or under; or

(B) You were hired or rehired as an Eligible Employee (regardless of age) after January 1, 2005 and before November 1, 2014.

(2) Requirement #2—Special Rules for Individuals Who First Terminated Employment as Eligible Retirees After October 31, 2014. Effective November 1, 2014, the Plan was closed to new Eligible Retirees who were hired or rehired on or after November 1, 2014. Accordingly, if you first became an Eligible Retiree after October 31, 2014 (i.e., if you were still an active employee on or after November 1, 2014), then you must also satisfy both requirement (2)(A) and requirement (2)(B) below:

(A) You must have been an Eligible Employee on October 31, 2014; and

(B) You must have remained an Eligible Employee from October 31, 2014 through the first day on which you are both (i) age 55 or older; and (ii) have accrued at least 15 Years of Full-Time Equivalent Service.

In other words, if you had not terminated employment as an Eligible Retiree before November 1, 2014, then you must have been hired as an Eligible Employee prior to November 1, 2014 and not terminated employment or transferred to an ineligible position or status before you were at least age 55 and had accrued at least 15 Years of Full-Time Equivalent Service. Below is an example of how an Eligible Retiree can satisfy this requirement:

Example. On February 1, 2000, you were hired by the Company, and you were an Eligible Employee on October 31, 2014. As of January 1, 2016, you are initially age 55 or older and have accrued 15 Years of Full-Time Equivalent Service. If you remained an Eligible Employee at all times between October 31, 2014 and January 1, 2016, you will qualify as an Eligible Retiree, provided that you satisfy all other applicable requirements under the Plan.

(3) Requirement #3—Not Eligible for Certain Other Coverage. You are not eligible for a Retiree Medical Account under the Plan if you are eligible for any of the following plans or benefits:

(A) Non-Retiree Medical Account subsidized coverage under the Agilent Technologies, Inc. Health Plan for Retirees (the "Agilent Health Plan for Retirees") (before age 65);

(B) The Agilent Technologies, Inc. Reimbursement Arrangement Plan[2] ("ARA");

(C) The Keysight Technologies, Inc. Retiree Medical Account Plan (the "Keysight RMA");

(D) The Keysight Technologies, Inc. Reimbursement Arrangement Plan (the "KRA"); or

(E) The Keysight Technologies, Inc. Health Plan for Retirees (the "Keysight Health Plan for Retirees")

B. Eligible Retirees—Retiree Medical Account Amounts.

If you are an Eligible Retiree, your Retiree Medical Account amount is either $55,000, $40,000 $27,500, or $20,000, based on various factors. That amount is determined as follows:

$55,000 or $27,500

(1) **$55,000**. If you are a qualifying Eligible Retiree, your Retiree Medical Account amount is $55,000 if (1)(A) through (1)(D) below are true:

(A) As of January 1, 2005, you were an Eligible Employee;

(B) As of January 1, 2005, you were at least age 45 and not older than age 49;

(C) After January 1, 2005, you were not rehired before you first qualified as an Eligible Retiree (i.e., you did not terminate employment after January 1, 2005 and before attaining age 55 and accruing 15 Years of Full-Time Equivalent Service); and

(D) If you first terminated employment as an Eligible Retiree on or after April 30, 2016, you were at least age 55 and had accrued at least 15 Years of Full-Time Equivalent Service as of April 30, 2016. In other words, if you were still an active employee as of April 30, 2016, then you must be at least age 55 with 15

[2] Prior to January 1, 2020, the Agilent Technologies, Inc. Reimbursement Arrangement Plan (ARA) only provided benefits to certain eligible participants who were age 65 or older. Effective January 1, 2020, the ARA was amended so that the ARA is comprised of two different programs—the Pre-65 Agilent Technologies, Inc. Reimbursement Arrangement Plan and the Post-65 Agilent Technologies, Inc. Reimbursement Arrangement Plan.

Years of Full-Time Equivalent Service on April 30, 2016 to be eligible for a $55,000 Retiree Medical Account upon your subsequent termination of employment as an Eligible Retiree.

$55,000 Retiree Medical Account Example. Jane was hired on April 1, 2000. On January 1, 2005 Jane was an Eligible Employee (meeting requirement (1)(A) and age 46 (meeting requirement (1)(B)). On April 30, 2016, Jane was age 57 and had 16 Years of Full-Time Equivalent Service (meeting requirement (1)(D)). On January 1, 2017, Jane terminates employment as an Eligible Retiree and satisfies all of the Plan's other eligibility requirements. Jane was not rehired between January 1, 2005 and January 1, 2017 (meeting requirement (1)(C)). Accordingly, Jane is eligible for a $55,000 Retiree Medical Account upon her termination of employment as an Eligible Retiree.

(2) **$27,500**. If you are a qualifying Eligible Retiree, your Retiree Medical Account amount is $27,500 if both (2)(A) and (2)(B) below are true:

(A) You meet requirements (1)(A), (1)(B), and (1)(C) above for a $55,000 Retiree Medical Account; but

(B) You do not meet requirement (1)(D) above for a $55,000 Retiree Medical Account.

In other words, your Retiree Medical Account amount is $27,500 if you meet all of the requirements for a $55,000 Retiree Medical Account except that, on April 30, 2016, you were still an active employee who was under age 55 or had less than 15 Years of Full-Time Equivalent Service (or both).

$27,500 Retiree Medical Account Example. Bob was hired on January 1, 2004. On January 1, 2005 Bob was an Eligible Employee (meeting requirement (1)(A)) and age 48 (meeting requirement (1)(B)). On January 1, 2020, Bob terminates employment as an Eligible Retiree and satisfies all of the Plan's other eligibility requirements. Bob was not rehired between January 1, 2005 and January 1, 2020 (meeting requirement (1)(C)). However, on April 30, 2016, Bob was age 59 but had only 12 Years of Full-Time Equivalent Service (failing to meet requirement (1)(D) for a $55,000 Retiree Medical Account). Accordingly, Bob is eligible for a $27,500 Retiree Medical Account upon his termination of employment as an Eligible Retiree.

$40,000 or $20,000

(3) **$40,000.** If you are a qualifying Eligible Retiree, your Retiree Medical Account amount is $40,000 if you do not meet the requirements for a $55,000 Retiree Medical Account and both (3)(A) and (3)(B) below are true:

(A) Either (3)(A)(i) or (3)(A)(ii) or (3)(A)(iii) below applies to you:

(i) As of January 1, 2005, you were an Eligible Employee and you were under age 45 (i.e., you do not meet requirement (1)(A) for a $55,000

Retiree Medical Account because you were not at least age 45 on January 1, 2005);

(ii) You were hired as an Eligible Employee (regardless of age) after January 1, 2005 and before November 1, 2014 (i.e., you do not meet requirement (1)(B) for a $55,000 Retiree Medical Account because you were not an Eligible Employee on January 1, 2005); or

(iii) You were rehired as an Eligible Employee (regardless of age) after January 1, 2005 and before November 1, 2014 (i.e., you do not meet requirement (1)(C) for a $55,000 Retiree Medical Account because you were rehired after January 1, 2005 and before first qualifying as an Eligible Retiree).

(B) If you first terminated employment as an Eligible Retiree on or after April 30, 2016, you were at least age 55 and had accrued at least 15 Years of Full-Time Equivalent Service as of April 30, 2016.

In other words, your Retiree Medical Account amount is $40,000 if (1) you were at least age 55 and had accrued at least 15 Years of Full-Time Equivalent Service as of April 30, 2016 (or you terminated employment and qualified as an Eligible Retiree before April 30, 2016); BUT (2) you do not meet the other requirements for a $55,000 Retiree Medical Account (e.g., you were rehired as an Eligible Employee after January 1, 2005).

$40,000 Retiree Medical Account Example. Dave was hired on January 1, 2001. On January 1, 2005 Dave was an Eligible Employee but was only age 44 (i.e., Dave meets requirement (3)(A)(i)). On April 30, 2016, Dave was age 55 and had 15 Years of Full-Time Equivalent Service (meeting requirement (3)(B)). On January 1, 2019, Dave terminates employment as an Eligible Retiree and satisfies all of the Plan's other eligibility requirements. Accordingly, Dave is eligible for a $40,000 Retiree Medical Account upon his termination of employment as an Eligible Retiree.

(4) **$20,000**. If you are a qualifying Eligible Retiree, your Retiree Medical Account amount is $20,000 if (4)(A) and (4)(B) below are true:

(A) On April 30, 2016, you were not at least age 55 or you had not accrued at least 15 Years of Full-Time Equivalent Service (or both); and

(B) You meet all of the other requirements for a $40,000 Retiree Medical Account (i.e., either (3)(A)(i) or (3)(A)(ii) or (3)(A)(iii) above applies to you).

In other words, your Retiree Medical Account amount is $20,000 if you meet all of the requirements for a $40,000 Retiree Medical Account except that, on April 30, 2016, you were still an active employee who was under age 55 or had less than 15 Years of Full-Time Equivalent Service (or both).

$20,000 Retiree Medical Account Example. Sandra was hired as an Eligible Employee on January 1, 2010. On April 30, 2016, Sandra was age 50 and had 6 Years of Full-Time Equivalent Service (meeting requirement (4)(A)). On January 1, 2026, Sandra terminates employment as an Eligible Retiree and satisfies all of the Plan's other eligibility requirements. Accordingly, Sandra is eligible for a $20,000 Retiree Medical Account upon her termination of employment as an Eligible Retiree because she met all of the other requirements for a $40,000 Retiree Medical Account but she was under age 55 and had fewer and 15 Years of Full-Time Equivalent Service on April 30, 2016.

C. When an Eligible Retiree's Participation Begins

An Eligible Retiree who meets the eligibility requirements for participation in the Plan will commence participation in the Plan as of the date he or she retires from the Company.[3]

Special rules apply if you were rehired after becoming an Eligible Retiree. See Section 5 ("If an Eligible Retiree is Rehired").

D. When an Eligible Retiree's Participation Ends

An Eligible Retiree's participation in the Plan will cease upon the occurrence of the earliest of the following events:

(1) The date that an Eligible Retiree and/or his or her Spouse exhaust the specified amount allowed under your Retiree Medical Account (i.e., when your account balance is zero); or

(2) Prior to January 1, 2014, the date coverage under a Company-sponsored pre-Medicare retiree medical plan is terminated due to non-payment of premiums (including, but not limited to, if coverage was waived or dropped); or

(3) The date that the Eligible Retiree dies; or

(4) The date that the Company terminates the Plan.

E. When an Eligible Retiree's Spouse's Participation Ends

A Spouse's participation in the Plan will cease upon the occurrence of the earliest of the following events:

(1) The date that you and/or your Spouse exhaust the specified amount allowed under your Retiree Medical Account (i.e., when your account balance is zero); or

[3] Prior to January 1, 2014, an Eligible Retiree must have elected and enrolled in a Company-sponsored pre-Medicare retiree medical plan within 30 days of termination of employment. Prior to January 1, 2014 if an Eligible Retiree was eligible to enroll in a Company-sponsored pre-Medicare retiree medical plan but did not enroll within the required timeframe (or failed to timely pay premiums) then his or her Retiree Medical Account was terminated.

(2) Prior to January 1, 2014, the date coverage under a Company-sponsored pre-Medicare retiree medical plan is terminated due to non-payment of premiums (including, but not limited to, if coverage was waived or dropped); or

(3) The date the Eligible Retiree's Spouse dies; or

(4) The date you and your Spouse divorce or legally separate; or

(5) The date the Company terminates the Plan.

If you are divorced or legally separated, your former Spouse's medical plan premiums for periods of coverage after the date of divorce or legal separation are not eligible for reimbursement from your Retiree Medical Account.

F. Company Couples

On and after January 1, 2017, new rules apply if you are in a "company couple." Essentially, a "company couple" is where there are two former Company Employees and each individual has a "dual status" as both an Eligible Retiree AND an eligible Spouse.

Thus, a "company couple" is comprised of two former Company Employees where the following is true for each former Employee:

(1) Each former Company Employee qualifies as an Eligible Retiree[4] (i.e., each individual is separately eligible for either a Retiree Medical Account under this Plan, for subsidized Agilent Health Plan for Retirees coverage, or for the ARA as a participant); and

(2) Each former Company Employee qualifies as the eligible Spouse (as defined under this Plan) of the other former Company Employee (or as the other former Company Employee's eligible "spouse" under the Agilent Health Plan for Retirees or the ARA).

See Appendix B ("Company Couples") for more information on the Plan rules for company couples.

Remember that you are required to notify the Plan of your eligible Spouse upon initially becoming eligible for the Plan. See Section 13.E ("Proof of Marriage").

