
Wolf Steel Acquisition, LLC. Health and Welfare
Plan

Master Summary Plan Description

Amended/Restated Effective January 1, 2026

This document, together with the additional documents provided along with it, constitute the written plan document required by ERISA § 402 and the Summary Plan Description required by ERISA § 102.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see the notice reproduced in Appendix B for more details.

This Wrap Summary Plan Document (SPD) has been formally modified through the Summary of Material Modification document(s) attached at the back of this document.

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1. Definitions

Capitalized terms used in this document have the following meanings:

"AD&D" means accidental death and dismemberment insurance.

"Affordable Care Act" means the Patient Protection and Affordable Care Act, as amended.

"**COBRA**" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

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

"**Company**" means Wolf Steel or any successor thereto, and any affiliated entity within the same controlled group, as that term is defined under section 414(b) of the Internal Revenue Code, that participates in the plan.

"**DCAP**" means a dependent care assistance program that may be established by the Company under a separate document. The DCAP is not a benefit program under the Plan. It may allow you to use pre-tax dollars to pay for the care of your eligible dependents while you are at work. It is not subject to ERISA.

"**Employee**" means any common-law employee of the Company who satisfies the eligibility provisions of in this document and is not excluded from participation by the terms of an applicable benefit program, except individuals classified or treated by the Company as independent contractors (regardless of any subsequent reclassification), or as an employee of an employment agency.

"**ERISA**" means the Employee Retirement Income Security Act of 1974, as amended.

"**HIPAA**" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"**NMHPA**" means the Newborns' and Mothers' Health Protection Act of 1996, as amended.

"**Plan**" means the Company Welfare Benefits Plan and includes this document, written amendments and updates to this document, and the terms of all policies and component benefit programs listed in Section 15.

"**Plan Administrator**" means the Company.

"**SPD**" means the Summary Plan Description required by ERISA § 102 summarizing this Plan and includes this document, information booklets supplied by insurance carriers, and other benefits descriptions provided to participants with this document or at any other period as appropriate to provide updates to the document, such as during open enrollment.

"**WHCRA**" means the Women's Health and Cancer Rights Act of 1998, as amended.

2. Introduction

The Company maintains the Plan for the exclusive benefit of eligible Employees and eligible family members or “dependents.” It is important that you share this document and the materials referenced here in with your covered dependents. The Plan provides health and welfare benefits through the benefit programs listed in Section 15. See Section 15 for a listing of benefit programs and the entities that help administer the programs.

Each of these benefit programs is summarized in a certificate of insurance booklet issued by an insurance company, a summary plan description or another document (a "Benefit Description"). A Benefit Description will be available from the insurer (if the benefit is fully-insured) or Plan Administrator (if the benefit is self-funded). Whether a benefit program is fully-insured or self-funded is noted in Section 15.

This document and its attachments constitute the plan document required by ERISA § 402. This document and its attachments, coupled with the information booklets and other descriptive materials provided for benefits as described in Section 15 constitutes the wrap Summary Plan Description as required by ERISA § 102.

3. General Information about the Plan

Plan Name:	Wolf Steel Acquisition, LLC. Health and Welfare Plan or Wolf Steel Basic Term Life and AD&D Plan
Type of Plan:	Health and Welfare plan providing coverages listed in Section 15.
Plan Year:	January 1 to December 31.
Plan Number:	501
Effective Date:	January 1, 2018. The Plan has been amended several times since its original effective date, most recently as of January 1, 2025.
Funding Medium and Type of Plan Administration:	<p>Some benefits under the Plan are self-funded, and some are fully-insured. See Section 15 for a description of the benefit programs and whether they are self-funded or fully-insured.</p> <p>For benefit programs which are fully-insured, benefits are insured under a group contract entered into between the Company and insurance companies or HMO.</p>

The insurance companies and/or HMO, not the Company, are responsible for paying claims with respect to these programs. The Company shares responsibility with the insurance companies and/or HMO for administering these program benefits, as described below.

For benefit programs which are self-funded, the Company is responsible for processing and paying appropriate claims. The Company may hire a third party administrator (a "TPA") to process claims.

Premiums for Employees and their eligible family members may be paid in part by the Company out of its general assets and in part by Employees' pre-tax and/or post-tax payroll deductions. The Plan Administrator provides a schedule of the applicable premiums during the initial and subsequent open enrollment periods and on request for each of the benefit programs, as applicable.

The Company provides Employees the opportunity to pay for benefits on a pre-tax basis through a cafeteria plan. Appendix C provides information with regard to such a plan.

Plan Sponsor:

The employer is the Plan Sponsor.

Wolf Steel Acquisition, LLC
103 Miller Drive
Crittenden, KY 41030

Email: hr@napoleon.com

Plan Sponsor's Employer
Identification Number:

84-3241774

Insurance
Companies/HMO:

See a complete list under the heading Plan Provider
Information later in this document.

Plan Administrator:

Attention: Human Resources Manager
Wolf Steel Acquisition, LLC
103 Miller Drive
Crittenden, KY 41030

Email: hr@napoleon.com

Named Fiduciary:

Wolf Steel Acquisition, LLC
103 Miller Drive
Crittenden, KY 41030

Email: hr@napoleon.com

Agent for Service of
Legal Process:

Attention: Human Resources Manager
Wolf Steel Acquisition, LLC
103 Miller Drive
Crittenden, KY 41030

Email: hr@napoleon.com

Service for legal process may also be made on the Plan Administrator.

4. Eligibility and Participation Requirements

Eligibility and Participation

An eligible Employee with respect to the Plan will be an Employee who is eligible to participate in and receive benefits under one or more of the benefit programs. To determine whether you or your family members are eligible to participate in a benefit program, please see Section 15. Reclassification from non-employee to employee status by a court or any agency or by the Company will not create any retroactive right to coverage.

Certain benefit programs require that you make an annual election to enroll for coverage. **Generally, you cannot enroll, drop coverage, or change your or your dependents coverage under the plan except during annual Open Enrollment.** However you may be able to add or drop coverage for yourself or a dependent during the plan year if you experience an event that triggers a HIPAA Special Enrollment Right (see discussion below) or if you have a Status Change Event (see Appendix C for an explanation of Status Change Events). Please review the rules for changing your benefits elections described in Appendix C very carefully as the rules regarding making benefits changes mid-year must be strictly enforced.

Information about enrollment procedures is provided by the Company. Information about when your participation begins in various benefit programs is found under Section 15. You must follow any required enrollment procedures. **Always make sure the Company has your current home address and other contact information for you and your covered dependent to correctly administer your benefits and to send you important benefits information.**

Eligible Dependent Status

Section 15 describes whether your spouse and or child can participate in a particular benefit program. Section 15 also describes any limits on such participation. For example, children covered under the Medical benefit program generally can be covered until the end of the month during which they reach age 26. However, coverage may end earlier for other benefits (or may not be available at all). For specifics on eligibility for

each benefit offered refer to Section 15. Note that the definition of dependent may be different for the different benefits offered under the Plan.

