BARRY-WEHMILLER COMPANIES, INC.

SUMMARY PLAN DESCRIPTION
for the
WELFARE BENEFIT PLANS

April 2020

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Introduction

This summary, together with the booklets, summaries, certificates and evidence of coverage documents listed in Appendix A (collectively, "EOCs"), is intended to serve as the Summary Plan Description ("SPD") required by the Employee Retirement Income Security Act of 1974 ("ERISA") for welfare benefit plans.

The SPD describes the following welfare benefit plans sponsored by Barry-Wehmiller Companies, Inc. (the "Sponsor") for eligible employees of the Sponsor and its affiliates (the "Employer") and their eligible dependents:

- Barry-Wehmiller Companies, Inc. Medical Plan
- Barry-Wehmiller Companies, Inc. Dental Plan
- Barry-Wehmiller Companies, Inc. Vision Plan
- Barry-Wehmiller Companies, Inc. Short-Term Disability ("STD") Plan
- Barry-Wehmiller Companies, Inc. Long-Term Disability ("LTD") Plan
- Barry-Wehmiller Companies, Inc. Life Insurance Plan
- Barry-Wehmiller Companies, Inc. Accidental Death and Dismemberment ("AD&D") Insurance Plan
- Barry-Wehmiller Companies, Inc. Flexible Spending Account ("FSA") under the Barry-Wehmiller Companies, Inc. Cafeteria Plan
- Barry-Wehmiller Companies, Inc. Employee Assistance Plan ("EAP")
- Barry-Wehmiller Companies, Inc. Business Travel Accident Plan
- Barry-Wehmiller Companies, Inc. Medical Plan for Puerto Rico
- Barry-Wehmiller Companies, Inc. Global Benefits Plan for Expatriates and Foreign Employees
- Right Choice Wellness Center, Sheboygan, Wisconsin
- Be Well Center, Green Bay, Wisconsin
- Best Doctors (second opinion services)

Reference to the "Plan" herein is a reference to each of the above-listed plans. When this SPD refers to one or more of the above-listed plans, it may refer to such plan(s) as "component plan(s)."

The Employer will provide benefits in accordance with applicable federal laws including the Patient Protection and Affordable Care Act (ACA), the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Health Insurance Portability and Accountability Act (HIPAA), the Mental Health Parity Act, the Newborns' and Mothers' Health Protection Act (NMHPA) and the Women's Health and Cancer Rights Act (WHCRA).

The following Plans are insured, and Plan benefits are provided under a policy with an insurance company: certain benefits under the Medical Plan (Blue Cross Blue Shield of Arizona), the Dental Plan (CIGNA DHMO option), the Long-Term Disability Plan, the Life Insurance Plan, the AD&D Plan, the Vision Plan, the EAP Plan, the Business Travel Accident Plan, the Medical Plan for Puerto Rico and the Global Benefits Plan for Expatriates and Foreign Employees. The following Plans are self-insured by the Employer and are administered by third-party service providers: certain benefits under the Medical Plan (all except Blue Cross Blue Shield of Arizona); Dental Plan (Delta Dental PPO option), the Flexible Spending Accounts ("FSAs")

under the section 125 cafeteria plan, the Short-Term Disability Plan, the Right Choice Wellness Center, the Be Well Center, and the Best Doctors program. All benefits are summarized in this document and in the EOCs.

This SPD should be read in conjunction with the EOCs (see "Appendix A Evidence of Coverage Documents" for a list of EOCs). The EOCs are prepared and distributed by the insurance companies and service providers. If you need another copy of an EOC, please contact the Culture & People Development Representative at (314) 862-8000. If there is ever a conflict or a difference between what is written in this SPD and the EOCs with respect to **the specific benefits provided**, the EOCs shall govern. If there is a conflict between the EOCs and this SPD with respect to **the legal compliance requirements of ERISA and any other federal law**, this SPD will govern. If there is ever a conflict between this SPD and the formal, legal Plan documents, the legal Plan documents will govern.