Note: The above rules apply only to reimbursements under this Plan. The plan document and Summary Plan Descriptions for the ARA programs (which include the Pre-65 Agilent Technologies, Inc. Reimbursement Arrangement Plan and the Post-65 Agilent Technologies, Inc. Reimbursement Arrangement Plan) contain the rules regarding reimbursements under the ARA, including for company couples. Similarly, the plan document for the Agilent Health Plan for Retirees contains the eligibility and benefits rules for the Agilent Health Plan for Retirees, including its requirements for spousal coverage.

[4] Totally Disabled Former Employees can also be part of a company couple. See Appendix A.

G. What Happens if an Eligible Retiree Dies?

Following an Eligible Retiree's death, remaining unused Retiree Medical Account amounts may be used by the Eligible Retiree's surviving Spouse to reimburse eligible medical plan premiums paid for coverage of the Eligible Retiree prior to the date of death or for the surviving Spouse's own eligible medical plan premiums until the balance of the specified amount in the Eligible Retiree's Retiree Medical Account is exhausted.

If on the date of death of the Eligible Retiree, there is no surviving Spouse, the Retiree Medical Account is terminated. Eligible medical plan premiums paid for coverage of the Eligible Retiree prior to the date of death may be reimbursed from the Retiree Medical Account. Upon payment of any final reimbursement, the Eligible Retiree's Retiree Medical Account will be terminated.

H. If an Eligible Retiree's Surviving Spouse Remarries

Access to the Retiree Medical Account does not end if your surviving Spouse remarries; however, medical plan premiums for your surviving Spouse's new spouse may not be reimbursed from the Retiree Medical Account.

5. IF AN ELIGIBLE RETIREE IS REHIRED

An Eligible Retiree will only be eligible for one Retiree Medical Account ($55,000, $40,000, $27,500, or $20,000, as applicable) as determined at the time of initial termination of employment. An Eligible Retiree who has a Retiree Medical Account at the time of rehire is not eligible for an additional Retiree Medical Account (i.e., a second Retiree Medical Account) upon subsequent retirement. When you retire again your original Retiree Medical Account will be reactivated; provided that you have not already been reimbursed for the full amount or your Retiree Medical Account was not terminated.

For years prior to 2014, an Eligible Retiree who was eligible for a Retiree Medical Account at the time of initial retirement had to elect coverage in the Pre-Medicare Medical Plan (or an HMO for retirees offered as an alternative to the Pre-Medicare Medical Plan) and timely pay premiums for that plan in order to maintain his or her Retiree Medical Account. If such Eligible Retiree either did not timely elect to participate in the Pre-Medicare Medical Plan (or an HMO for retirees offered as an alternative to the Pre-Medicare Medical Plan), or timely elected to participate in the Pre-Medicare Medical Plan (or an HMO for retirees offered as an alternative to the Pre-Medicare Medical Plan) but subsequently lost eligibility prior to January 1, 2014 due to non-payment of premiums or for any other reason and is subsequently rehired, he or she will have lost his or her Retiree Medical Account and will not be eligible for an additional Retiree Medical Account (i.e., a second Retiree Medical Account) upon subsequent retirement.

(1) **Rehired Retiree Who Was Either Receiving Subsidized Coverage Under the Agilent Health Plan for Retirees or Was Enrolled in the ARA.** A former Company employee who previously qualified for subsidized coverage under the Agilent Health Plan for Retirees (before age 65) or for the ARA and who is rehired on or after January 1, 2005 is not eligible for a Retiree Medical Account upon subsequent retirement. Rather, when you retire again, you may again be eligible for

subsidized Agilent Health Plan for Retirees coverage (if you are under age 65) or the ARA—that is, the coverage that you would have received (or continued to receive) if you had not been rehired by the Company.

(2) **Rehired Retiree Who Waived or Lost Subsidized Agilent Health Plan for Retirees Coverage.** A former Company employee who previously qualified for, but waived or lost, subsidized coverage under the Agilent Health Plan for Retirees (before age 65) and who is rehired on or after January 1, 2005 is not eligible for a Retiree Medical Account upon subsequent retirement. When you retire again, your eligibility for Agilent Health Plan for Retirees coverage will be based on the terms of the Agilent Health Plan for Retirees.

(3) **Rehired Eligible Retiree Enrolled in the Plan.** A former Company employee who previously qualified as an Eligible Retiree, who is rehired on or after January 1, 2005 and who is enrolled in the Plan at the time of rehire, is not eligible for an additional Retiree Medical Account (i.e., a second or third Retiree Medical Account) upon subsequent retirement. When you retire again your original Retiree Medical Account will be reactivated provided that you have not already been reimbursed for the full amount. An Eligible Retiree may only have one Retiree Medical Account, regardless of the number of times he or she retires from the Company and is later rehired.

(4) **Rehired Former Company Employee Who Was Not an Eligible Retiree.** A former Company employee who was not an Eligible Retiree at the time of termination of employment with the Company and who is rehired by the Company after January 1, 2005 and before November 1, 2014 may be eligible for a $40,000 or $20,000 Retiree Medical Account, as applicable, upon his or her subsequent termination of employment with the Company if he or she qualifies as an Eligible Retiree and meets the eligibility requirements for participation in this Plan. A former Company employee who was not an Eligible Retiree at the time of termination of employment with the Company and who is rehired by the Company after October 31, 2014 will not be eligible for a Retiree Medical Account upon his or her subsequent termination of employment with the Company.

Rehired Eligible Retirees may not use their Retiree Medical Account for reimbursement of their medical plan premiums while an active employee. While you are an active employee (at any level—fulltime or part-time), the Company will suspend reimbursements from your Retiree Medical Account until your subsequent retirement from the Company. See Section 6.C ("Expenses Not Eligible for Reimbursement From Your Retiree Medical Account").

6. ELIGIBLE RETIREES—USING THE RETIREE MEDICAL ACCOUNT

A. Retiree Medical Account Enrollment and Reimbursements

An Eligible Employee who qualifies as an Eligible Retiree when he or she retires from the Company will automatically commence participation in the Plan as of the date he or she retires from the Company.[5]

As an Eligible Retiree, reimbursements may only be made for the payment of eligible medical plan premiums that you incur while a participant in the Plan. As a surviving Spouse, reimbursement may only be made for the payment of eligible medical plan premiums that the surviving Spouse incurs while a participant (i.e., surviving Spouse) in the Plan. With respect to an Eligible Retiree, the Retiree Medical Account may not be used to reimburse the expenses of anyone who is not an Eligible Retiree or their Spouse or surviving Spouse.

Reimbursements Prior to a Participant's Becoming Age 65

You are not required to purchase Company-sponsored pre-Medicare retiree medical plan coverage to maintain your Retiree Medical Account—it may be used to pay either eligible medical plan premiums for individual coverage that you purchase in the individual insurance market or premiums for the Agilent Health Plan for Retirees.[6] You must pay the full cost of coverage for you and your Spouse, if applicable. You may then submit a claim for reimbursement to the Initial Claims Administrator.

Any portion of the specified amount under your Retiree Medical Account that remains unspent may carry forward from year to year. Reimbursements from your Retiree Medical Account will be made until the specified amount under your Retiree Medical Account has been exhausted or your Retiree Medical Account is otherwise terminated in accordance with the termination of coverage provisions in Section 4 ("Eligible Retirees").

Once the specified amount of your Retiree Medical Account is exhausted, you will be responsible for paying retiree medical plan premiums with your own funds and you will receive no further reimbursement from the Company or the Plan.

Reimbursements After a Participant Becomes Age 65

The Agilent Health Plan For Retirees contains numerous eligibility and participation requirements, including that once an Eligible Retiree reaches age 65, he or she will no longer be eligible to participate in the Agilent Health Plan for Retirees.

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[5] Prior to January 1, 2014, an Eligible Retiree who was under age 65 had to enroll in a Company-sponsored pre-Medicare retiree medical plan within 30 days after an Eligible Retiree retired. Such individuals also had to maintain (and not lose) coverage under a Company-sponsored pre-Medicare retiree medical plan in order to maintain his or her Retiree Medical Account.

[6] Prior to January 1, 2014, an Eligible Retiree who was under age 65 could not use his or her Retiree Medical Account to pay for premiums for insurance coverage obtained on the individual market.

If you have a remaining balance in your Retiree Medical Account after reaching age 65, then the Retiree Medical Account may be used to reimburse you for payments you make to cover eligible premiums for other Medicare medical, dental and vision insurance that you purchase on the individual insurance market, as well as premiums for certain other employer-sponsored (i.e., non-Company) retiree health coverage (see Section B below).

Any portion of the specified amount under your Retiree Medical Account that remains unspent may carry forward from year to year. Reimbursements from your Retiree Medical Account will be made until the specified amount under your Retiree Medical Account has been exhausted or your Retiree Medical Account is otherwise terminated in accordance with termination of coverage provisions in Section 4 ("Eligible Retirees").

B. Expenses Eligible for Reimbursement Under Your Retiree Medical Account

If you are a qualifying Eligible Retiree, your Retiree Medical Account may only be used to reimburse you for premiums you pay for the following types of coverage:

(1) Agilent Health Plan for Retirees (If Under Age 65). The Agilent Health Plan for Retirees. (Note: The Agilent Health Plan for Retirees contains limitations on who can participate, including that it limits eligibility to those under age 65. As a result, this reimbursement category does not apply to Plan participants or their Spouses who are over age 65.)

(2) Certain Individual Medical Insurance (On and After January 1, 2014 for Those Under Age 65). Medical coverage that you purchase in the individual insurance market (e.g., an individual medical insurance policy purchased on the Federal exchange or a state exchange such as Covered California). This category does not include medical coverage sponsored by the Company or any other employer (see additional rules under category #6 below). For individuals who are under age 65, this category #2 applies only on and after January 1, 2014.[7]

(3) Certain Individual Dental and Vision Insurance (for Those Either Under Age 65 or Over Age 65). Dental and vision coverage that you purchase in the individual insurance market (e.g., an individual dental insurance policy purchased from Liberty Dental in California). This category does not include dental or vision coverage sponsored by the Company or any other employer (but see category #6 below).

(4) Medicare Parts A and B (If over Age 65 or an SSA Disabled Individual). Medicare Part A and Medicare Part B coverage, as applicable. For example, this category applies if you are covered by Medicare Part A and Part B because you are over age 65 or because you are under age 65 and an SSA Disabled Individual.

(5) Individual Medicare Medical and Medicare Part D Coverage (Only if Over Age 65). Individual Medicare medical (including Medicare HMO plans) and Medicare Part D coverage (e.g., a non-employer-sponsored Medicare Part D prescription drug plan

[7] Prior to January 1, 2014, an Eligible Retiree who was under age 65 could not use his or her Retiree Medical Account to pay for premiums for insurance coverage obtained on the individual market.

purchased from an insurance company). This category applies only if you are over age 65 (i.e., not to SSA Disabled Individuals who are under age 65).

(6) Certain Other Employer-Sponsored (i.e., non-Company-sponsored) Retiree Medical, Dental, and Vision Coverage (On and After January 1, 2017). Effective for expenses incurred on or after January 1, 2017, your Retiree Medical Account can also be used (both before and after you attain age 65) to reimburse premium payments made for medical, dental, and vision coverage under certain other employer-sponsored retiree group health plans, such as military, local, state, Federal, university, and private-sector employer retiree health plans. This category applies only to other employer-sponsored coverage and does not include any kind of Company-sponsored coverage (e.g., active employee or COBRA coverage under the Agilent Technologies, Inc. Health Plan). All five requirements listed in A through E below must be met for such other employer-sponsored retiree health plan premiums to be reimbursable under the Plan:

(A) The other employer-sponsored plan is a retiree health plan (i.e., you cannot be eligible for the other employer-sponsored coverage as an active employee or the spouse/dependent of an active employee);

(B) The other employer-sponsored coverage is not COBRA continuation coverage;

(C) The premiums were paid on an after-tax basis;

(D) The expense is not otherwise excluded from reimbursement under the Plan; and

(E) You must provide proof, in a manner determined by the Company, that the above requirements in A through D above are satisfied.

With regard to the eligible expenses listed in categories #1-6 above, you are responsible for paying the entire cost of such coverage and then submitting a claim for reimbursement to the Plan's Initial Claims Administrator.

Please note that the Initial Claims Administrator will determine whether an expense is reimbursable by the Plan.