You cannot be covered both as an employee and as a dependent under the plan.

Full Time Status and the ACA

Under the ACA, employers are required to report specific benefits information to IRS on “full-time” employees as defined by the ACA. A “full-time” employee is generally an employee who works on average 130 hours per month. Employers may also face penalties if they do not offer major medical coverage to substantially all full-time employees or if the coverage they offer is unaffordable or does not meet a minimum value standard. The Company determines full-time status using the Monthly method. ACA full-time status is not a guarantee of major medical benefits eligibility. Benefits eligibility is described in Section 15.

Special Enrollment Provisions under HIPAA

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a special enrollment period for the Medical benefit program (or similar benefit programs providing medical benefits) may be available, usually if you lose medical coverage under certain conditions or when you acquire a new dependent by marriage, birth, or adoption.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 31 after your other coverage ends. In addition, if you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

In addition, if you declined enrollment in the Plan for yourself or your dependents (including a spouse) because of coverage under Medicaid or a State Children's Health Insurance Program, there may be a right to enroll in this Plan if there is a loss of eligibility for the government-provided coverage. However, a request for enrollment must be made within 60 days after the government-provided coverage ends.

Finally, if you declined enrollment in the Plan for yourself or your dependents (including a spouse), and you or a dependent later becomes eligible for state “premium assistance” through Medicaid or a State Children's Health Insurance Program which provides help with paying for Plan coverage, then there may be a right to enroll in this Plan. However, a request for enrollment must be made within 60 days after the determination of eligibility for the state assistance.

Coverage during Certain Leaves of Absence

Certain Federal (and State) statutes like the Family and Medical Leave Act (FMLA) require that eligibility for medical benefits continue for employees on those protected leaves of absence under the same terms as active employees. When wages continue during such a leave, your contributions will be deducted from those wages on a pre-tax basis. When such a leave is unpaid, you are still required to pay your portion of the premium. Your portion of the premium may be paid as regular monthly intervals during the leave on a post-tax basis.

You may also generally discontinue coverage at the beginning of such an unpaid leave and when you return your benefits will either be reinstated or you may re-enroll for the remainder of the coverage period or plan year.

Human Resources must determine whether or not you are eligible for a statutory or other leave of absence.

Terms of Participation

Your participation and the participation of your spouse and dependents in a benefit program will terminate according to the terms of the specific benefit program. Generally, coverage for most benefit programs terminates on the last day of the month in which you terminate employment, but certain benefit programs may provide coverage only through the date your employment terminates. Please see Section 15 for further information on the date participation in a specific benefit program will terminate.

Coverage may also terminate if you fail to pay your share of an applicable premium, if your hours drop below the required hourly threshold for the particular benefit, if you engage in fraud or make an intentional misrepresentation of a material fact, or for any other reason as set forth in the attached documents. You should consult Section 15 for a general summary and the attached documents for specific termination events and information.

Coverage may be terminated retroactively in the normal course of business due to a participant's termination of employment, nonpayment of premiums, loss of dependent eligibility or other, similar factors. When you or a dependent lose eligibility for benefits, regardless of whether or not you timely report that loss of eligibility, a change to any existing salary reduction election will be made automatically. To the extent that the coverage at issue does not allow for retroactive termination of that coverage and election to the date of the loss of eligibility, such changes will be prospective. If coverage can be terminated retroactively to the date of the loss of eligibility, or sometime thereafter, excess salary reduction contributions will be refunded on a post-tax basis to the date the termination of coverage can be made effective.

Any person claiming benefits under the Plan shall furnish the Company, any insurance company or other entity working on behalf of the Plan or a benefit program with such information and documentation as may be necessary to verify eligibility for and/or

entitlement to benefits under the Plan or a benefit program. This may include but is not limited to providing social security numbers, birth certificates, marriage certificates, or proof of dependent eligibility. Failure to cooperate and provide such information will lead to a loss of eligibility for benefits.

Knowingly enrolling an ineligible dependent in plan benefits constitutes fraud and is considered a material misrepresentation that will result in termination of coverage as well as other disciplinary action up to and including termination of employment. Eligibility for benefits is described in Section 15. If you have questions about whether a dependent is eligible you must contact Human Resources before enrolling that dependent.

COBRA Rights

You may be eligible for COBRA continuation coverage or conversion policies when your coverage for a medical benefit program under this Plan terminates. Information about continuation coverage or conversion is contained in Appendix A. If you have questions about this law or these rights, please contact the Plan Administrator (for benefit programs that are self-funded) or the insurance carrier (if the benefit is fully-insured). You can determine whether a benefit program is self-funded or fully-insured by consulting Section 15.

5. Summary of Plan Benefits

Benefits and Contribution

The Plan provides you and your eligible spouse and dependents with the benefit programs listed in Section 15. A summary of each benefit program provided under the Plan may be provided in the attached documents (such as a certificate of insurance booklet, summary plan description for a specific benefit program or other governing document). Note that some of the attached documents may be labeled as a "summary plan description." If so, that document will only be a summary of the specific benefit program to which it relates. Notwithstanding any of the terms of such a document, that document is not the formal, single "Summary Plan Description" for this Plan. Rather, this document constitutes the formal, single "Summary Plan Description."

The cost of the benefits provided through the benefit programs may be funded in part by Company contributions and in part by pre-tax and/or post-tax employee contributions. The Company will determine and periodically communicate your share of the cost, if any, of the benefit programs. The Company reserves the right to change that determination.

The Company will make its contributions, if any, in an amount that (in the Company's sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by your contributions. The Company

will pay its contribution and your contributions to any insurance carrier or, with respect to benefits that are self-insured, will use these contributions to pay benefits directly to, or on behalf of, you or your eligible family members from the Company's general assets. Your contributions toward the cost of a particular benefit program will be used in their entirety prior to using Company contributions to pay for the cost of such benefit program.

Medical benefits under this Plan may be subject to cost-sharing provisions, premiums, deductibles, co-insurance, copayment amounts, annual or lifetime limits, pre-authorization requirements or utilization review. There may also be limitations on the selection of primary care or network providers, limits on emergency medical care, or limited coverage for preventive services, drugs, medical tests, medical devices or medical procedures. These limitations are set forth in the attached documents.

Certain prescription drug benefits are considered "Creditable Coverage" under Medicare Part D. The attached documents provide details regarding this coverage and an annual notice (attached and incorporated by reference in Appendix B) explains how this creditable coverage works for these prescription drug benefit programs.