The Sponsor reserves the right to change, amend, suspend or terminate any or all of the benefits described in this SPD, in whole or in part, at any time and for any reason in its sole discretion. Amendment or termination shall be effective if it is adopted by a duly authorized officer or committee of the Sponsor, or if it is adopted pursuant to the Sponsor's procedures allocating or delegating authority to act on behalf of the Sponsor, as such procedures exist from time to time.

Note that by adopting and maintaining these benefits, the Sponsor has not entered into an employment contract with any employee. Nothing in the legal Plan documents or in the SPD gives any employee the right to be employed by the Employer or to interfere with the Employer's right to discharge any employee at any time.

The terms "Plan" and "Component Plan" do not include any voluntary group insurance program that is made available through the Sponsor but that is not endorsed by the Sponsor.

Eligibility

Eligible Employees

General Rule

Except as otherwise set forth below, you are considered an "eligible employee" and are eligible to participate in each of the Plans on your date of hire if you:

- Are classified by your Employer as a regular, full-time employee of the Employer who normally works at least 30 hours per week and is paid through the U.S. payroll; and
- Meet the applicable eligibility waiting period requirement listed on "Appendix B Waiting Period."

Special Rules

Temporary Employees. See Appendix B.

Puerto Rico Employees. If you are employed in Puerto Rico and you satisfy the eligibility requirements under the General Rule (except the requirement that an employee be paid through the U.S. payroll), you are eligible to participate in the following Plans:

- Medical Plan for Puerto Rico (medical, dental and vision benefits);
- Short-Term Disability Plan;
- Long-Term Disability Plan;
- Life Insurance Plan; and
- Accidental Death and Dismemberment Insurance Plan.

Expatriate employees and Third Country Nationals. If you are an expatriate employee, i.e., a U.S. citizen working overseas, or a third country national, i.e., a non-U.S. citizen working away from your home country, and you satisfy the eligibility requirements under the General Rule (except the requirement that an employee be paid through the U.S. payroll), you are eligible to participate in the Global Benefits Plan for Expatriates and Foreign Employees (medical, dental, life and disability benefits).

Be Well Center, Green Bay, Wisconsin. If you are employed as an employee at the Paper Converting Machine Company or the Hudson-Sharp location in Green Bay, Wisconsin or an employee working at one of these locations, you are eligible to receive certain preventive and primary care services described in Appendix C at the Be Well Center in Green Bay, Wisconsin.

Right Choice Wellness Center. If you are employed as an employee at Will-Pemco, Inc. or an employee working at this location, you are eligible to receive certain preventive and primary care services described in Appendix D at the Right Choice Wellness Center in Sheboygan, Wisconsin.

Best Doctors. If you are eligible to participate in the Barry-Wehmiller Companies, Inc. Medical Plan, you are eligible to participate in the Best Doctors program which offers second opinion services.

Temporary Expansion of Coverage. At the discretion of the Sponsor, the requirements to qualify as an "eligible employee" may be temporarily expanded for a nondiscriminatory group of

employees to address unforeseen circumstances, such as a public health emergency or significant economic contraction

Continuation Coverage under Severance Agreement. At the discretion of an Employer an eligible employee, who is offered a severance agreement under which severance benefits are paid in a manner other than in a lump sum payment, may be permitted, pursuant to the severance agreement, to continue to be treated as an eligible employee under the Barry-Wehmiller Companies, Inc. Medical Plan, the Barry-Wehmiller Companies, Inc. Dental Plan, and/or the Barry-Wehmiller Companies, Inc. Vision Plan by agreeing to continue to pay the active employee contribution rate for employee and/or dependent coverage for up to a maximum of 12 months after the month in which termination of employment occurred, as determined by the Employer. The portion of the cost of such coverage which is self-funded by the Employer, if any, will be included in the taxable income of the terminated employee. Upon termination of the severance agreement, if the former employee experienced a qualifying event at the time of termination of employment, COBRA continuation will be offered and the maximum period of COBRA coverage will not be offset by the period of coverage provided under the severance agreement.