C. Expenses Not Eligible for Reimbursement From Your Retiree Medical Account

For Eligible Retirees, the following types of expenses are not eligible for reimbursement from your Retiree Medical Account:

(1) Company active employee medical plan premiums; (i.e., the Eligible Employee contribution required for the Agilent Medical Plan or an HMO, if available);

(2) Prior to January 1, 2014, if under age 65, premiums for coverage other than under a Company-sponsored pre-Medicare retiree medical plan, including the Pre-Medicare

Plan (or an HMO for retirees offered as an alternative to the Pre-Medicare Medical Plan)), if available;

(3) Premiums that you or your Spouse pay for any coverage sponsored by another employer (i.e., premiums for other employer-sponsored plans) that does not meet the requirements set forth in Section 6.B above (e.g., active employee coverage);

(4) Eligible medical plan premiums paid for anyone other than the Eligible Retiree or their Spouse or, with respect to a deceased Eligible Retiree, anyone other than their surviving Spouse;

(5) Health Savings Account ("HSA") contributions;

(6) Medical Savings Account ("MSA") contributions;

(7) Medical, dental or vision plan co-payments and co-insurance;

(8) Medical, dental or vision plan deductibles;

(9) Any additional expenses not covered under a medical plan;

(10) Direct expenses for medical or hospital services;

(11) Expenses for over-the-counter medicines or drug products;

(12) Dental plan premiums incurred for coverage prior to January 1, 2012;

(13) Vision plan premiums incurred for coverage prior to January 1, 2012;

(14) Long-term care insurance premiums;

(15) Preventive care expenses; and

(16) Any other expenses not specified as covered in the section "Eligible Expenses for Reimbursement Under Your Retiree Medical Account."

D. Tax Consequences of the Retiree Medical Account

Reimbursements from your Retiree Medical Account for eligible medical plan premiums paid for an Eligible Retiree or their Spouse are not currently subject to federal income tax. Reimbursements from your Retiree Medical Account for eligible medical plan premiums paid for a surviving Spouse of a deceased Eligible Retiree are also not currently subject to federal income tax.

If you receive reimbursement from your Retiree Medical Account to pay for eligible medical plan premiums, you cannot claim the amount of those premiums as a deduction for medical expenses on your income tax returns. You should consult your personal tax advisor for further information.

E. Possible Impact of Coverage under the Pre-65 ARA – Premium Tax Credit

There are state and federal programs that you may qualify for that can assist you with paying for health insurance. For example, if certain requirements are met, you may be eligible for a premium tax credit ("PTC") if you purchase health insurance coverage on a government exchange (e.g., Covered California). In general, you are not eligible for a PTC if you are eligible for coverage under Medicare, Medicaid or TRICARE.

Please note that coverage under the RMA will cause you and your Eligible Spouse or Domestic Partner to be ineligible for the PTC on a government exchange. In addition, coverage under the RMA may make you ineligible for other state and federal subsidy programs.

We cannot provide you with information about if you are eligible for any government subsidy program. Please consult your advisor for more information if you have any questions.

Note that each year, for a Participant (and his/her Eligible Spouses or Domestic Partner) who are under age 65, the Company will provide information to the IRS about coverage under the RMA. The impacted Participant will also be provided with a similar annual notice.

7. ELIGIBILITY CLAIMS AND REVIEW PROCEDURES

Any person who has a question regarding eligibility to participate in the Plan should contact the Agilent Service Center at Fidelity. If the person is not satisfied with the outcome, they can file a Claim for eligibility by following the procedures set forth below.

A. Claim Regarding Eligibility

If a person has been denied participation in the Plan when they believe they should be eligible, the person can file a written Claim with the Program Manager. The writing should include the grounds on which the Claim is based and any documents, records, written comments or other information that will support the Claim. The Program Manager will make a determination on the Claim within 60 days after the Claim is received. However, if there are special circumstances that require additional time, the Program Manager will provide written notice of the extension prior to the termination of the initial 60-day period. In such case, the Program Manager will make a determination within 120 days after the Claim is received. If the Program Manager denies the Claim for participation in the Plan, in whole or in part, the Program Manager will send a written notice explaining the reason(s) for the denial, including references to the specific Plan provision(s) or Employer policy upon which the denial was based. If the Claim was denied because the claimant did not furnish complete information or documentation, the notice will specify the additional materials or information needed to support the Claim and an explanation of why such information or materials are necessary. The notice will also state how and when to request a review of the denied Claim and will include a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following denial of the Claim on appeal.

B. Right to Appeal A Denied Eligibility Claim

Any person whose Claim for eligibility to participate in the Plan is denied, in whole or in part, may appeal such denial by submitting to the Global Benefits Director a written request for

review of the Claim within 60 days after receiving written notice of such denial from the Program Manager. The request for review must be in writing and shall set forth all of the grounds upon which it is based, all facts in support thereof and any other matters that the claimant deems pertinent. The claimant shall have the opportunity to submit written comments, documents, records, and other information relating to the Claim. Upon request, and free of charge, the claimant will be provided reasonable access to and copies of, all documents, records, and other information Relevant to the claimant's Claim that is not privileged or protected.

The Global Benefits Director will act on each request for a review within 60 days after receipt thereof. However, if there are special circumstances that require additional time, the Global Benefits Director will provide written notice of the extension prior to the termination of the initial 60-day period. In such case, the Global Benefits Director will make a determination within 120 days after the appeal is received.

The Global Benefits Director will either reverse the earlier decision and permit participation in the Plan or deny the appeal. In the event that the Global Benefits Director confirms the denial of the Claim, in whole or in part, the Global Benefits Director will give written notice of its decision to the claimant. The notice will set forth, in a manner calculated to be understood by the claimant, the following information:

(1) The specific reasons for the denial and the specific Plan provision(s) or Employer policy on which the denial is based; and

(2) A statement that, upon request, and free of charge, the claimant will be provided reasonable access to and copies of, all documents, records, and other information Relevant to the claimant's Claim that is not privileged or protected; and

(3) A statement of the claimant's right to bring a civil action under Section 502(a) of ERISA.

The Program Manager and the Global Benefits Director may require the claimant to submit (at the claimant's expense) additional information, documents or other material that it believes is necessary for the review. Any litigation or legal action by a claimant under the Plan must be initiated no later than one year following a final decision on appeal with respect to the Claim for eligibility. No such legal action may be taken until you have:

(1) Submitted a written claim for eligibility to the Program Manager; and

(2) Been notified by the Program Manager that your eligibility claim is denied; and

(3) Filed a written request for a review of the denied eligibility claim with the Global Benefits Director; and

(4) Been notified in writing that the denial of the eligibility claim has been affirmed by the Global Benefits Director.

8. BENEFIT CLAIMS PROCEDURES

A. How to File a Claim for Reimbursement

Initial claims are handled by the Initial Claims Administrator—Willis Towers Watson's Via Benefits ("Via Benefits"). You may submit claims online or by using a paper claim form and submitting it by mail or fax.

Online. To obtain a claim form, sign on to your account at https://my.viabenefits.com/Agilent. Once you are logged in, there will be a link directing you on how to file your claim. You will need to follow the steps outlined on the website, including how to fax or PDF proof of your eligible medical plan premium costs and evidence that you have paid those costs. If you have any questions about how to file a claim online, please contact Via Benefits at 1-888-232-3855.

Fax or U.S. Mail. You will need to complete a claim form, including signing and dating the claim form. A claim form was mailed to you with your Funding and Reimbursement Guide. You can also print additional forms online at https://my.viabenefits.com/Agilent or call Via Benefits to obtain additional copies of the form (1-888-232-3855). In addition to completing the claim form, you will need to attach a copy of the premium invoice and a copy of your bank statement or cashed checked as proof of payment. You must fax or mail the claim form and accompanying documentation to:

Via Benefits/Agilent RMA
P.O. Box 981155
El Paso, TX 79998-1155
Fax #: 1-855-321-2605

B. Filing Deadline

Your request for reimbursement must be submitted by March 31 of the year following the year in which the eligible medical plan premium is paid. Claims submitted later than March 31 of the year following the year in which the eligible medical plan premium is paid will be denied unless it is established that lack of legal capacity prevented timely submission.

C. Timing on Decision on Claims for Reimbursement ("Claims")

Claims for reimbursement will generally be processed by the Initial Claims Administrator twice a month. The Initial Claims Administrator will reimburse you or notify you that your Claim is denied within thirty (30) days of receipt of the initial claim for reimbursement unless an extension of up to fifteen (15) days is necessary due to matters beyond the control of the Plan. If an extension is necessary, you will be notified of the extension within thirty (30) days of the initial claim.

D. If You Receive Notice of an Incomplete Claim

If an initial claim is determined to be incomplete, the Initial Claims Administrator must notify you within fifteen (15) days of receiving the initial claim what information is required to complete the claim. Once such notification is made, you will have forty-five (45) days to

provide the required information. The Initial Claims Administrator will notify you of its decision within fifteen (15) days from the time you provide the required information or from the end of the forty-five (45) day deadline for you to provide the required information, whichever is sooner. If you do not provide additional information, a determination will be made based on the information received.

E. If You Receive Notice of an Adverse Benefit Determination

If all or part of your claim for reimbursement is denied, the Initial Claims Administrator will send you a written notice. This notice will explain:

(1) The reason(s) for the denial, including references to specific RMA provision(s) upon which the denial was based.

(2) If the claim was denied because you did not furnish complete information or documentation, the notice will specify the additional materials or information needed to support the claim and an explanation of why such information or materials are necessary.

(3) If the claim is denied based on an internal rule, guideline, protocol, or other similar criterion, the notice will either state the specific rule, guideline, protocol, or other similar criterion; or include a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request.

(4) The notice will also state how and when to request a review of the denied claim.

(5) The notice will also contain a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse determination on review.

9. PROCEDURES FOR APPEALING AN ADVERSE BENEFIT DETERMINATION

A. How to Appeal a Denied Claim

You (or your authorized representative) may appeal a denied claim by submitting a written request for review to the Appeals Administrator. You must make the request within 180 days after the date of the denial notice. Send the written request to the Appeals Administrator at:

Agilent Technologies, Inc.
Attention: Global Benefits
5301 Stevens Creek Blvd., MS 1A-20
Santa Clara, CA 95051

The request must explain why you believe a review is in order and it must include supporting facts and any other pertinent information. The Appeals Administrator may require you to submit such additional facts, documents or other material as it may deem necessary or appropriate in making its review.

B. Procedures on Appeal

As part of the review procedure, you may submit written comments, documents, records, and other information relating to the claim.

Upon request and free of charge, you will be provided reasonable access to, and copies of, all documents, records, and other information (other than legally or medically privileged documents) Relevant to your claim.

The Appeals Administrator will review the claim, taking into account all comments, documents, records, and other information submitted relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The review shall not afford deference to the initial claim denial and shall be conducted by an appropriate named fiduciary who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of that individual.

C. Timing of Appeal Determinations

The Appeals Administrator will act upon each request for a review not later than 60 days after receiving the appeal.

D. Notice of Determination on Appeal

Within the time prescribed above, the Appeals Administrator will provide you with written notice of its decision. If the Appeals Administrator determines that benefits should have been paid, the Appeals Administrator will instruct the Initial Claims Administrator to take whatever action is necessary to pay them as soon as possible.

If your claim is denied on review, the notice shall state:

(1) The reason(s) for the denial, including references to specific Plan provisions upon which the denial was based.

(2) That you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information (other than legally or medically privileged documents) Relevant to your claim for benefits.

(3) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the notice will state the specific rule, guideline, protocol, or other similar criterion; or include a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request.

(4) The notice will also describe any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures.

(5) The notice will also include a statement of your right to bring an action under Section 502(a) of ERISA.

E. Exhaustion of Remedies

No legal action may be taken to gain benefits from the Plan after two years from when the premium for which a claim was made was paid by the Member. No legal action may be taken to gain benefits from the Plan until you have:

(1) Submitted a written claim for benefits to the Initial Claims Administrator; and

(2) Been notified by the Initial Claims Administrator that the claim is denied; and

(3) Filed a written request for a review of the denied claim with the Appeals Administrator; and

(4) Been notified in writing that the denial of the claim has been affirmed by the Appeals Administrator.

10. COBRA CONTINUATION COVERAGE

Under a federal law commonly known as COBRA, in the event a covered Spouse of an Eligible Retiree or a covered Spouse and/or a covered eligible Dependent Child of a Totally Disabled Former Employee suffers a Qualifying Event, such covered Spouse and/or covered eligible Dependent Child may be eligible to elect a temporary extension of coverage when coverage under the Plan would otherwise be lost. The eligibility, enrollment, benefits, period of coverage, cost and all other terms and conditions associated with the provision of health care during a period of COBRA continuation coverage shall be determined pursuant to COBRA and the regulations thereunder.

11. FUTURE OF THE PLAN, AMENDMENT AND TERMINATION OF PLAN

The Company reserves the right to amend or to terminate the Plan at any time.

The Company, acting through the Board of Directors, has delegated the power and authority to amend the Plan as may be necessary to comply with ERISA, the Internal Revenue Code or any other applicable law, or to adopt amendments which do not substantively change the Plan or do not add materially to the Company's costs under the Plan to the Benefits Committee. In these circumstances, the Benefits Committee shall have the power and authority to amend the Plan at any time by written instrument. In all other circumstances, the Company reserves the right to amend the Plan at any time by resolution of the Compensation Committee. The Company reserves the right to terminate the Plan at any time by resolution of the Board of Directors.