The Plan will provide benefits in accordance with the requirements of all applicable Federal laws regulating group health plans, such as COBRA, HIPAA, NMHPA, WHCRA and the Affordable Care Act. A brief summary of some of these laws is below.

Newborns' and Mothers' Health Protection Act (NMHPA) of 1996

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act (WHCRA) of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan.

Qualified Medical Child Support Orders

Group health plans and health insurance issuers generally must provide benefits as required by any qualified medical child support order, or "QMCSO." The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

Lifetime and Annual Limits

Lifetime or annual limit on the dollar value of "essential health benefits" are no longer permitted under the major medical plans offered by the Plan. For more information on "essential health benefits" refer to the terms of policies and benefit program materials listed in Section 15. These documents are provided to you during enrollment and are available from Human Resources, the insurer (if the benefit is fully-insured), or Plan Administrator (if the benefit is self-funded).

6. Grandfathered Status under the Affordable Care Act

Non-Grandfathered Benefit Programs under the Affordable Care Act

The following benefit programs that provide health benefits are not "grandfathered health plans" under the Affordable Care Act:

- Anthem PPO 750
- Anthem PPO 3000

These benefit programs must, under the Affordable Care Act, provide additional protections. The protections provided by the Affordable Care Act include the following:

Preventive Services covered at 100%

In-network preventive care services will be covered at 100% with no cost sharing (e.g., copayment, coinsurance percentage, deductible, etc.). Preventive services include those services outlined in the US Preventive Services Taskforce

recommendations (services rated “A” or “B”). Please see the attached documents for the preventive services included at no cost share.

Non-Network Emergency Services covered as In-Network

Emergency services must be covered without the need for prior authorization, regardless of the participating status of the provider or facility, and at the in-network cost sharing level.

7. How the Plan Is Administered

Plan Administration

The administration of the Plan is under the supervision of the Plan Administrator. The Plan Administrator is a named fiduciary within the meaning of ERISA § 402 and has full discretionary authority to administer the Plan, to interpret the Plan, and to determine eligibility for participation and for benefits under the terms of the Plan. However, insurers and parties that have entered into administrative service agreements (Third Party Service Providers or TPAs) assume sole responsibility for their performance under applicable policies or administrative services agreements and, under ERISA, may be fiduciaries with respect to their performance.

The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, and authorizing benefit payments and gathering information necessary for administering the Plan. (However, as noted below, one or more insurance companies may have these responsibilities with respect to fully-insured benefits.)

The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s) and expressly describes the nature and scope of the delegated responsibility. The Plan Administrator has the discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan.

Power and Authority of Insurance Company

As detailed in Section 15, certain benefits under the Plan may be fully insured. The insurance companies are responsible for: (1) determining eligibility for and the amount of any benefits payable under their respective benefit programs, and (2) prescribing claims procedures to be followed and the claims forms to be used by employees pursuant to their respective benefit programs.

Questions

If you have any general questions regarding the Plan, or your eligibility for or the amount of any benefit payable under any benefit program, please contact the Plan Administrator or the appropriate insurance company as applicable.

8. Circumstances Which May Affect Benefits

Denial or Loss of Benefits

Your benefits (and the benefits of your eligible spouse and dependents) will cease when your participation in the Plan terminates. See Section 15. Your benefits will also cease on termination of the Plan.

Right to Recover Benefit Overpayments and Other Erroneous Payments

The Plan and its benefit programs (including any insurance company on behalf of a benefit program) have all necessary or helpful rights to subrogation or reimbursement of benefits. If, for any reason, any benefit under the Plan is erroneously paid or exceeds the amount appropriately payable under the Plan, the recipient of such benefit (the "Recipient") shall be responsible for refunding the overpayment to the Plan or insurance company to the fullest extent permitted by law. In addition, if the Plan or insurance company makes any payment that, according to the terms of the Plan, policy or contract should not have been made, the insurance company, the Plan Administrator, or the Plan Sponsor (or designee) may, to the fullest extent permitted by law, recover that incorrect payment, whether or not it was made due to the insurance company's or Plan Administrator's (or its designee's) own error, from the person to whom it was made or from any other appropriate party.

As may be permitted in the sole discretion of the Plan Administrator or insurance company, the refund or repayment may be made in one or a combination of the following methods: (a) as a single lump-sum payment, (b) as a reduction of the amount of future benefits otherwise payable under the Plan, (c) as automatic deductions from pay, or (d) any other method as may be required or permitted in the sole discretion of the Plan Administrator or the insurance company. The Plan may also seek recovery of the erroneous payment or benefit overpayment from any other appropriate party.

Any benefit payments or reimbursements made by check must be cashed or deposited within one year after the check is issued. If any check or other payment for a benefit is not cashed or deposited within one year of the date of issue, the Plan will have no liability for the benefit payment and the amount of the check will be deemed a forfeiture. No funds will escheat to any state.

9. Amendment or Termination of the Plan

Amendment or Termination

The Plan and any benefit program under the Plan may be amended or terminated at any time, in the sole discretion of the Company as Plan sponsor, by a written instrument signed by an authorized individual. Some benefit programs may also be amended or terminated by an insurance carrier, as more fully described in any attached documents from an insurance carrier. The policies and agreements may also be amended or terminated at any time in accordance with their terms. No individual (including a retired employee) shall have a right to continuing benefits except to the extent required by law.

10. No Contract of Employment

The Plan is not intended to be, and may not be construed as, constituting a contract or other arrangement between you and the Company to the effect that you will be employed for any specific period of time.

11. No Assignment

Except as may otherwise be specifically provided in this Plan, the benefit programs, or applicable law, an individual's rights, interests or benefits under this Plan or the benefit programs shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, prior to being received by the persons entitled thereto under the terms of the benefit programs, and any such attempt shall be void.

Specifically, participants and beneficiaries covered under this plan cannot assign their rights to medical providers to pursue direct payment of claims either as the participant or beneficiaries' agent or under power of attorney. Under the terms of this plan, medical providers cannot take action enforcing a patient's right to recover benefits under ERISA or assert any claims under ERISA on behalf of patients, even where the patient(s) have assigned their rights to their medical providers.

12. Claims Procedure

Claims for Fully-Insured Benefits

For purposes of determining of the amount of, and entitlement to, benefits of the benefit programs provided under insurance contracts or policies, the respective insurer is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to benefits.

To obtain benefits from the insurer of a benefit program, you must follow the claims procedures under the applicable insurance contract, which may require you to complete, sign and submit a written claim on the insurer's form.

The insurance company will decide your claim in accordance with its reasonable claims procedures as required by ERISA.