The term "Employer" includes Barry-Wehmiller Companies, Inc. and any other entity in the Sponsor's controlled group that adopts the Plan. Such an entity will be deemed to have adopted the Plan by making contributions to the Plan.

Individuals Not Eligible

You are not eligible to participate in the Plan if you are:

- Normally working less than 30 hours per week;
- a leased employee; or
- an independent contractor.

Please see the applicable EOCs for additional eligibility requirements.

An individual who is not classified by the Employer as an employee will not be eligible to participate in the Plan regardless of whether a court or tax or regulatory authority retroactively reclassifies the individual as an employee of the Employer.

Eligible Dependents

- Your dependents are eligible for coverage only if you are enrolled; provided, however, that dependents of eligible employees may participate in the Be Well Center and the Right Choice Wellness Center even if the employees are not enrolled in the Barry-Wehmiller Companies, Inc. Medical Plan.

The following dependents are eligible for coverage:

- Your legal spouse of the opposite sex or same sex, as determined under applicable state law at the time and location that the marriage was entered into;
- Your Child, until such child attains age 26; or

- Your permanently and totally disabled unmarried Child who is: 26 or more years old and primarily supported by you, provided that the Child was disabled prior to age 26. An individual is permanently and totally disabled if he or she is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months. To cover a disabled Child, you must supply proof of the disability as requested by the Plan Administrator within 31 days after the date the Child ceases to qualify under one of the above. During the next two years the Plan Administrator may require proof of the continuation of the condition from time to time. After that, the Plan Administrator may require proof no more than once a year.

The term "Child" means any of the following individuals:

- Your natural child;
- Your stepchild,
- Your legally adopted child;
- A child placed with you for adoption; and
- A child who has been placed with you by an authorized placement agency or by a judgment, decree or other order of any court of competent jurisdiction.

Please see the applicable EOCs for additional eligibility requirements.

If your child ceases to meet the eligibility requirements set forth above, you must notify the Culture & People Development Representative within 30 days.

The Plan Administrator retains the right to verify dependent status and impose additional requirements for enrollment of eligible dependents. For example, you may be required to sign an affidavit that an individual qualifies as your Child, or that your permanently and totally disabled Child has the same principal place of abode as you for more than half of the year and that such Child does not provide over one-half of his or her own support.

Special Component Plan Exclusions

In general, if you are an eligible employee, you (and your eligible dependents) are eligible to participate in each of the component plans, and in each level of coverage offered by the component plan. However, certain component plans (and levels of coverage under the component plans) are not available to certain groups. The special component plan exclusions that apply to you are listed on "Appendix E Special Component Plan Exclusions".

Eligible Retirees

Generally, retirees of the Employers are not entitled to welfare plan benefits. However, in some cases, retirees and their eligible dependents are eligible to participate in the Plan, e.g., retirees of companies that have been acquired by Barry-Wehmiller Companies, Inc. If you are eligible for retiree benefits under the Plan, the component plan and coverage levels that are available to you are listed in "Appendix F Retiree Coverage." The Employer reserves the right to amend or terminate retiree coverage, in whole or in part, and at any time.

Qualified Medical Child Support Orders

A court may order you to provide health coverage for your eligible child in accordance with a qualified medical child support order ("QMCSO"). If the Plan receives a valid QMCSO, it will extend coverage to the eligible child(ren) named in the order. You will be notified if such an order is received, and you will be required to pay any applicable contributions for such coverage. You may obtain from the Plan Administrator, without charge, a more detailed description of the procedures governing QMCSO determinations.