12. ADMINISTRATION AND OPERATION OF THE PLAN

The Company is the "plan administrator" and "plan sponsor" as such terms are used in ERISA. The Company, in its capacity as the Plan Administrator, is the named fiduciary which has the discretionary authority to control and manage the operation and administration of the Plan. In its

discretion it may adopt rules and regulations under the Plan and interpret the Plan text. The Company will discharge its duties under the Plan in accordance with the standards set forth in Section 404(a)(1) of ERISA.

A. Duties and Responsibilities of the Plan Administrator

The Company will carry out its duties and responsibilities under the Plan (which are not delegated) through its directors, officers and employees, acting on behalf of and in the name of the Company in their capacities as directors, officers and employees and not as individual fiduciaries. The Company may employ other persons to render advice or to perform services with regard to its responsibilities under the Plan. These persons may include (without limitation) accountants, actuaries, attorneys, claims administrators, and consultants.

B. Delegation of Fiduciary Responsibilities

In lieu of carrying out any of its fiduciary responsibilities under the Plan, the Company may delegate its fiduciary responsibilities to any person or persons, including any claims administrator or the Benefits Committee, pursuant to a written contract (or charter approved by the Board of Directors of the Company, in the case of the Benefits Committee) with such other person which specifies the fiduciary responsibilities so delegated. The Company has delegated certain of its responsibilities under the Plan to the Benefits Committee.

C. Indemnification

To the extent permitted by law, the Company shall indemnify and hold harmless the members of the Board of Directors, the Benefits Committee, its officers and any other employee of the Company to whom any fiduciary responsibility with respect to the Plan is allocated or delegated, from and against any and all liabilities, costs and expenses, including attorneys' fees, incurred by any such person as a result of any act, or omission to act, in connection with the performance of such person's fiduciary duties, responsibilities and obligations under the Plan, other than such liabilities, costs and expenses as may result from the bad faith, gross negligence, willful misconduct or criminal acts of any such person or to the extent such indemnification is prohibited by law.

The Company shall have the obligation to conduct the defense of such persons in any proceedings to which this indemnification applies. If any person to whom Plan responsibilities have been delegated and who is covered by this indemnification provision determines that the defense of the Company is inadequate, that person shall be entitled to retain separate legal counsel for his or her defense and the Company shall be obligated to pay for all reasonable legal fees and other court costs incurred in the course of such defense unless a court of competent jurisdiction finds such person acted in bad faith, gross negligence or engaged in criminal acts or willful misconduct.

13. ADDITIONAL RULES THAT APPLY TO THE PLAN

A. Recovery of Overpayments

An "Overpayment" is a payment made to any Covered Person (or elsewhere for the benefit of the

Covered Person) in excess of the amount properly payable under this Plan with respect to the Covered Person.

Upon any Overpayment, the Plan shall have a first right of reimbursement and restitution with an equitable lien by contract in such amount. Further, the holder of such Overpayment shall hold it as the Plan's constructive trustee.

If any Covered Person has cause to reasonably believe that an Overpayment may have been made, the Covered Person shall promptly notify the Plan Administrator of the relevant facts. If the Plan Administrator determines (on the basis of any relevant facts) that an Overpayment was made to any Covered Person (or any other person on the Covered Person's behalf), it shall notify the Covered Person in writing and the Covered Person shall promptly pay (or cause another person to pay) the amount of such Overpayment to the Plan Administrator.

If the Plan Administrator has made a written demand for the repayment of an Overpayment and the Covered Person (or other person) has not repaid (or caused to be repaid) the Overpayment within 30 days following the date on which the demand was mailed to the Covered Person (or other person), then any amounts subsequently payable as benefits under this Plan with respect to the Covered Person may be reduced by the amount of the outstanding Overpayment or the Plan Administrator may recover such Overpayment by any other appropriate method that the Plan Administrator shall determine.

The Plan's right to reimbursement, restitution, to an equitable lien by contract, and as beneficiary of a constructive trust shall in no way be affected, reduced, compromised, or eliminated by any doctrines limiting its rights (equitable or otherwise) such as the make-whole doctrine, contributory or comparative negligence, the common fund doctrine, or any other defense. The Plan's rights against the Covered Person and the Covered Person's obligation to the Plan shall also not be affected if the Overpayment was made to another person or entity on behalf of the Covered Person.

If an Overpayment is not in the Covered Person's possession (other than in possession by or on behalf of the Plan), the Covered Person shall immediately take whatever steps possible to regain possession of the Overpayment or have it transferred to or on behalf of the Plan pursuant to its direction.

The Covered Person shall cooperate with the Plan and take any action that may be necessary to protect its interests herein.

Notwithstanding the foregoing in this Section 13.A, the Plan Administrator has the sole discretion whether to pursue recovery of an Overpayment or not, based on its fiduciary duties and any other requirements under applicable law.

B. Terms of the Plan Govern

The terms of the Plan shall govern the benefits provided thereunder. Errors and omissions, such as inaccurate effective or termination dates, incorrect benefit payments, incorrect oral or written statements, or erroneous mailings will not change the rights or obligations of any person under the Plan and will not operate to grant additional benefits to any person.

C. Nonassignability of Rights

The right of any Member to receive any reimbursement under the Plan shall not be alienable by the Member by assignment or any other method, and will not be subject to be taken by his or her creditors by any process whatsoever, and any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

D. Governing Law

This Plan and the rights of all persons under the Plan shall be interpreted and construed in accordance with and under applicable provisions of the Internal Revenue Code of 1986, as amended, the Employee Retirement Income Security Act of 1974 ("ERISA"), and, to the extent that state laws are not preempted by ERISA, the laws of the State of California.

E. Proof of Marriage

Eligible Retirees and their Spouses may be required to furnish proof that their marriage is valid under the law of the state where it was contracted as a condition of maintaining coverage for such Spouse under the Plan. Totally Disabled Former Employees and their Spouses may be required to furnish proof that their marriage is valid under the law of the state where it was contracted as a condition of maintaining coverage for such Spouse under the Plan. Totally Disabled Former Employees may also be required to furnish proof of dependency when covering an eligible Dependent Child. In addition, an Eligible Retiree or Totally Disabled Former Employee must notify the Plan at their termination of employment or initial qualification as a Totally Disabled Former Employee, as applicable, of the identity of the Eligible Retiree's or Totally Disabled Former Employee's Spouse and provide such other information that the Plan determines is necessary for administration of the Plan. The Plan can deny reimbursements for the Spouse of an Eligible Retiree or Totally Disabled Former Employee who fails to provide any information requested by the Plan in accordance with this Section E.

F. Eligibility Audits

From time to time the Company or its delegate may conduct audits for eligibility under the Plan. Such audits may include, without limitation, requests that the Member certify or otherwise provide information which establishes the eligibility of the Spouse and/or with respect to a Totally Disabled Former Employee an eligible Dependent Child. In the event that the Member fails to comply with the requirements of any such audit, he or she shall not be eligible to receive any further benefits under the Plan with respect to the Spouse and/or with respect to a Totally Disabled Former Employee an eligible Dependent Child whose eligibility is in question until he or she has so complied.

G. Workers' Compensation

This Plan is not in lieu of, and does not affect any requirement for coverage by, Workers' Compensation Insurance.

H. Employment Rights

Nothing in this Plan shall be deemed to give any person a right to remain in the employ of the Company nor affect any right of the Company to terminate the employment of any person with or without cause.

I. Number

Except as otherwise clearly indicated, the singular shall include the plural, and vice versa.

J. Headings and Captions

The headings and captions herein are provided for reference and convenience only and shall not be considered part of the Plan nor shall be employed in the construction of the Plan.

K. Severability of Provisions

If any provision of this Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provisions hereof, and this Plan shall be construed and enforced as if such provision had not been included.

L. No Duplication of Benefits

Notwithstanding any provision of this Plan to the contrary, no individual is eligible for a Retiree Medical Account under this Plan if such individual is eligible for the Keysight Technologies, Inc. Retiree Medical Account Plan, the Keysight Technologies, Inc. Reimbursement Arrangement Plan, or the Keysight Technologies, Inc. Health Plan for Retirees. The determination of whether an individual is not eligible for a Retiree Medical Account under this Plan shall be made by the Company, and such determination shall be conclusive and binding on all persons.

The terms of this Plan will not be interpreted or applied to grant any individual service credit or benefits to the extent that receipt of such service credit or benefits would result in duplication of benefits provided to such individual under the Keysight Technologies, Inc. Retiree Medical Account Plan, the Keysight Technologies, Inc. Reimbursement Arrangement Plan, or any other plan, program or arrangement sponsored or maintained by the Company or Keysight Technologies, Inc.

M. Section 401(h) Account and Funding

To the extent permitted by the Code and the terms of the Agilent Technologies, Inc. Retirement Plan (the "Retirement Plan"), reimbursements under the Plan will be paid from the Code Section 401(h) account of the Retirement Plan. All other reimbursements will be paid solely by the Company out of its general assets. Any such general assets earmarked to make payments under the Plan shall continue to belong to the Company and no Covered Person or other individual shall have any property interest in any specific asset of the Company solely because he or she participates in the Plan. No interest or earnings will be credited to an Eligible Retiree's or a Totally Disabled Former Employee's Retiree Medical Account under the Plan.

N. HIPAA Privacy and Security

This document incorporates by reference an omnibus HIPAA privacy and security amendment ("HIPAA Privacy Amendment") that applies to all of the self-funded group health plans sponsored by the Company. That HIPAA Privacy Amendment is not attached to this document but is a separate stand-alone document.

14. GLOSSARY

Agilent Health Plan for Retirees — means the Agilent Technologies, Inc. Health Plan for Retirees which: (a) on and prior to December 31, 2019, included the Pre-Medicare Medical Plan provisions set forth in the Agilent Technologies, Inc. Health Plan For Retirees and any of the direct service health care programs commonly known as Health Maintenance Organizations (HMOs) made available to participants in that plan and (b) on and after January 1, 2020, only includes the HMO made available to participants in the Agilent Technologies, Inc. Health Plan for Retirees.

Agilent Medical Plan — means those sections of the Agilent Technologies, Inc. Health Plan document that relate to the provision of hospital and physicians' services and medical supplies to active Eligible Employees and their dependents enrolled under the Agilent Medical Plan.

Appeals Administrator — means the individual or subcommittee appointed by the Benefits Committee to make final determinations on appeals from denied claims under the Plan.

Benefits Committee — means the Benefits Committee appointed by the Board of Directors and acting in accordance with the applicable plan administration, amendment and termination provisions of the Plan. The members of the Benefits Committee shall serve at the pleasure of the Board of Directors.

Board of Directors — means the Board of Directors of Agilent Technologies, Inc.

Child or Children — means one or more:

(1) Natural children of the Member or legally adopted children of the Member whose domicile is exclusively the same as that of the Member (including a child whose domicile is exclusively the same as that of the Member but who is away at school on a full-time basis) or who receive more than one-half (1/2) of their support from the Member; provided, however, that children shall become legally adopted children hereunder upon the assumption and retention by the Member of the legal obligation of total or partial support of a child in anticipation of adoption as specified in the Omnibus Budget Reconciliation Act of 1993;

(2) Foster children of the Member (as well as those placed in the home during legal adoption proceedings) whose domicile is exclusively the same as that of the Member and who receive more than one-half (1/2) of their support from the Member;

(3) Step-children whose domicile is primarily the same as that of the Member; or

(4) Children who are "alternate recipients" under a state court Qualified Medical Child Support Order (QMCSO).

Company — means Agilent Technologies, Inc., a Delaware Corporation, and those of its domestic subsidiaries and domestic affiliates which the Board of Directors has designated to participate in the Plan.

Compensation Committee — means the Compensation Committee appointed by the Board of Directors and acting in accordance with this Plan's provisions governing amendment and termination of the Plan. The members of the Compensation Committee shall serve at the pleasure of the Board of Directors.

Covered Person — means an Eligible Retiree or an Eligible Retiree's Spouse or an Eligible Retiree's surviving Spouse or a Totally Disabled Former Employee or a Totally Disabled Former Employee's Spouse and/or eligible Dependent Child or a Totally Disabled Former Employee's surviving Spouse and/or surviving eligible Dependent Child who are eligible for benefits under the Plan.

Dependent Child — means with respect to a Totally Disabled Former Employee only, the Totally Disabled Former Employee's:

(1) Unmarried Child through age twenty-two (22); or

(2) An unmarried Child who immediately after a period of coverage under the Agilent Technologies, Inc. Health Plan ends is continuously physically or mentally incapable of self-support when coverage would otherwise terminate solely because of age; provided, that within 30 days of coverage ending under the Agilent Technologies, Inc. Health Plan, proof of incapacity shall be submitted to the Claims Administrator of the Agilent Technologies, Inc. Health Plan and such other additional proof as is periodically required by the Company or by the Claims Administrator for the Agilent Health Plan for Retirees.