See the appropriate certificate of insurance or booklet for details regarding the insurance company's claims procedures. You must fully follow and exhaust these claims procedures before you can file a lawsuit in state or federal court. You may have a right to seek external review of your claims, if so noted in the applicable insurance contract or policy.

Claims for Self-Funded Benefits

For purposes of determining the amount of, and entitlement to, benefits under the benefit programs which are self-funded, the Plan Administrator is the named fiduciary under the Plan, with the full power to make factual determinations and to interpret and apply the terms of the Plan.

To obtain benefits from a benefit program which is self-funded you must complete, execute, and submit to the Plan Administrator a written claim on the form available from the Plan Administrator. The Plan Administrator has the right to secure independent medical advice and to require such other evidence, as it deems necessary to decide your claim.

The Plan Administrator will decide your claim in accordance with reasonable claims procedures, as required by ERISA. You may have a right to seek external review of your claims, if so noted in the applicable attached document for the self-funded benefit program.

See the appropriate benefits description for information about how to file a claim and for details regarding the claims procedures applicable to your claim. You must fully follow and exhaust these claims procedures before you can file a lawsuit in court.

The Role of Authorized Representatives

Under ERISA and the ACA participants and beneficiaries have the right to designate an Authorized Representative for certain purposes. These purposes are generally limited to requesting documents or other information on behalf of a participant or beneficiary or acting on their behalf during claims and appeals procedures that can follow an adverse benefits determination. In any situation that does not constitute an urgent care claim, to designate any third party as an Authorized Representative a participant or beneficiary must use the signed statement included as an appendix of this document with the required witness signature. A medical provider will not become a participant or beneficiary's Authorized Representative as a result of an attempt to secure an assignment of benefits. The Plan does not guarantee that any purported assignment will be valid under the terms of the Plan.

13. Statement of ERISA Rights

This Statement of ERISA Rights applies to those benefit programs which are subject to ERISA. Not all benefit programs which are part of this Plan will be subject to ERISA. The following benefit programs are not subject to ERISA: cafeteria plan

Your Rights

As a participant in an ERISA plan you are entitled to certain rights and protections under ERISA. ERISA provides that, as a participant, you are entitled to:

- examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan documents, including insurance contracts, and copies of all documents filed by the Plan with the U.S. Department of Labor (if any) such as annual reports and Plan descriptions;
- obtain copies of the benefit program documents and other program information on written request to the Plan Administrator (the Plan Administrator may make a reasonable charge for the copies);
- receive a summary of the Plan's annual financial report, if any (the Plan Administrator is required by law to furnish each participant with a copy of this summary annual report);
- continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Fiduciary Obligations

In addition to creating rights for participants, ERISA imposes duties on the people who are responsible for the operation of the benefit program. These people, called "fiduciaries" of the program, have a duty to operate the program prudently and in the interest of you and other program participants. Fiduciaries who violate ERISA may be removed and may be required to reimburse the Plan for any losses they have caused the program.

No Discrimination

No one, including the Company or any other person, may fire you or discriminate against you in any way with the purpose of preventing you from obtaining welfare benefits or exercising your rights under ERISA.

Right to Review

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan Administrator review and reconsider your claim.

Filing Suit

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator 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 Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a court.

Any lawsuit must be filed within 36 months of the final decision on the claim. Exhaustion of the internal claims and appeals procedure is required prior to filing suit.

If it should happen that benefit program fiduciaries misuse the Program'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 (for example, if the court finds your claim is frivolous), the court may order you to pay these costs and fees.

Questions

If you have any questions about this statement or your rights under ERISA, 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.

14. General Information

COBRA

Benefit programs which provide health benefits generally are subject to the federal law known as COBRA. COBRA generally allows covered participants and beneficiaries to continue in the benefit program, even after a "qualifying event" occurs. For more information about COBRA please see Appendix A. You may also have state law continuation or conversion rights.

Subrogation and Reimbursement

If an individual has a claim for benefits under this Plan or any benefit program, and that individual acquires any right or action against a third party for the person's injury, sickness or other illness which is so covered, then: (a) the Plan shall be entitled to reimbursement for such benefits from such third party up to 100% of the benefits paid by the Plan; and (b) the Plan is automatically subrogated to all such rights or claims of the covered person. The covered person shall cooperate fully with the Plan in the enforcement of the Plan's subrogation and reimbursement rights. In addition, the person shall permit suit to be brought in the person's name under the direction of and at the expense of the Company if the Company so chooses. The Plan shall not be liable for such a person's attorney's fees absent prior written approval from the Plan. The Plan Administrator may require the receipt of a signed and dated subrogation and reimbursement agreement from the person before advancing any monies.

The failure or refusal of a covered person to fully cooperate with the Plan in the enforcement of the Plan's subrogation and reimbursement rights shall result in a forfeiture of all benefits payable to that person, even if such benefits have already been paid, in which event the Company shall retain a right to recover paid benefits which are forfeited in such a manner.

The Company, on behalf of this Plan, shall have a first priority right to recover from and a lien against any payment, whether designated as a payment for medical benefits or any other type of damages, from the proceeds of any recovery, including but not limited to any settlement, award or judgment which results from a claim or lawsuit by or on behalf of a covered person who received benefits under this Plan (even if such covered person is not made whole). The plan is not required to contribute to any expenses or fees (including attorney's fees or costs) incurred in obtaining the funds. The plan's recovery will not be limited or reduced by doctrines (equitable or other) including but not limited to, the make-whole doctrine, contributory or comparative negligence, or the common fund doctrine. The plan's right to full recovery is not reduced if settlement funds or other payments to you are spent or no longer in an individual's possession or control. Notice of the Plan's claim shall be sufficient to establish this Plan's lien against the third party or insurance carrier. The Company shall be entitled to deduct the amount of the lien from any future claims payable to or on behalf of the covered person or payee if the covered person or payee fails to promptly notify the Plan Administrator of a payment received from a third party or insurance carrier that is subject to this Plan's subrogation and reimbursement rights.

In the event that the Plan obtains a recovery against a third party in excess of payments made to or on behalf of the covered person and reasonable out of pocket expenses of the recovery, then the Plan shall pay to the covered person that excess amount recovered by the Plan.

In the event of any direct conflict between this Section 13 and the subrogation and reimbursement provisions in any benefit program, the subrogation and reimbursement

provisions in the benefit program shall control. Otherwise, the provisions of this Section 13 shall apply and may supplement those contained in any benefit program.

The above provisions of this "Subrogation and Reimbursement" section apply with respect to a benefit program that is self-funded and does not, in its governing documents (but excluding this Plan document) have a subrogation and reimbursement section. If the benefit program does have such a section that section shall control. With respect to a fully-insured benefit program, the contract or policy from the insurer shall control with respect to subrogation and reimbursement matters.