Notification

If you experience a qualifying change in status event, you must notify the Culture & People Development Representative in order to make a change in your election during the year. The notice must be in writing and contain the change in status event, the date of the event and your requested change. Changes in family status include: marriage; divorce; legal separation; annulment; death of a spouse or child; birth or adoption or placement for adoption of a child; a change in your, your spouse's or your dependent's employment status; a change in the health coverage of your spouse or dependent under another employer's plan; a change in the place of your, your spouse's or dependent's residence; an event that causes your dependent to satisfy or cease to satisfy eligibility requirements; with respect to a dependent care spending account, a change in your day care provider or the cost associated with the day care provider; and such other events that the Plan Administrator determines will permit a mid-year election or election change under regulations and rulings of the Internal Revenue Service.

In most cases, the notice of a change in status must be provided within 30 days of the status event. However, you must notify the Culture & People Development Representative in writing within 60 days in the event of divorce or in the event your child ceases to meet the eligibility requirements for benefit coverage in order for you and your dependents to elect COBRA coverage. For more information about your duty to notify the Plan in such an event, see the *COBRA* section of this SPD.

Additional Eligibility Information

Additional information regarding how and when you and your eligible dependents become eligible to participate in the benefits referred to in this SPD and any conditions and limitations on eligibility are contained in the EOCs you received from the applicable insurance companies or service providers and in the legal Plan documents. If you need another copy of an EOC, please contact the Culture & People Development Representative at (314) 862-8000.

Enrollment

When you begin working at the Employer, if you are eligible you will receive the information necessary to enroll in the Plans.

HIPAA Special Enrollment Events

A federal law called HIPAA requires that we notify you about the special enrollment provisions in the Barry-Wehmiller Companies, Inc. Medical Plan, the Barry-Wehmiller Companies, Inc.

Medical Plan for Puerto Rico and the medical benefits for expatriates under the Barry-Wehmiller Companies, Inc. Global Benefits Plan for Expatriates and Foreign Employees.

If you are declining enrollment for yourself or your eligible dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your eligible dependents in the Plan if you or your eligible dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your eligible dependents' other coverage). However, you must request enrollment within 30 days after your or your eligible dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new eligible dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your eligible dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Lastly, if you or your eligible dependents become eligible for a Medicaid or Children's Health Insurance Program ("CHIP") premium-assistance subsidy for qualified employer-sponsored health coverage or if your or your eligible dependents' coverage under a Medicaid plan or CHIP is terminated due to loss of eligibility for such coverage, you may be able to enroll yourself and your eligible dependents in the Plan. However, you must request enrollment within 60 days after the date you or your dependents are determined to be eligible for such assistance or the date your or your dependents' Medicaid or CHIP coverage terminates.

To request special enrollment or obtain more information, contact the Culture & People Development Representative.

Cost of Coverage

The Employer and employees will share the cost of coverage under the Plan, and current employees will pay their share of that cost on a pre-tax basis under a cafeteria plan. The amount the Employer contributes to the Plan will be determined at the Employer's discretion from time to time. Employees who participate in a Medical Plan option with a Health Savings Account ("HSA") may make contributions to the HSA in addition to any contributions made by the Employer. Employees who elect FSAs are responsible for the full cost of such coverage. The Employer makes no contributions to FSAs.

The Employer reserves the right to require or increase employee contributions at any time and for any reason.

Coverage During Leaves of Absence

The sections below describe benefit continuation for various types of leave: Family and Medical Leave of Absence, Active Military Leave of Absence and Other Leaves of Absence. For more information about any type of leave of absence, contact the Culture & People Development Representative.

FMLA Leave

The federal Family and Medical Leave Act ("FMLA") allows eligible employees, other than expatriates and third country nationals, to take a specific amount of unpaid leave for serious

illness, the birth or adoption of a child, to care for a spouse, child, or parent who has a serious health condition, to care for family members wounded in active duty in the Armed Forces or to deal with any qualifying emergency that arises from a family member's active duty in the Armed Forces.

If you take FMLA leave, your coverage will continue during the leave.

If you do not return to work at the end of your FMLA leave, you may be entitled to purchase COBRA continuation coverage. See the *COBRA* section of this SPD.