Distribution Date — means November 1, 2014.

Divested Employee — means an employee who is determined by the Plan Administrator to have met all of the following requirements:

(1) Has been identified as an employee of a business being divested by the Company to a purchasing company, as defined in the purchase and sale agreement relevant to that transaction; and

(2) Has been made an offer of employment by the purchasing company in accordance with the terms of the purchase and sale agreement relevant to that transaction; and

(3) Has accepted the offer of employment from the purchasing company; and

(4) Has terminated employment with the Company as a result of the completion of the purchase and sale transaction.

Notwithstanding anything to the contrary in the Plan, the 2014 transaction whereby the Company was separated into two publicly traded companies, the Company and Keysight Technologies, Inc., is not a divestiture.

Eligible Employee — means an individual on the U.S. dollar Payroll of the Company who is engaged in regular full-time employment or regular part-time employment of not less than 20 hours per week, provided, however, that an employee in Company approved non-pay status is an Eligible Employee if he or she was otherwise an Eligible Employee immediately prior to such non-pay status.

Any individual whose wages are paid directly by a third party agency, any individual classified as an independent contractor by the Company, and any individual who is part of the Company's flexible work force, including, but not limited to, leased employees, temporary employees, freelancers and short term employees, shall not be an Eligible Employee hereunder notwithstanding that any such individual might be classified as a common law employee for any other purpose by any government agency or other entity. Furthermore, if during any period, the Company has not treated such an individual as a common law employee and, for that reason, has not withheld employment taxes with respect to that individual, then that individual shall not be an Eligible Employee for that period, even in the event that the individual is determined, retroactively, to have been a common law employee during all or any portion of that period. Notwithstanding the foregoing, an Eligible Employee does not include an individual who resides in Puerto Rico.

An individual's status as an Eligible Employee shall be determined by the Company, and such determination shall be conclusive and binding on all persons.

Eligible Retiree — means any former employee of the Company who terminates employment while on the U.S. Payroll of the Company with not less than 15 Years of Full-Time Equivalent Service as an Eligible Employee and who is not less than 55 years of age at the time of termination of employment who meets all other applicable eligibility requirements set forth in this Plan.

An Eligible Retiree shall also include any former employee of the Company who participated in the Workforce Management Plan or the Voluntary Severance Plan who terminates employment while on the U.S. Payroll of the Company and who (A) within 365 days of termination of employment with the Company would have had not less than 15 Years of Full-Time Equivalent Service as an Eligible Employee; and (B) is not less than 55 years of age at the time of termination of employment or attains 55 years of age within 365 days of termination of employment with the Company provided they also meet any other requirements of this RMA Plan.

An Eligible Retiree shall also include any former employee of the Company who terminates employment while on the U.S. Payroll of the Company due to the Company's NSD Divestiture and who (A) within 365 days of termination of employment with the Company would have had not less than 15 Years of Full-Time Equivalent Service as an Eligible Employee; and (B) is not less than 55 years of age at the time of termination of employment or attains 55 years of age

within 365 days of termination of employment with the Company provided they also meet any other requirements of this RMA Plan.

Prior to January 1, 2014, an Eligible Retiree also included any former employee of the Company who terminated employment while on the U.S. Payroll of the Company and who was a Divested Employee and who (A) within 365 days of termination of employment with the Company would have had not less than 15 Years of Full-Time Equivalent Service as an Eligible Employee; and (B) was not less than 55 years of age at the time of termination of employment or attained 55 years of age within 365 days of termination of employment with the Company provided they also meet any other requirements of the Plan.

Notwithstanding any contrary Plan provision (including any provision in an Appendix), no individual will be considered an Eligible Retiree unless such individual also: (i) was an Eligible Retiree prior to November 1, 2014; or (ii) was age 55 or older and accrued 15 Years of Full-Time Equivalent Service prior to November 1, 2014; or (iii) was an Eligible Employee on October 31, 2014, and remained an Eligible Employee at all times between October 31, 2014 and the date such individual initially attains age 55 and has accrued 15 Years of Full-Time Equivalent Service.

An individual's status as an Eligible Retiree shall be determined by the Company in its sole discretion, and such determination shall be conclusive and binding on all persons.

Employee Matters Agreement — means the Employee Matters Agreement by and between Agilent Technologies, Inc. and Keysight Technologies, Inc., dated August 1, 2014.

ERISA — means the Employee Retirement Income Security Act of 1974, as amended from time to time.

Initial Claims Administrator — means Via Benefits, the entity that was appointed to process and administer claims under the Plan.

Member — means an Eligible Retiree and, with respect to an Eligible Retiree, the Eligible Retiree's Spouse, if not divorced or legally separated, or in the case of a deceased Eligible Retiree the Eligible Retiree's surviving Spouse, or a Totally Disabled Former Employee and, with respect to a Totally Disabled Former Employee, the Totally Disabled Former Employee's Spouse, if not divorced or legally separated, and/or the Totally Disabled Former Employee's eligible Dependent Children or in the case of a deceased Totally Disabled Former Employee the Totally Disabled Former Employee's surviving Spouse and/or the deceased Totally Disabled Former Employee's eligible Dependent Children.

NSD Divestiture — means the divestiture of the Company's Network Solutions Division pursuant to the Company's Asset Purchase Agreement dated as of February 10, 2010, with JDS Uniphase Corporation ("JDSU") under which JDSU will purchase substantially all of the assets associated with the Company's Network Solutions Division.

Payroll — means the system used by an entity to pay those individuals it regards as its common law employees for their services and to withhold employment taxes from the compensation it pays to such common law employees. "Payroll" does not include any system an entity uses to

pay individuals whom it does not regard as its common law employees and for whom it does not actually withhold employment taxes (including, but not limited to, individuals it regards as independent contractors) for their services.

Plan — means the Agilent Technologies, Inc. Retiree Medical Account Plan.

Plan Administrator — means Agilent Technologies, Inc. or its delegate(s).

Plan Sponsor — means Agilent Technologies, Inc.

Pre-Medicare Medical Plan — means for the period on and prior to December 31, 2019 the Pre-Medicare Medical Plan set forth in the Agilent Health Plan for Retirees (or an HMO for retirees offered as an alternative to the Pre-Medicare Medical Plan).

Qualified Medical Child Support Order or QMCSO — means any judgment, decree, or order (including approval of a settlement agreement) which meets the requirements for a Qualified Medical Child Support Order (QMCSO) as defined in Section 609 of ERISA. A Qualified Medical Child Support Order shall also include a properly completed National Medical Support Notice.

Qualifying Event — means loss of dependent status as a Spouse or an eligible Dependent Child due to:

(1) Death of the Eligible Retiree or Totally Disabled Former Employee;

(2) Divorce or legal separation of the Spouse from the Eligible Retiree or Totally Disabled Former Employee; or

(3) A Totally Disabled Former Employee's eligible Dependent Child ceasing to qualify as an eligible Dependent Child under the terms of the Plan; or

(4) Such other events that are established as "Qualifying Events" under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time, and the regulations thereunder.

Relevant — means a document, record, or other information regarding a claimant's claim for a Plan benefit if such document, record, or other information:

(1) Was relied upon in making the benefit determination; or

(2) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; or

(3) Demonstrates compliance with the administrative processes and safeguards required pursuant to the ERISA claims regulations; or

(4) Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Separation Date — means August 1, 2014.

Spouse — means the individual to whom the Eligible Retiree is married pursuant to a valid legal marriage under the law of the state or other jurisdiction where the marriage took place at the time of the initial retirement from the Company. With respect to an Eligible Employee who qualifies as an Eligible Retiree under this Plan, but who dies while still actively employed with the Company, Spouse shall also mean a person to whom the Eligible Employee is married to pursuant to a valid legal marriage under the law of the state or other jurisdiction where the marriage took place at the time of the Eligible Employee's death. With respect to a Totally Disabled Former Employee, Spouse means a person to whom the Totally Disabled Former Employee is married to pursuant to a valid legal marriage under the law of the state or other jurisdiction where the marriage took place at the time the Totally Disabled Former Employee first qualifies as such under the terms of this Plan.

SSA Disabled Individual — means an Eligible Retiree, a Totally Disabled Former Employee, or an eligible Dependent of an Eligible Retiree or a Totally Disabled Former Employee who has been determined by the Social Security Administration to be disabled and who is therefore eligible for and enrolled in Medicare Part A and/or Part B prior to reaching age 65. An SSA Disabled Individual may be covered under Agilent Health Plan for Retirees until such time as they reach age 65 or are determined by the Social Security Administration to no longer be disabled, whichever is earlier, in accordance with the terms of the Agilent Health Plan for Retirees.

Totally Disabled Former Employee — means a former employee of the Company who has been and continues to be approved for long-term disability coverage under the Agilent Technologies, Inc. Disability Plan (the "Agilent Disability Plan"), and who was an Eligible Employee enrolled in the Agilent Medical Plan immediately prior to the onset of disability; provided, however, that a former employee who loses long-term disability coverage under the Agilent Disability Plan solely due to reaching a limiting age shall continue to be a Totally Disabled Former Employee under this Plan. If at the time of termination of employment the determination of eligibility for long-term disability coverage under the Agilent Disability Plan has not been made, a former employee shall not be considered a Totally Disabled Former Employee for purposes of this Plan pending such determination.

Notwithstanding any contrary Plan provision, no individual will be considered a Totally Disabled Former Employee for purposes of this Plan unless the individual also satisfies one of the following requirements: (i) the individual was a Totally Disabled Former Employee prior to November 1, 2014; or (ii) the individual terminated employment prior to November 1, 2014 due to an onset of disability, but the individual's determination of eligibility for long-term disability coverage under the Disability Plan had not been made as of November 1, 2014; or (iii) the individual was an Eligible Employee on October 31, 2014, the disability on which the individual's qualification as a Totally Disabled Former Employee is based first occurred before

January 1, 2016, and the individual remained an Eligible Employee at all times between October 31, 2014 and the date that disability first occurred.

An individual's status as a Totally Disabled Former Employee shall be determined by the claims administrator of the Agilent Disability Plan, and such determination shall be conclusive and binding on all persons.

Years of Full-Time Equivalent Service — means a 12-month period of service or, in the case of an individual employed in other than full-time status, such longer period of service required to aggregate 2080 standard hours, and during which an individual is in active pay status on the U.S. dollar Payroll of the Company. Such periods shall include, without limitation, flexible time off, vacation, sick leave, jury duty, holidays, bereavement leave, medical Leaves of Absence and military Leaves of Absence. Such periods shall not include personal Leaves of Absence.

With respect to individuals who were employees of Hewlett-Packard Company and who first became eligible to participate in the Agilent Medical Plan on May 1, 2000, Years of Full-Time Equivalent Service shall also include all "Years of Service" as defined in the HP Health Plan and accrued as an employee of Hewlett-Packard Company as of December 31, 1988, and all Years of Full-Time Equivalent Service as defined in the HP Health Plan and accrued as an employee of Hewlett-Packard Company as of April 30, 2000.

With respect to individuals who were employees of Hewlett-Packard Company and who first become eligible to participate in the Agilent Medical Plan after May 1, 2000, Years of Full-Time Equivalent Service shall also include all "Years of Service" as defined in the HP Health Plan and accrued as an employee of Hewlett-Packard Company as of December 31, 1988, and all Years of Full-Time Equivalent Service as defined in the HP Health Plan and accrued as an employee of Hewlett-Packard Company as of June 2, 2000.

With respect to individuals who were employees of Varian, Inc. and its subsidiaries who became employees of the wholly owned subsidiary of the Company on May 14, 2010, pursuant to the Agreement and Plan of Merger as of July 26, 2009 that the Company entered into with Varian, Inc., a Delaware corporation, Years of Full-Time Equivalent Service shall include all years of service while on the U.S. Payroll of the wholly owned subsidiary of the Company on and after May 14, 2010. Previous service with Varian, Inc. and its subsidiaries shall not be included in this definition.

With respect to individuals who were employees of Dako, Inc. and its subsidiaries who became employees of the wholly owned subsidiary of the Company in June of 2012, Years of Full-Time Equivalent Service shall include all years of service while on the U.S. Payroll of the wholly owned subsidiary of the Company on and after November 1, 2013. Previous service with Dako, Inc. and its subsidiaries shall not be included in this definition.

With respect to Eligible Employees whose employment with the Company includes employment on a non-U.S. dollar payroll of the Company or a foreign subsidiary or an affiliate of the Company, Years of Full-Time Equivalent Service shall include all "years of service" during which such employees were in active pay status on the non-U.S. dollar payroll of such foreign subsidiary or affiliate.