No Vesting of Benefits

Nothing in the Plan, nor anything in any benefit program, shall be construed as creating any vested rights to benefits in favor of any employee, former employee or covered person.

Waiver and Estoppel

No term, condition, or provision of this Plan or any benefit program shall be deemed to be waived, and there shall be no estoppel against enforcing any provision of the Plan or benefit program, except through a writing of the party to be charged by the waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless explicitly made so, and shall operate only with regard to the specific term or condition waived, and shall not be deemed to waive such term or condition in the future, or as to any act other than as specifically waived. No covered person other than as named or described by class in the waiver shall be entitled to rely on the waiver for any purposes.

Effect on Other Benefit Plans

Amounts credited or paid under this Plan or any benefit program shall not be considered to be compensation for purposes of any benefit program hereunder or any qualified or nonqualified pension plan maintained by the Company unless expressly provided in such benefit program or qualified or nonqualified pension plan, as applicable, or if required by applicable law. The treatment of amounts paid under this Plan or any benefit program for purposes of any other employee benefit plan maintained by the Company shall be determined under the provisions of the applicable employee benefit plan.

Severability

If any provision of this Plan or any benefit program is held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions hereof shall continue to be fully effective.

Rebates

In some situations, a rebate may be paid by an insurance company which provides coverage under the Plan. For example, a rebate may be provided under the Medical Loss Ratio ("MLR") rules, which are part of the Affordable Care Act. Except as

specifically and unambiguously provided in a Benefit Description, or as otherwise required by applicable law, any rebate from any source will be:

- Considered an asset of the Company, not the Plan. The Company does not need to use such a rebate to benefit Employees, participants or beneficiaries. The Company can use such a rebate for the Company's own purposes
- An asset of the Plan in proportion to how much of the rebate relates to Employee, participant, or beneficiary contributions. The portion relating to Company contributions shall not be considered a Plan asset. The Company will have the ability to make certain assumptions or minor changes (such as rounding to the nearest \$1 or \$10) when determining the amount which is considered a plan asset. The Company shall have discretion to determine how to use all amounts. Amounts which are plan assets will be used to benefit individuals selected by the Company. This group of individuals may not be identical to the group which relates to the rebate. In addition, certain individuals can receive the rebate (or the benefit of the rebate) even if the rebate related to a different benefit, to the extent allowed by applicable law.
- The entire amount shall be an asset of the Plan, to be used for the benefit of individuals covered by the Plan.

In all situations where ERISA applies the use of any ERISA-covered plan assets will be governed by applicable law, including but not limited to U.S. Department of Labor Technical Release 2011-04.

Controlling Law

This Plan shall be administered, construed, and enforced according to the federal law and the laws of the State of Kentucky, to the extent not preempted by federal law. However, with respect to a fully-insured benefit program, the applicable insurance policy or contract will control with respect to which state's laws apply.

15. Benefit Program Information

Summary of Eligibility and Participation Provisions

Note: If you have any questions about eligibility or participation, contact the Plan Administrator

Benefit Program	Fully-insured or self-funded? if fully-insured, carrier name	Policy or Group #, if fully-insured	Who is eligible	When Participation begins	When Participation Ends¹	To File a Claim, Contact:
Medical	Fully-Insured / Anthem	L09899	Full time employees working 30+ hours per week.	On the first of the month following with date of hire.	End of the month following date of termination. Continuation coverage is available.	Claims: P.O. Box 105187 Atlanta, GA 30348-5187 (888) 578-4443
Dental	Fully-Insured/ Delta Dental	713420	Full time employees working 30+ hours per week.	On the first of the month following with date of hire.	End of month following date of termination. Continuation coverage is available.	Dental Claims: P.O. Box 242810 Louisville, KY 40224-2810 (877) 664-3576
Vision	Fully-Insured/ VSP	30045487	Full time employees working 30+ hours per week. Enrollment in vision is voluntary.	On the first of the month following with date of hire.	Date of termination. Continuation coverage is available.	Claims: P.O. Box 385018 Birmingham, AL 35238 (800) 216-6248, option 2 or file online at vsp.com

¹ Other Events (such as fraud or intentional misrepresentation of a material fact) can also terminate coverage -- see the benefit program details.

Benefit Program	Fully-insured or self-funded? if fully-insured, carrier name	Policy or Group #, if fully-insured	Who is eligible	When Participation begins	When Participation Ends¹	To File a Claim, Contact:
Basic Life/AD&D	Fully-Insured/ MetLife	5393432	Full time employees working 30+ hours per week.	On the first of the month following or coinciding with date of hire.	Date of termination.	Claims: lifeclaimsubmit@metlife.com fax: (570) 558-8645 (859) 389-6505
Voluntary Accident Plan	Fully-Insured/ Colonial Life	E4165759	Full time employees working 30+ hours per week.	On the first of the month following or coinciding with date of hire.	Date of termination. Continuation coverage is usually available.	Claims: P.O. Box 100195 Columbia, SC 29202-3195 Phone: (800) 325-4368 Fax: (800) 880-9325 or ColonialLife.com
Voluntary Critical Illness Plan	Fully-Insured/ Colonial Life	E4165759	Full time employees working 30+ hours per week.	On the first of the month following or coinciding with date of hire.	Date of termination. Continuation coverage is usually available.	Claims: P.O. Box 100195 Columbia, SC 29202-3195 Phone: (800) 325-4368 Fax: (800) 880-9325 or ColonialLife.com
Voluntary Short Term Disability Insurance	Fully-Insured/ Colonial Life	E4165759	Full time employees working 30+ hours per week.	On the first of the month following or coinciding with date of hire.	Date of termination. Continuation coverage is usually available.	Claims: Phone: (800) 325-4368 Fax: (800) 880-9325 or ColonialLife.com

Benefit Program	Fully-insured or self-funded? if fully-insured, carrier name	Policy or Group #, if fully-insured	Who is eligible	When Participation begins	When Participation Ends¹	To File a Claim, Contact:
Voluntary Life Insurance	Fully-Insured/ Colonial Life	E4165759	Full time employees working 30+ hours per week.	On the first of the month following or coinciding with date of hire.	Date of termination. Continuation coverage is usually available.	Claims: P.O. Box 100194 Columbia, SC 29202 Phone: (800) 325-4368 Fax: (800) 880-9325 or ColonialLife.com
Employee Assistance Program	Fully-Insured/ MetLife	5393432	Full time employees working 30+ hours per week.	On the first of the month following or coinciding with date of hire.	End of month following date of termination.	Metliffeap.lifeworks.com (888) 319-7819

Appendix A: COBRA Continuation



HEALTH INSURANCE CONTINUATION INFORMATION:

COBRA CONTINUATION COVERAGE

Introduction to COBRA: This information is intended to provide information about your rights and responsibilities under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). This information does not change your status on the group health plan in any way. Rather, this information explains rights and responsibilities you may have in the future under the following group health plan(s):

GROUP HEALTH PLAN(S) SPONSORED BY: **Wolf Steel**

Are there other coverage options besides COBRA Continuation Coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid or other group health plan coverage options (such as a spouse's plan) through what is called a *special enrollment period*. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If a COBRA qualifying event, which would terminate your group health plan coverage, occurs in the future, you would have the option to continue your coverage at your own expense. COBRA continuation coverage is the same group health plan coverage you had before your qualifying event. It is the same coverage provided to similarly situated active employees who have not experienced a qualifying event, but it does not include life insurance or disability coverage. Once you and your spouse or dependents (if any) become covered by the group health plan, there are specific qualifying events that may occur that cause you to lose coverage. Those events and the length of continuation coverage you could be allowed are:

Event	Duration of Coverage
Termination of employment (voluntary or involuntary, other than for gross misconduct)	18 months
Reduction in hours (layoff, leave of absence, reduced work hours, etc.)	18 months
Death of the covered employee	36 months
Divorce or legal separation	36 months
Covered employee's entitlement to Medicare	36 months
Dependent child ceasing to be dependent	36 months
Bankruptcy (Title XI) of the employer	Possible lifetime coverage for covered retirees and their spouses and dependents only

If your employer provides a retiree health plan, sometimes filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a bankruptcy proceeding is filed with respect to WOLF STEEL, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse and dependent children will also become qualified beneficiaries if the bankruptcy results in the loss of their coverage under the Plan.

Who can elect COBRA: Each employee, spouse and dependent child covered by the group health plan the day before the qualifying event and who would lose coverage due to the qualifying event would be a COBRA qualified beneficiary. A child born to, or placed for adoption with, the covered employee during the period of COBRA continuation would also be a qualified beneficiary, if the employer/plan administrator is notified within 30 days of the birth or placement for adoption.

Each qualified beneficiary has an independent right to elect continuation coverage under COBRA. This means all qualified beneficiaries, including a spouse and/or a dependent child, may elect single coverage. However, if two or more family members elect the same coverage, you will be required to pay the applicable premium for the closest level of coverage that a similarly situated active employee would have, such as "two-person" or "family". If the monthly premium for single coverage is not shown above, or if you wish to elect a level of coverage not shown in this notice, please call Isolved Benefit Services at 800-594-6957 for more information. The covered employee or spouse may elect on behalf of all other qualified beneficiaries; a parent or legal guardian may elect on behalf of dependent children.

How to elect COBRA: Isolved Benefit Services mails COBRA notices on behalf of **WOLF STEEL**, and Isolved Benefit Services is the party responsible for all other COBRA administration, including COBRA elections and payments. Isolved Benefit Services is not an insurance company or the provider of benefits. Once a qualifying event occurs and is reported properly, **WOLF STEEL** will instruct Isolved Benefit Services to notify you, in writing, with specific information about your qualifying event. The notice will contain instructions for electing continuation coverage, as well as the last date on which you can elect. You will be allowed at least 60 days to elect continuation coverage. Verbal elections will not be accepted. If you elect continuation coverage, **WOLF STEEL** has the right to verify your eligibility for coverage. If you are not eligible, continuation coverage may be denied or retroactively terminated.

The covered employee or spouse may elect on behalf of all other qualified beneficiaries; a parent or legal guardian may elect on behalf of dependent children. If you fail to timely elect, you will lose your right to continue coverage. Proof of timely election is your responsibility (the United States Postal Service offers several proof of mailing services). A COBRA election is deemed made on the date it is postmarked. If you waive continuation coverage in writing, you have 60 days from the later of the loss of coverage date or the date the notification was mailed to you to revoke your waiver and elect continuation coverage.

Any claims you incur during the waiver period may not be covered. isolved Benefit Services does not administer waivers of continuation coverage. Instead of waiving your COBRA rights if you do not want COBRA, you simply do not send in your COBRA Continuation Coverage Election Form. During your election period, you may find that you have been removed from the group health plan. Once you make a timely election and payment, your coverage will be reinstated retroactive to your loss of coverage date. If you do not elect, any expenses you incur will become your financial responsibility. You are not required to make a payment with your COBRA election, but coverage may not be reinstated until a timely payment is made. The time frame for reinstatement of coverage often depends upon the insurance company. To confirm your coverage status, please call the insurance company directly.

Paying for Continuation Coverage: Once you elect COBRA continuation coverage, it must be **paid for from the "Loss of Coverage" date forward in consecutive monthly payments.** Gaps in continuation coverage are not permitted. The first payment for coverage (including coverage retroactive to the loss of coverage) is due in full within 45 days of your election date. For monthly payments following your date of election, the premium is due, in full, on the "Day Due" each month as shown in the table above. Each monthly coverage period has a grace period of at least 30-days. If your first and last month's premiums are partial months, they will be prorated.

A COBRA payment is deemed made on the date it is postmarked (or when it is submitted online at isolved Benefit Services' website). **Payments made after any grace period ends (either the 45-day grace period, or a monthly 30-day grace period) are considered late, and will not be accepted.** WOLF STEEL and isolved Benefit Services are not required to make exceptions based upon individual circumstances, and if you make a late payment, coverage will be terminated permanently, with no possibility of reinstatement. Invoices are not required, and you must postmark your payments by the monthly grace date even if you do not get an invoice. Returned checks (for instance, closed accounts, non-sufficient funds, or stop payments) are the same as no payment at all. Proof of timely payment is your responsibility (the United States Postal Service offers several proof of mailing services).

Certain states and certain plans may suspend coverage each month until payment is confirmed. Therefore, if you pay during your grace period your coverage and your claims may be temporary suspended each month.(This action is allowable under applicable federal COBRA law and regulations and may be required by certain state laws.).

Extending Continuation Coverage: If the qualifying event leading to your election of COBRA continuation coverage was your Termination or Reduction of Hours (or by any other name, a qualifying event that allowed for 18 months of continuation), you may be able to extend your COBRA continuation coverage period for two reasons.

Social Security Disability Determination: If any qualified beneficiary is determined to be disabled by the Social Security Administration, all

qualified beneficiaries may receive an additional 11 months of COBRA continuation coverage (29 months total from the original qualifying event). To qualify for this extension **all** requirements must be met:

1. The qualified beneficiary must be disabled at any time during the first 60 days of continuation coverage.
2. The qualified beneficiary must provide the Social Security disability award letter to isolved Benefit Services within 60 days from the later of his or her "Event Date", "Loss of Coverage" date, or the date of the award letter.
3. The qualified beneficiary must provide the Social Security disability award letter to isolved Benefit Services before his or her 18-month continuation coverage period ends (refer to the "Coverage Expires" date above).