With respect to Eligible Employees who were former employees of Keysight Technologies, Inc., Years of Full-Time Equivalent Service, shall include all "Years of Full-Time Equivalent Service," as such term is defined in the Keysight Technologies, Inc. Retiree Medical Account Plan (and only with respect to service at Keysight Technologies, Inc.) accrued between the Separation Date and the Distribution Date.

The determination of an individual's Years of Full-Time Equivalent Service shall be made by the Company, and such determination shall be conclusive and binding on all persons.

15. EXECUTION

To record the amendment and restatement of the Plan to read as set forth herein effective as of January 1, 2020, the Company has caused it to be executed in its name and behalf by its officer thereunto duly authorized on this _____ day of _____, 2019.

AGILENT TECHNOLOGIES, INC.

By:_____

Dominique Grau
Senior Vice President, Human Resources

PLAN ADMINISTRATION

This information about the administration of the Plan is provided in compliance with the Employee Retirement Income Security Act (ERISA) of 1974, as amended.

Plan Sponsor

The name, address and telephone number of the Plan Sponsor are:

Agilent Technologies, Inc.
Attention: Global Benefits
5301 Stevens Creek Blvd., MS lA-20
Santa Clara, CA 95051
Phone: 408.553.4336

This Plan is a group health plan that provides for reimbursement of certain medical plan premiums from a health reimbursement account.

Plan Administrator

The name, address and telephone number of the Plan Administrator are:

Agilent Technologies, Inc.
Attention: Global Benefits
5301 Stevens Creek Blvd., MS 1A-20
Santa Clara, CA 95051
Phone: 408.553.4336

Name of Plan

The Name of the Plan is the Agilent Technologies, Inc. Retiree Medical Account Plan.

Agent for Service of Legal Process

The name, address and telephone number of the agent for service of legal process are:

Agilent Technologies, Inc.
Attention: Global Benefits
5301 Stevens Creek Blvd., MS 1A-20
Santa Clara, CA 95051
Phone: 408.553.4336

Identification Numbers

The Employer Identification Number (EIN) assigned by the Internal Revenue Service to Agilent Technologies, Inc. is 77-0518772. The plan number for the Agilent Technologies, Inc. Retiree Medical Account Plan is 550.

Plan Year

The plan year for the Agilent Technologies, Inc. Retiree Medical Account Plan is January 1 through December 31.

Initial Claims Administrator

The name, address and telephone number of the Initial Claims Administrator is:

Via Benefits/Agilent RMA
PO Box 981155
El Paso, TX 79998-1155
Fax # 1-855-321-2605

Sources of Contributions and Funding

To the extent permitted by the Code and the terms of the Retirement Plan, reimbursements under the Plan will be paid from the Code Section 401(h) account of the Retirement Plan. All other reimbursements will be paid solely by the Company out of its general assets and, except as provided in the following sentence, no contributions from participants are required. To the extent that COBRA is required to be provided and is timely elected, Qualified Beneficiaries will be required to pay COBRA premiums to the Plan.

YOUR RIGHTS UNDER ERISA

As a participant in the 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

1) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

2) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated SPD. The administrator may make a reasonable charge for the copies.

3) If applicable, receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a plan benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file a 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 a federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are

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

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest 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.

APPENDIX A

ELIGIBILITY, PARTICIPATION AND BENEFITS FOR TOTALLY DISABLED FORMER EMPLOYEES

This Appendix A contains the eligibility and participation rules for Totally Disabled Former Employees. ***Effective January 1, 2016, the Plan was closed to new Totally Disabled Former Employees who first became disabled on or after January 1, 2016.*** Accordingly, if you are not an Eligible Retiree (see Section 4.A ("Eligible Retirees—Eligibility Requirements"), you might be eligible for the Plan as a Totally Disabled Former Employee if you first became disabled prior to January 1, 2016 and met certain other requirements.

A. Overview

Introduction.

In general, a Totally Disabled Former Employee is a former employee of the Company who became disabled, was enrolled in the Agilent Medical Plan at the time of the disability and is subsequently determined to be eligible for long-term disability coverage under the Agilent Disability Plan. Certain capitalized words used in the Plan Document and SPD and this Appendix A have special meanings. These words are defined in the "Glossary".

The following chart provides a snapshot of the eligibility, participation, and benefits rules for Totally Disabled Former Employees. Those rules are described in more detail in other sections of this Appendix A, and this chart is provided for informational purposes only

Totally Disabled Former Employees Eligibility and Benefits Overview			
Who is a Totally Disabled Former Employee?	**Core Eligibility Requirements**	**Potential Retiree Medical Account Amounts**	**Individuals Eligible for Reimbursement**
A former employee of the Company who became disabled, was enrolled in the Agilent Medical Plan at the time of the disability and is subsequently determined to be eligible for long-term disability coverage under the Agilent Disability Plan. *See the definition of "Totally Disabled Former Employee" in the "Glossary."*	• Became disabled after January 1, 2009 and before January 1, 2016; and • Not hired or rehired on or after November 1, 2014. *See Section B of this Appendix A ("Eligibility Requirements")*	• $55,000; or • $40,000 *See Section C of this Appendix A ("Retiree Medical Account Amounts")*	• Totally Disabled Former Employee • Eligible Spouse • Eligible Dependent Children *See Section L of this Appendix A ("Using the Retiree Medical Account")*

Eligibility.

The requirements for a Totally Disabled Former Employee (who is not an Eligible Retiree) to be eligible for a Retiree Medical Account under the Plan, which are described in more detail in Section B of the Appendix A ("Eligibility Requirements"), are as follows:

(1) First, you must meet the Plan's definition of Totally Disabled Former Employee (See the "Glossary");

(2) Second, you must have become disabled after January 1, 2009 and before January 1, 2016; and

(3) Third, if you first became disabled after October 31, 2014 and before January 1, 2016, then you also must meet the requirements in both (A) and (B) below:

(A) You must have been an Eligible Employee on October 31, 2014 (i.e., you must not have been hired after October 31, 2014)[8]; and

(B) You must have remained an Eligible Employee from October 31, 2014 through the date you first become disabled (i.e., you must not have terminated employment or transfer to an ineligible position between October 31, 2014 and the date you first become disabled).

Plan Benefits.

The Plan provides a qualifying Totally Disabled Former Employee with a "virtual" or "notional" unfunded account (a "Retiree Medical Account") representing amounts available for reimbursement of eligible medical, Medicare Part A, Medicare Part B, prescription drug, dental and vision plan premiums that are paid by the Totally Disabled Former Employee for coverage of the Totally Disabled Former Employee or his or her eligible Spouse or eligible Dependent Children. Funds are not actually set aside in a Totally Disabled Former Employee's Retiree Medical Account under the Plan.

Sections L ("Using the Retiree Medical Account") and M ("Expenses Eligible for Reimbursement Under Your Retiree Medical Account") of this Appendix A contain the rules regarding what expenses can be reimbursed from a Retiree Medical Account. It is important that you read Sections L and M closely to determine what kinds of premiums meet the Plan's reimbursement requirements.

[8] In general, to be an Eligible Employee you must have been on the U.S. Dollar Payroll of the Company and in regular employment of not less than 20 hours per week. See the "Glossary" for the complete definition of an Eligible Employee.

B. Eligibility Requirements

You are eligible for a Retiree Medical Account under the Plan as a Totally Disabled Former Employee only if you satisfy all of the following requirements:

(1) Requirement #1—Not Disabled on January 1, 2009. As of January 1, 2009, you must not have been disabled.

(2) Requirement #2—First Became Disabled Prior to January 1, 2016. The disability on which your status as a Totally Disabled Former Employee is based (your "Qualifying Disability") must have first occurred prior to January 1, 2016 (i.e., you must have first become disabled prior to January 1, 2016).

(3) Requirement #3—Special Rules for Disabilities First Occurring Between November 1, 2014 and January 1, 2016. Effective November 1, 2014, the Plan was closed to new Totally Disabled Former Employees who were hired or rehired after October 31, 2014. (As explained above, the Plan was also closed on January 1, 2016 to new Totally Disabled Former Employees who first became disabled on or after January 1, 2016.) Accordingly, if you first became disabled on or after November 1, 2014 and before January 1, 2016, then you must satisfy both requirements (A) and (B) below:

(A) You must have been an Eligible Employee on October 31, 2014; and

(B) You must have remained an Eligible Employee from October 31, 2014 through the date your Qualifying Disability first occurred (i.e., the date you first became disabled).

In other words, if you had not first become disabled prior to November 1, 2014 (i.e., you were still an active employee after October 31, 2014), then you must have been hired as an Eligible Employee prior to November 1, 2014 and not terminated employment or transferred to an ineligible position or status before you first became disabled (and qualified as a Totally Disabled Former Employee based on that disability). Below is an example of how a Totally Disabled Former Employee can satisfy this requirement:

Example. On July 1, 2010, you were hired by the Company, and you are an Eligible Employee on October 31, 2014. On August 15, 2015, you become disabled and subsequently satisfy the requirements to be considered a Totally Disabled Former Employee. If you remained an Eligible Employee at all times between October 31, 2014 and August 15, 2015, then you qualified as a Totally Disabled Former Employee, provided that you satisfied all other applicable requirements under the Plan.

(4) Not Eligible for Certain Other Coverage. You are not eligible for a Retiree Medical Account under the Plan if you are eligible for any of the following plans or benefits:

(A) Non-Retiree Medical Account subsidized coverage under the Agilent Health Plan for Retirees (before age 65);

(B) The Agilent Technologies, Inc. Reimbursement Arrangement Plan[9] ("ARA");

(C) The Keysight Technologies, Inc. Retiree Medical Account Plan (the "Keysight RMA");

(D) The Keysight Technologies, Inc. Reimbursement Arrangement Plan (the "KRA"); or

(E) The Keysight Technologies, Inc. Health Plan for Retirees (the "Keysight Health Plan for Retirees").

C. Retiree Medical Account Amounts

The Retiree Medical Account amount for a qualifying Totally Disabled Former Employee depends on various factors and is either $55,000 or $40,000. The applicable Retiree Medical Account amount for a qualifying Totally Disabled Former Employee is determined as follows:

(1) $55,000. Your Retiree Medical Account amount is $55,000 if you meet requirements (A), (B), and (C) below:

(A) As of January 1, 2009, you were an Eligible Employee;

(B) As of January 1, 2009, you were age 49 or over; and

(C) You were not rehired after January 1, 2009 and before the date your Qualifying Disability first occurred (i.e., before you first become disabled).

(2) $40,000. Your Retiree Medical Account amount is $40,000 if you are a qualifying Totally Disabled Former Employee but do not meet the requirements above for a $55,000 Retiree Medical Account. For example, your Retiree Medical Account amount is $40,000 if either (A) or (B) below is true:

(A) As of January 1, 2009, you were an Eligible Employee, not disabled, and under age 49 (i.e., you do not qualify for a $55,000 Retiree Medical Account because you were under age 49 on January 1, 2009); or

(B) You were hired or rehired as an Eligible Employee of the Company after January 1, 2009 and before November 1, 2014 (i.e., you do not qualify for a

[9] Prior to January 1, 2020, the Agilent Technologies, Inc. Reimbursement Arrangement Plan (ARA) only provided benefits to certain eligible participants who were age 65 or older. Effective January 1, 2020, the ARA was amended so that the ARA is comprised of two different programs—the Pre-65 Agilent Technologies, Inc. Reimbursement Arrangement Plan and the Post-65 Agilent Technologies, Inc. Reimbursement Arrangement Plan.

$55,000 Retiree Medical Account because you were not an Eligible Employee on January 1, 2009 or you were rehired after January 1, 2009).

D. When a Totally Disabled Former Employee's Participation Began

A Totally Disabled Former Employee who met the eligibility requirements for participation in the Plan commenced participation in the Plan as of the date he or she meets the requirements for being a Totally Disabled Former Employee.[10]

Special rules apply if you were rehired after becoming a Totally Disabled Former Employee. See Section H of this Appendix A ("If a Totally Disabled Former Employee is Rehired").

E. When a Totally Disabled Former Employee's Participation Ends

A Totally Disabled Former Employee's participation in the Plan will cease upon the occurrence of the earliest of the following events:

(1) The date that a Totally Disabled Former Employee and/or his or her Spouse and eligible Dependent Child exhaust the specified amount allowed under your Retiree Medical Account (i.e., when your account balance is zero); or

(2) Prior to January 1, 2014, the date coverage under a Company-sponsored pre-Medicare retiree medical plan is terminated due to non-payment of premiums (including, but not limited to, if coverage was waived or dropped); or

(3) The date that a Totally Disabled Former Employee is determined by the Company to no longer be disabled; or

(4) The date that the Company terminates the Plan.

F. When a Totally Disabled Former Employee's Spouse's Participation Ends

A Totally Disabled Former Employee Spouse's participation in the Plan will cease upon the occurrence of the earliest of the following events:

(1) The date that you and/or your Spouse and/or your eligible Dependent Children exhaust the specified amount allowed under your Retiree Medical Account (i.e., when your account balance is zero); or

(2) Prior to January 1, 2014, the date coverage under a Company-sponsored pre-Medicare retiree medical plan is terminated due to non-payment of premiums (including, but not limited to, if coverage was waived or dropped); or

[10] Prior to January 1, 2014, a Totally Disabled Former Employee must have elected and enrolled in a Company-sponsored pre-Medicare retiree medical plan within 30 days of meeting the requirements for being a Totally Disabled Former Employee. Prior to January 1, 2014, if a Totally Disabled Former Employee was eligible to enroll in a Company-sponsored pre-Medicare retiree medical plan but did not enroll within that timeframe (or failed to timely pay premiums) then his or her Retiree Medical Account was terminated.

(3) The date that a Totally Disabled Former Employee is determined by the Company to no longer be disabled; or

(4) The date the Totally Disabled Former Employee's Spouse dies; or

(5) The date you and your Spouse divorce or legally separate; or

(6) The date the Company terminates the Plan.

If you are divorced or legally separated, your former Spouse's medical plan premiums for periods of coverage after the date of divorce or legal separation are not eligible for reimbursement from your Retiree Medical Account.

G. When a Totally Disabled Former Employee's Eligible Dependent Child's Participation Ends

A Totally Disabled Former Employee's eligible Dependent Child's participation in the Plan will cease upon the occurrence of the earliest of the following events:

(1) The date that you and/or your Spouse and/or your eligible Dependent Child exhaust the specified amount allowed under your Retiree Medical Account (i.e., when your account balance is zero); or

(2) Prior to January 1, 2014, the date coverage under a Company-sponsored pre-Medicare retiree medical plan is terminated due to non-payment of premiums (including, but not limited to, if coverage was waived or dropped); or

(3) The date that a Totally Disabled Former Employee is determined by the Company to no longer be disabled; or

(4) The date your eligible Dependent Child ceases to qualify as an eligible Dependent Child under the terms of the Plan; or

(5) The date your eligible Dependent Child dies; or

(6) The date the Company terminates the Plan.

H. What Happens if a Totally Disabled Former Employee is Rehired?

A Totally Disabled Former Employee is only be eligible for one Retiree Medical Account ($55,000 or $40,000, as applicable) as determined at the time of initial termination of employment. A Totally Disabled Former Employee who has a Retiree Medical Account at the time of rehire is not eligible for an additional Retiree Medical Account (i.e., a second Retiree Medical Account) upon subsequent retirement, even if the Totally Disabled Former Employee qualifies as an Eligible Retiree at his or her subsequent retirement. When you retire again your original Retiree Medical Account will be reactivated; provided that you have not already been reimbursed for the full amount or your Retiree Medical Account was not terminated.

For years prior to 2014, a Totally Disabled Former Employee who was eligible for a Retiree Medical Account at the time of initial retirement had to elect coverage in the Pre-Medicare Medical Plan (or an HMO for retirees offered as an alternative to the Pre-Medicare Medical Plan) and timely pay premiums for that plan in order to maintain his or her Retiree Medical Account. If that Totally Disabled Former Employee either did not timely elect to participate in the Pre-Medicare Medical Plan (or an HMO for retirees offered as an alternative to the Pre-Medicare Medical Plan), or timely elected to participate in the Pre-Medicare Medical Plan (or an HMO for retirees offered as an alternative to the Pre-Medicare Medical Plan) but subsequently lost eligibility prior to January 1, 2014 due to non-payment of premiums or for any other reason and is subsequently rehired, he or she lost his or her Retiree Medical Account and will not be eligible for an additional Retiree Medical Account (i.e., a second Retiree Medical Account) upon subsequent retirement.

Rehired Totally Disabled Former Employees may not use their Retiree Medical Account for reimbursement of their medical plan premiums while an active employee. While you are an active employee (at any level—fulltime or part-time), the Company will suspend reimbursements from your Retiree Medical Account until your subsequent retirement from the Company. See Section N of this Appendix A ("Expenses Not Eligible for Reimbursement From Your Retiree Medical Account").

I. Company Couples

On and after January 1, 2017, new rules apply if you are in a "company couple." Essentially, a "company couple" is where there are two former Company Employees and each individual has a "dual status" as both a Totally Disabled Former Employee AND an eligible Spouse.

Thus, a "company couple" is comprised of two former Company Employees where the following is true for each former Employee:

(1) Each former Company Employee qualifies a Totally Disabled Former Employee[11] (i.e., each individual is separately eligible for either a Retiree Medical Account under this Plan, for subsidized Agilent Health Plan for Retirees coverage, or for the ARA as a participant); and

(2) Each former Company Employee qualifies as the eligible Spouse (as defined under this Plan) of the other former Company Employee (or as the other former Company Employee's eligible "spouse" under the Agilent Health Plan for Retirees or the ARA).

See Appendix B ("Company Couples") for more information on the Plan rules for company couples.

Remember that you are required to notify the Plan of your eligible Spouse upon initially becoming eligible for the Plan. See Section 13.E ("Proof of Marriage").

[11] Eligible Retirees can also be part of a company couple. See Section 6 of the main body of this Plan Document and SPD.

Note: The above rules apply only to reimbursements under this Plan. The plan document and Summary Plan Description for the ARA (which includes the Pre-65 Agilent Technologies, Inc. Reimbursement Arrangement Plan and the Post-65 Agilent Technologies, Inc. Reimbursement Arrangement Plan) contain the rules regarding reimbursements under the ARA, including for company couples. Similarly, the plan document for the Agilent Health Plan for Retirees contains the eligibility and benefits rules for the Agilent Health Plan for Retirees, including its requirements for spousal coverage.

J. What Happens if a Totally Disabled Former Employee Dies?

Following a Totally Disabled Former Employee's death, remaining unused Retiree Medical Account amounts may be used by the Totally Disabled Former Employee's surviving Spouse and/or surviving eligible Dependent Children to reimburse eligible medical plan premiums paid for coverage of the Totally Disabled Former Employee prior to the date of death or for the surviving Spouse's and/or the eligible Dependent Children's own eligible medical plan premiums until the balance of the specified amount in the Totally Disabled Former Employee's Retiree Medical Account is exhausted.

If on the date of death of the Totally Disabled Former Employee, there is no surviving Spouse and/or eligible Dependent Children, the Retiree Medical Account is terminated. Eligible medical plan premiums paid for coverage of the Totally Disabled Former Employee prior to the date of death may be reimbursed from the Retiree Medical Account. Upon payment of any final reimbursement, the Totally Disabled Former Employee's Retiree Medical Account will be terminated.

K. If Your Surviving Spouse Remarries?

Access to the Retiree Medical Account does not end if your surviving Spouse remarries; however, medical plan premiums for your surviving Spouse's new spouse may not be reimbursed from the Retiree Medical Account.

L. Using the Retiree Medical Account.

Retiree Medical Account Enrollment and Reimbursements.

A Totally Disabled Former Employee automatically commenced participation in the Plan as of the date he or she met the requirements for being a Totally Disabled Former Employee.[12]

As a qualifying Totally Disabled Former Employee, reimbursements may only be made for the payment of eligible medical plan premiums that you and your Spouse and/or your eligible Dependent Children or your surviving Spouse and/or your surviving eligible Dependent Children incur while a participant in the Plan. The Retiree Medical Account may not be used to reimburse the expenses of anyone who is not a Totally Disabled Former Employee or their Spouse or an

[12] Prior to January 1, 2014, a Totally Disabled Former Employee who was under age 65 had to enroll in a Company-sponsored pre-Medicare retiree medical plan within 30 days after an individual qualified as a Totally Disabled Former Employee. Such individuals also had to maintain (and not lose) coverage under a Company-sponsored pre-Medicare retiree medical plan in order to maintain his or her Retiree Medical Account.

eligible Dependent Child or a surviving Spouse or a surviving eligible Dependent Child. Section M ("Expenses Eligible for Reimbursement From Your Retiree Medical Account") contains the rules regarding which expenses can be reimbursed from your Retiree Medical Account.

Reimbursements Prior to a Participant's Becoming Age 65.

You are not required to purchase Company-sponsored pre-Medicare retiree medical plan coverage to maintain your Retiree Medical Account—it may be used to pay premiums for the Agilent Health Plan for Retirees or eligible medical plan premiums for individual coverage that you purchase in the individual insurance market.[13] You must pay the full cost of coverage for you and your Spouse and/or your eligible Dependent Children, if applicable. You may then submit a claim for reimbursement to the Initial Claims Administrator.

Any portion of the specified amount under your Retiree Medical Account that remains unspent may carry forward from year to year. Reimbursements from your Retiree Medical Account will be made until the specified amount under your Retiree Medical Account has been exhausted or your Retiree Medical Account is otherwise terminated in accordance with the termination of coverage provisions in this Appendix A.

Once the specified amount of your Retiree Medical Account is exhausted, you will be responsible for paying retiree medical plan premiums with your own funds and you will receive no further reimbursement from the Company or the Plan.

Reimbursements After a Participant Becomes Age 65.

The Agilent Health Plan For Retirees contains numerous eligibility and participation requirements, including that once a Totally Disabled Former Employee reaches age 65, he or she will no longer be eligible to participate in the Agilent Health Plan For Retirees. .

If you have a remaining balance in your Retiree Medical Account after reaching age 65, then the Retiree Medical Account may be used to reimburse you for payments you make to cover eligible premiums for other Medicare medical, dental and vision insurance that you purchase on the individual insurance market, as well as premiums for certain other employer-sponsored (i.e., non-Company-sponsored) retiree health coverage (see Section M below).

Any portion of the specified amount under your Retiree Medical Account that remains unspent may carry forward from year to year. Reimbursements from your Retiree Medical Account will be made until the specified amount under your Retiree Medical Account has been exhausted or your Retiree Medical Account is otherwise terminated in accordance with termination of coverage provisions in in this Appendix A.

M. Expenses Eligible for Reimbursement Under Your Retiree Medical Account

If you are a qualifying Totally Disabled Former Employee, your Retiree Medical Account may only be used to reimburse you for premiums you pay for the following:

[13] Prior to January 1, 2014, a Totally Disabled Former Employee who was under age 65 could not use his or her Retiree Medical Account to pay for premiums for insurance coverage obtained on the individual market.

(1) Agilent Health Plan for Retirees (If Under Age 65). Agilent Health Plan For Retirees. (Note: The Agilent Health Plan for Retirees contains limitations on who can participate, including that it limits eligibility to those under age 65. As a result, this reimbursement category does not apply to Plan participants or their Spouses who are over age 65.)

(2) Certain Individual Medical Insurance (On and After January 1, 2014 for Those Under Age 65). Medical coverage that you purchase in the individual insurance market (e.g., an individual medical insurance policy purchased on the Federal exchange or a state exchange, such as Covered California). This category does not include medical coverage sponsored by the Company or any other employer (see additional rules under category #6 below). For individuals who are under age 65, this category #2 applies only on and after January 1, 2014.[14]

(3) Certain Individual Dental and Vision Insurance (for Those Either Under Age 65 or Over Age 65). Dental and vision coverage that you purchase in the individual insurance market (e.g., an individual dental insurance policy purchased from Liberty Dental in California). This category does not include dental or vision coverage sponsored by the Company or any other employer (but see category #6 below).

(4) Medicare Parts A and B (If over Age 65 or an SSA Disabled Individual). Medicare Part A and Medicare Part B coverage, as applicable. For example, this category applies if you are covered by Medicare Part A and Part B because you are over age 65 or because you are under age 65 and an SSA Disabled Individual.

(5) Individual Medicare Medical and Medicare Part D Coverage (Only if Over Age 65). Individual Medicare medical (including Medicare HMO plans) and Medicare Part D coverage (e.g., a non-employer-sponsored Medicare Part D prescription drug plan purchased from an insurance company). This category applies only if you are over age 65 (i.e., not to SSA Disabled Individuals who are under age 65).

(6) Certain Other Employer-Sponsored (i.e., non-Company-sponsored) Retiree Medical, Dental and Vision Coverage (On and After January 1, 2017). Effective for expenses incurred on or after January 1, 2017, your Retiree Medical Account can also be used (both before and after you attain age 65) to reimburse premium payments made for medical, dental, and vision coverage under certain other employer-sponsored retiree group health plans, such as military, local, state, Federal, university, and private-sector employer retiree health plans. This category applies only to other employer-sponsored coverage and does not include any kind of Company-sponsored coverage (e.g., active employee or COBRA coverage under the Agilent Technologies, Inc. Health Plan). All five requirements listed in A through E below must be met for such other-employer-sponsored retiree health plan premiums to be reimbursable under the Plan:

[14] Prior to January 1, 2014, an Eligible Retiree who was under age 65 could not use his or her Retiree Medical Account to pay for premiums for insurance coverage obtained on the individual market.