You must also follow the reporting instructions described at the end of this notice. During a disability extension, you may be charged up to 150% of the applicable premium (including the employer's cost) for the coverage. The increased cost begins in the 19th month.

If the Social Security Administration later determines that the disabled qualified beneficiary is no longer disabled, the disability extension will end. Continuation coverage will terminate for all qualified beneficiaries at the end of the month that is 30 days after the date of the Social Security Determination (but not before the end of the original 18 months). If you are determined to be no longer disabled, you must report this change within 30 days, following the instructions described at the end of this notice.

Second Qualifying Events: If a second qualifying event that would normally cause a loss of coverage as a first qualifying event (death of the covered employee, divorce or legal separation, or a dependent child ceasing to be a dependent child) occurs during the 18-month continuation coverage period, the spouse and/or dependent children who are qualified beneficiaries and who would have lost coverage may receive an additional 18 months of continuation coverage (36 months total from the original qualifying event). You may be eligible for this extension even if you have already been granted an extension of continuation coverage for Social Security Disability. You must report a second qualifying event within 60 days of the qualifying event.

You can report these events using the COBRA Event Notice on our website at www.isolved Benefit Services.com or by mailing in the notice or a description of the event. Please see the instructions at the end of this notice for more details. Once you report one of these events, isolved Benefit Services and WOLF STEEL will review your

eligibility. If you are not eligible, you will receive a Notice of Unavailability that will explain why.

Conversion Coverage: After continuation coverage expires, you may be eligible to elect an individual conversion policy, if your group health plan has such an option. Conversion coverage is not the same as group health plan coverage, and it is not the same as continuation coverage. Rates and benefits may be different. For more information, refer to your plan booklet, summary plan description or contact the insurance company directly. Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

Additional Website, Election, Event Reporting and Payment Instructions

Copies of important documents relating to your COBRA rights, such as this notice, are available on our secure website, www.isolvedbenefitservices.com.

Online Reporting of Disability Determination or Additional Qualifying Events

isolved Benefit Services has a form titled the "COBRA Event Notice" on our website. From the login page, select "Employees/Participants", "Continuation Coverage" and enter your User ID and Password in the area provided.

Paper Reporting of Disability Determination or Additional Qualifying Events

You may call isolved Benefit Services at **(800) 594-6957** to request a "COBRA Event Notice" form.

You must report these events in writing, but use of the form is not required if you include the following information:

- Name, address and phone number of the covered employee
- Name, address and phone number of qualified beneficiaries experiencing the event
- Group health plan coverage
- The event experienced
- The date of the event
- For Social Security Disability Awards, you must include a copy of the award letter
- If deemed No Longer Disabled, you must also include a copy of that letter, and
- For all other events, you must include your signature and a statement that the event occurred as represented.

Send the "COBRA Event Notice" or other written format to:
isolved Benefit Services, Attention: COBRA Event Notice
PO Box 949

Coldwater, MI 49036
or fax to 517-278-0764.

How long does COBRA continuation coverage last: If you elect COBRA continuation coverage, your coverage will begin and end on the dates shown in the table above. COBRA continuation coverage may terminate earlier than the end date noted above for the following reasons:

- You first become, after the date you elect continuation coverage, covered by another group health plan
- You first become, after the date you elect continuation coverage, entitled to Medicare Part A, Part B or both
- Your payment is not timely made as described below.
- "COMPANY_NAME» ceases to provide any group health plan
- During any 11-month disability extension, a disabled qualified beneficiary is deemed no longer disabled by the Social Security Administration
- Your coverage is terminated for cause, such as fraud, on the same basis that coverage can be terminated under the WOLF STEEL Plan for active employees.

After electing COBRA continuation coverage, you or any qualified beneficiary must notify involved Benefit Services or WOLF STEEL in writing within 30 days of:

- Becoming entitled to Medicare Part A, Part B or both; OR
- Becoming covered under another group health plan

Failure to provide this notice as required may result in retroactive termination of COBRA continuation coverage. Any expenses incurred during a period for which coverage is later terminated will become your financial responsibility, and may require repayment to the providers.

HIPAA SPECIAL ENROLLMENT and COBRA: You should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you keep continuation coverage for the maximum time available to you.

More Information: This notice does not fully describe your continuation coverage or other plan rights. You can find more complete information in your summary plan description, plan booklet or certificate. If you have questions about your COBRA rights, please contact involved Benefit Services at (800) 594-6957. For more information about your rights under ERISA, including COBRA, HIPAA and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through

the Health Insurance Marketplace and to locate an assister in your area who you can talk to about the different options, visit www.HealthCare.gov. It is important to keep WOLF STEEL and involved Benefit Services informed of address changes for all qualified beneficiaries. This notice contains important information about your rights and responsibilities under the COBRA law. Please keep this notice for future reference.

Women's Health and Cancer Rights Act of 1998 (WHCRA): WHCRA requires a group health plan to notify you, as a participant or a beneficiary, of your potential rights related to coverage in connection with a mastectomy. Your plan may provide medical and surgical benefits in connection with a mastectomy and reconstructive surgery. If it does, coverage will be provided in a manner determined in consultation with your attending physician and the patient for a) all stages of reconstruction on the breast on which the mastectomy was performed; b) surgery and reconstruction of the other breast to produce a symmetrical appearance; c) prostheses; and d) treatment of physical complications of the mastectomy, including lymphedema. The coverage, if available under your group health plan, is subject to the same deductible and coinsurance applicable to other medical and surgical benefits provided under the plan. For specific information, please refer to your summary plan description or benefits booklet, or contact **WOLF STEEL**.

Appendix B: Medicare Part D

Important Notice from Wolf Steel LLC About Your Prescription Drug Coverage and Medicare

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

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

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

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your Wolf Steel LLC coverage **will not** be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under Wolf Steel LLC is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your Wolf Steel LLC prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Wolf Steel LLC and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Wolf Steel LLC changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

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

Date: January 1, 2026
Name of Entity/Sender: Wolf Steel, LLC
Contact-Position/Office: Denice McKibbon, Manager Compensation & Benefits/HR
Address: 103 Miller Drive, Crittenden, KY 41030
Phone Number: (705) 721-1212 ext. 20824

Appendix C: Notice of HIPAA Privacy Practices

Purpose: Privacy notices must be given to individuals covered by the plan. A single notice to a covered employee is effective for all covered dependents. Notices must be provided upon enrollment, and within 60 days of a material change to the notice. Plans must notify participants every 3 years that a privacy notice is available. Consistent with other template forms, this Notice assumes the plan does not, with respect to protected health information: (1) engage in fundraising; (2) engage in marketing, where the plan receives financial remuneration for such marketing; (3) sell protected health information; (4) use genetic information for underwriting purposes; or (5) engage in research. If these assumptions are not correct this Notice should be changed.