(A) The other employer-sponsored plan is a retiree health plan (i.e., you cannot be eligible for the other employer-sponsored coverage as an active employee or the spouse/dependent of an active employee);

(B) The other employer-sponsored coverage is not COBRA continuation coverage;

(C) The premiums were paid on an after-tax basis;

(D) The expense is not otherwise excluded from reimbursement under the Plan; and

(E) You must provide proof, in a manner determined by the Company, that the above requirements in A through D above are satisfied.

With regard to the eligible expenses listed in categories #1-6 above, you are responsible for paying the entire cost of such coverage and then submitting a claim for reimbursement to the Plan's Initial Claims Administrator.

Please note that the Initial Claims Administrator will determine whether an expense is reimbursable by the Plan.

N. Expenses Not Eligible for Reimbursement From Your Retiree Medical Account

As a Totally Disabled Former Employee, the following types of expenses are not eligible for reimbursement from your Retiree Medical Account:

(1) Company active employee medical plan premiums; (i.e., the Eligible Employee contribution required for the Agilent Medical Plan or an HMO, if available);

(2) Prior to January 1, 2014, if under age 65, premiums for coverage other than under a Company-sponsored pre-Medicare retiree medical plan, including the Pre-Medicare Plan (or an HMO for retirees offered as an alternative to the Pre-Medicare Medical Plan), if available;

(3) Premiums that you or your Spouse pay for any coverage sponsored by another employer (i.e., premiums for other employer-sponsored plans) that <u>does not meet</u> the requirements set forth in Section M above (e.g., active employee coverage);

(4) Eligible medical plan premiums paid for anyone other than the eligible Totally Disabled Former Employee or their Spouse or eligible Dependent Children or, with respect to a deceased eligible Totally Disabled Former Employee, anyone other than their surviving Spouse or surviving eligible Dependent Children;

(5) Health Savings Account ("HSA") contributions;

(6) Medical Savings Account ("MSA") contributions;

(7) Medical, dental or vision plan co-payments and co-insurance;

(8) Medical, dental or vision plan deductibles;

(9) Any additional expenses not covered under a medical plan;

(10) Direct expenses for medical or hospital services;

(11) Expenses for over-the-counter medicines or drug products;

(12) Dental plan premiums incurred for coverage prior to January 1, 2012;

(13) Vision plan premiums incurred for coverage prior to January 1, 2012;

(14) Long-term care insurance premiums;

(15) Preventive care expenses; and

(16) Any other expenses not specified as covered in the section "Eligible Expenses for Reimbursement Under Your Retiree Medical Account."

O. Tax Consequences of the Retiree Medical Account

Reimbursements from your Retiree Medical Account for eligible medical plan premiums paid for a Totally Disabled Former Employee or his or her eligible Spouse and/or their eligible Dependent Children are not currently subject to federal income tax. Reimbursements from your Retiree Medical Account for eligible medical plan premiums paid for a surviving Spouse and/or surviving eligible Dependent Children of a Totally Disabled Former Employee are also not currently subject to federal income tax.

If you receive reimbursement from your Retiree Medical Account to pay for eligible medical plan premiums, you cannot claim the amount of those premiums as a deduction for medical expenses on your income tax returns. You should consult your personal tax advisor for further information.

P. Additional Plan Rules

The following Plan rules that also apply to Totally Disabled Former Employees can be found in the following sections in the main body of this Plan Document and SPD:

- Section 7 ("Eligibility Claims and Review Procedures") contains the Plan's rules regarding eligibility claims and appeals;

- Section 8 ("Benefit Claims Procedures") and Section 9 ("Procedures for Appealing an Adverse Benefit Determination") contain Plan's rules regarding benefit claims and appeals;

- Section 10 ("COBRA Continuation Coverage") contains the Plan's rules regarding COBRA continuation coverage;

- Section 11 ("Future of the Plan, Amendment and Termination of the Plan") contains the Plan's rules regarding amendment and termination of the Plan;

- Section 12 ("Administration and Operation of the Plan") contains the Plan's rules regarding how the Plan is administered; and

- Section 13 ("Additional Rules that Apply to the Plan") contains the other relevant and miscellaneous Plan rules; and

- The "Glossary" contains definitions for capitalized terms used in the Plan and this Appendix A.

APPENDIX B

COMPANY COUPLES

The rules in this Appendix B apply on and after January 1, 2017 to "company couples". For periods prior to January 1, 2017, the rules set in the prior versions of this Plan Document and SPD applied.

Section 1—What is a "Company Couple"?

Essentially, a "company couple" is where there are two former Company Employees and each individual has a "dual status" as both an Eligible Retiree/Totally Disabled Former Employee AND an eligible Spouse. Thus, a "company couple" is two former Company Employees (i.e., retirees) who each have the following statuses:

(1) Each individual in the company couple is either an Eligible Retiree or a Totally Disabled Former Employee (i.e., each is separately eligible for a Retiree Medical Account under the Plan, for subsidized Agilent Health Plan for Retirees coverage, or the ARA); and

(2) Each individual in the company couple also separately qualifies as the other individual's eligible "spouse" for purposes of Company-sponsored retiree medical coverage (i.e., as the other individual's eligible Spouse under this Plan, an eligible "spouse" under the Agilent Health Plan for Retirees, or an eligible "spouse" under the ARA).

For example, a "company couple" includes two Eligible Retirees where each Eligible Retiree qualifies for his or her own Retiree Medical Account under the Plan and also qualifies as the other Eligible Retiree's eligible Spouse under the Plan. Section 2 below describes the various company couple scenarios.

Section 2—Company Couple Scenarios

Because there are generally two different retiree medical tracks for Eligible Retirees and Totally Disabled Former Employees (this Plan and the ARA), there are different possible company couple scenarios:[15]

(1) Scenario #1—Each Individual has His or Her Own Retiree Medical Account Under the Plan. In this scenario, each Eligible Retiree/Totally Disabled Former Employee Spouse is eligible for his or her own Retiree Medical Account under the Plan. Below is an example of this scenario:

[15] Note: Not all Totally Disabled Former Employees are eligible for either this Plan for the ARA. Specifically, Totally Disabled Former Employees who first became disabled on or after January 1, 2016 are not eligible for either a Retiree Medical Account under the Plan. See the ARA for rules regarding eligibility for Totally Disabled Former Employees. . See Appendix A of this document for the Totally Disabled Former Employee eligibility requirements for this Plan.

- John – Eligible for his own Retiree Medical Account under the Plan as an Eligible Retiree. John's wife, Jane, qualifies as John's Spouse under the Plan.

- Jane – Eligible for her own Retiree Medical Account under the Plan as an Eligible Retiree. Jane's husband, John, qualifies as Jane's Spouse under the Plan.

(2) Scenario #2—One Individual has a Retiree Medical Account Under the Plan and the Other Individual is a Participant in the ARA. In this scenario, one Eligible Retiree/Totally Disabled Former Employee Spouse is eligible for a Retiree Medical Account under the Plan, and the other Eligible Retiree/Totally Disabled Former Employee Spouse is eligible for the ARA. (See Scenario #3 below for where one individual is receiving subsidized Health Plan for Retirees coverage instead of the ARA.) Below is an example of this scenario:

- Ron – Eligible for his own Retiree Medical Account under the Plan as an Eligible Retiree. Ron's wife, Mandy, qualifies as John's Spouse under the Plan.

- Mandy – Eligible for the ARA as a participant. Whether Mandy's husband, Ron, is treated as an eligible spouse under the ARA is determined under the terms of the ARA (not this Plan document).

(3) Scenario #3—One Individual has a Retiree Medical Account Under the Plan and the Other Individual is Receiving Subsidized Agilent Health Plan for Retirees Coverage. This scenario is similar to Scenario #2 above, except that the second individual is receiving subsidized coverage under the Agilent Health Plan For Retirees. Below is an example of this scenario:

- Michael – Eligible for his own Retiree Medical Account under the Plan as a Totally Disabled Former Employee. Michael's wife, Laura, qualifies as Michael's Spouse under the Plan.

- Laura – Under age 65 and receiving subsidized Health Plan for Retirees coverage. Whether Michael is Laura's eligible spouse under the Agilent Health Plan for Retirees is determined by the terms of the Agilent Health Plan for Retirees. Upon turning age 65, Laura might be eligible for the Post-65 ARA as a participant (Scenario #2 above), and whether Michael will be Laura's eligible spouse under the Post-65 ARA at that time will be determined by the terms of the ARA.

Section 3—How do the Plan Eligibility and Reimbursement Rules Apply to Company Couples?

Below are how the Plan's eligibility and participation rules operate for the three scenarios described in Section 2 above:

(1) Scenario #1 – Two Retiree Medical Accounts Under the Plan. In this scenario, each Eligible Retiree/Totally Disabled Former Employee has his or her own Retiree Medical Account under the Plan and may seek reimbursements for the amount credited to that Retiree Medical Account in accordance with the rules set forth in this Plan Document and SPD. In other words, each individual in the company couple does not lose access to his or her own Retiree Medical Account simply because they have a "dual status" as an Eligible Retiree (or Totally Disabled Former Employee) and as an eligible Spouse. Continuing from the example for this scenario in Section 2 above:

- John – Assume that John has a $55,000 Retiree Medical Account. John may seek up to $55,000 in reimbursements under the Plan for eligible expenses, including eligible premiums for himself (e.g., individual insurance coverage) and for his eligible Spouse, Jane.

- Jane – Assume that Jane has a $40,000 Retiree Medical Account. Jane may seek up to $40,000 in reimbursements under the Plan for eligible expenses, including eligible premiums for herself (e.g., individual insurance coverage) and for her eligible Spouse, John.

(2) Scenario #2 – One Retiree Medical Account Under the Plan and One Individual Who is an ARA Participant. Here, the Eligible Retiree/Totally Disabled Former Employee Spouse with a Retiree Medical Account under the Plan may seek reimbursements for the amount credited to that Retiree Medical Account in accordance with the rules set forth in this Plan Document and SPD. This includes reimbursements of eligible premiums for coverage of that individual's eligible Spouse, who is a participant in the ARA. The rules for how the other Eligible Retiree/Totally Disabled Former Employee Spouse may seek reimbursement under the ARA are set forth in the ARA (not this Plan Document and SPD). Continuing from the example for this scenario in Section 2 above:

- Ron – Assume that Ron has a $40,000 Retiree Medical Account. Ron may seek up to $40,000 in reimbursements under the Plan for eligible expenses, including eligible premiums for himself (e.g., individual insurance coverage purchased on the Covered California exchange) and for his eligible Spouse, Mandy.

- Mandy – Here, Mandy is not eligible for her own Retiree Medical Account under the Plan. Instead, Mandy is eligible for the ARA as a participant. How Mandy is able to seek reimbursement under the ARA, including whether she may receive an additional ARA subsidy amount for Ron (her husband), is determined under the terms of the ARA.

(3) Scenario #3 – One Retiree Medical Account Under the Plan and One Individual Who is Receiving Subsidized Agilent Health Plan for Retirees Coverage. As with the other two scenarios described above, the Eligible Retiree/Totally Disabled Former Employee Spouse with a Retiree Medical Account under the Plan may seek

reimbursements for the amount credited to that Retiree Medical Account in accordance with the rules set forth in this Plan Document and SPD. This includes reimbursements of Agilent Health Plan for Retirees premiums for that individual's eligible Spouse's pre-65 coverage under the Agilent Health Plan for Retirees. Continuing from the example for this scenario in Section 2 above:

- Michael – Assume that Michael has a $40,000 Retiree Medical Account. Michael may seek up to $40,000 in reimbursements under the Plan for eligible expenses, including eligible premiums for himself (e.g., individual insurance coverage purchase on the Covered California exchange) and for his eligible Spouse, Laura (e.g., Health Plan for Retirees premiums).

- Laura – Laura does not have her own Retiree Medical Account under the Plan. Instead, Laura is currently receiving subsidized Agilent Health Plan for Retirees coverage (until age 65) and is on track to become eligible for the ARA as a participant upon turning age 65. The rules regarding Laura's Agilent Health Plan for Retirees coverage (e.g., whether she may cover Michael as a dependent) are set forth in the plan document for the Agilent Health Plan for Retirees. In addition, if Laura becomes a participant in the ARA, the terms of the ARA will determine how she can seek reimbursement under the ARA (e.g., whether she can seek reimbursement for Michael's premiums) as well as any other participation rules.