Wolf Steel Acquisition, LLC. Health and Welfare Plan PRIVACY PRACTICES NOTICE

(Version 02/16/2026)

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

Your Information. Your Rights. Our Responsibilities.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services

- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

To the extent that we have your substance use disorder patient records, subject to 42 CFR part 2, we will not share that information for investigations or legal proceedings against you without (1) your written consent or (2) a court order and a subpoena.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home, office, or mobile phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no,” for example, if it could affect your care. If we agree to your request, we may still share this information in the event that you need emergency treatment.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If someone has authority to act as your personal representative, such as if someone has your medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting <https://www.hhs.gov/hipaa/filing-a-complaint/index.html>.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. And in all cases, if we have substance use disorder patient records about you, subject to 42 CFR part 2, we cannot use or share information in those records in civil, criminal, administrative, or legislative investigations or proceedings against you without (1) your consent or (2) a court order and a subpoena.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.

- We will not use or share your information other than as described in this notice unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Other Instructions for Notice

- Insert Effective Date of this Notice
- Insert name or title of the privacy official (or other privacy contact) and his/her email address and phone number.
- Insert any special notes that apply to your entity's business such as "we do not use or share any of your information for marketing purposes."
- The Privacy Rule requires you to describe any state or other laws that require greater limits on disclosures. For example, you might describe the effects of a state law by stating, "We will not share your mental health treatment billing records without your written consent unless it is for treatment or another law requires us to share the information." Insert this type of information here. If no laws with greater limits apply to your entity, no information needs to be added.
- If your entity provides patients with access to their health information using an online portal, you may want to insert a reference to it here.
- If your entity is part of an OHCA (organized health care arrangement) that has agreed to a joint notice, use this space to inform your patients of how you share information within the OHCA (such as for treatment, payment, and operations related to the OHCA). Also, describe the other entities covered by this notice and their service locations. For example, "This notice applies to Corporation Group Health Plan and Grace Health Insurance, which provides health coverage to Corporation Group Health Plan in the greater Dayton area."

Appendix D: Authorized Representatives

Appointment of Authorized Representative

I, _____

[name of claimant]

hereby appoint _____ to act on my behalf

[name of Authorized Representative]

or on behalf

of _____

[name of patient: plan participant or beneficiary]

in connection with any claim for coverage or benefits, including receipt of any approvals or authorizations that are required before medical services are provided under the plan named above ("Plan"). I authorize my representative to receive any and all information that is provided to me, and to act for me and for my covered spouse or dependent, if named above as the patient, in providing any information to the Plan that relates to any claim for coverage or benefits under the Plan.

This form does not constitute an assignment of rights for direct payment.

Distribute to me and to my Authorized Representative: All information and notifications should be distributed to me and to my Authorized Representative.

Claimant's signature

Date

Accepted: _____

Authorized Representative's signature

Date

Witness: _____

Witness signature

Date

Appendix E: Summary of Material Modification

Summary of Material Modification

To

Wolf Steel Acquisition, LLC Health and Welfare Plan

To: Employee participants in the Wolf Steel Acquisition, LLC Health and Welfare Plan and COBRA participants

From: Wolf Steel (Napoleon) Human Resources Team

Date: January 1, 2025

The Wolf Steel Acquisition, LLC Health and Welfare Plan sponsored by Wolf Steel DBA has been revised. All of the changes summarized below are effective January 1, 2025.

1. Anthem Pharmacy changes are outlined below.

Program Name/Benefit	Product Type	2024 benefit	2025 renewing benefit
Pharmacy Network	All	Rx Choice Network with Retail 90	Base Network with Retail 90
Home Delivery Multiplier	All	Tier 1a/1b: 2 times retail Tier 2: 2.5 times retail Tier 3: 2.5 times retail Tier 4: 1 times retail	Tier 1a/1b: 3 times retail Tier 2: 3 times retail Tier 3: 3 times retail Tier 4: 1 times retail

2. Source and Amount of Contributions

The contribution amount for employee has changed for 2025, please review the benefit communication materials for full contribution amounts.

Please contact Human Resources (acting on behalf of the plan administrator, Wolf Steel Acquisition, LLC), if you have questions regarding the information in this SMM. We can be reached as follows:

Phone: (859) 428-9555 x35

E-mail: hr@napoleon.com

Address: 103 Miller Drive Crittenden, KY 41030

FILING INSTRUCTIONS

Please keep this memorandum with your copy of the Plan's Summary Plan Description (SPD), as it explains important changes that may affect your benefits (please contact me if you need another copy of the SPD).

ERISA INFORMATION

Plan Sponsor: The employer is the Plan Sponsor.

Sponsor's EIN#: 84-3241774

Plan Name: Wolf Steel Acquisition, LLC. Health and Welfare Plan

Plan Number: 501

Plan Year: January 1, 2025

Appendix F: Summary of Material Modification

Summary of Material Modification

To

Wolf Steel Acquisition, LLC Health and Welfare Plan

To: Employee participants in the Wolf Steel Acquisition, LLC Health and Welfare Plan and COBRA participants

From: Wolf Steel (Napoleon) Human Resources Team

Date: January 1, 2026

The Wolf Steel Acquisition, LLC Health and Welfare Plan sponsored by Wolf Steel DBA has been revised. All of the changes summarized below are effective January 1, 2026.

1. Anthem: Benefit Enhancements due to passed legislation.

- Cognitive Rehabilitation Therapy will be a separate benefit in 2026 (currently covered under speech therapy). Member cost share will be the same as the Speech Therapy benefit.
- Air Ambulance limits are removed (per Federal Mandate – No Surprises Act)
- Out-of-Network Preventive Chronic Conditions: cost share will be based on the service setting

2. Source and Amount of Contributions

- The contribution amount for employee has changed for 2026, please review the benefit communication materials for full contribution amounts.

Please contact Human Resources (acting on behalf of the plan administrator, Wolf Steel Acquisition, LLC), if you have questions regarding the information in this SMM. We can be reached as follows:

E-mail: hr@napoleon.com

Address: 103 Miller Drive Crittenden, KY 41030

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Plan Sponsor: The employer is the Plan Sponsor.

Sponsor's EIN#: 84-3241774

Plan Name: Wolf Steel Acquisition, LLC. Health and Welfare Plan

Plan Number: 501

Plan Year: January 1, 2026