Military Leave

If you take a military leave of absence, whether for active duty or for training, you are entitled to continue your Medical, Dental and Vision Plan coverage for up to 24 months as long as you give the Employer advance notice of the leave (with certain exceptions). This continuation coverage is pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). Your total leave, when added to any prior periods of military leave from the Employer, cannot exceed five years (with certain exceptions).

If the entire length of the leave of absence is 31 days or longer, you may be required to pay up to 102% of the full cost of coverage.

COBRA continuation coverage will run concurrently with military leave continuation coverage, under USERRA, subject to the limitations of COBRA. This means that COBRA coverage and USERRA coverage begin at the same time. If you do not return to work at the end of your military leave you may be entitled to continue COBRA continuation coverage for the remainder of the COBRA continuation period, if any. In other words, any continuation of coverage under USERRA will reduce the maximum COBRA continuation period for which you and/or your dependents may be eligible. Your rights under COBRA and USERRA are similar but not identical. Any election that you make pursuant to COBRA will also be an election under USERRA, and COBRA and USERRA will both apply with respect to continuation coverage elected. If COBRA and USERRA give you (or your covered spouse or dependent children) different rights or protections, the law that provides the greater benefit will apply.

Other Leaves of Absence

- **Other Paid Leaves of Absence.** If you are on a paid leave of absence other than under FMLA or due to a military leave, you will continue paying your share of the cost of benefits on the same basis as for benefits that are continued during a paid FMLA leave.
- **Other Unpaid Leaves of Absence or Layoff.** If you are on an unpaid leave of absence other than under FMLA or due to a miliary leave, or on a temporary layoff, you will not be eligible to participate in the Plan during the layoff or leave unless the terms of the layoff or leave provide for continued participation. If the leave or layoff provides for continued participation, you must pay your share of the premiums to continue your coverage under the Plan. If you do not pay your portion of the premium within 31 days of the due date, your coverage under the Plan may be terminated. The termination will be retroactive to the premium due date.).

When Coverage Ends

Your coverage will terminate on the earliest of the following dates:

- The end of the month that your coverage is terminated by amendment of the Plan or termination of the insurance contract or agreement;
- The end of the month you cease to be an eligible employee. This includes your death, reduction in hours or termination of active employment;
- The end of the month you report for active military service, unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act (USERRA) as explained in the *Military Leave* section above.

Other circumstances that can result in the termination, reduction, loss or denial of benefits are described in the EOCs.

Coverage for your spouse and other dependents terminates when your coverage terminates or when they cease to be eligible dependents. Their coverage will also cease for other reasons specified in the EOCs.

For children covered pursuant to a QMCSO, coverage will end as of the date that the child is no longer covered under a QMCSO.

The Plan Administrator may also terminate any covered person's coverage for Cause. "Cause" means the covered person's willful engagement in misconduct that is materially injurious to the Plan, dishonesty by the covered person in connection with the provision of benefits under the Plan, fraudulent or unethical conduct or intentional misrepresentation of a material fact by the covered person relating to or affecting the provision of benefits under the Plan, the covered person's being indicted or charged with any crime constituting a felony or the covered person's failure to repay any amounts due and owing to the Plan or his or her Employer. Such misconduct may be subject to criminal prosecution and disciplinary action up to and including termination of employment.

Depending on the reason for termination of coverage, you and your covered spouse and dependent child(ren) might have the right to continue health coverage temporarily under COBRA (see the *COBRA* section below) or under a conversion right under a particular benefit plan. Refer to your EOCs for more information on conversion.

Retroactive Termination

In the case of medical coverage subject to the Patient Protection and Affordable Care Act (including pharmacy), the Plan Administrator may only retroactively terminate a covered person's coverage as follows:

- in the case of fraud or an intentional misrepresentation of a material fact;
- due to a failure to pay required contributions toward the cost of coverage; or
- for any purpose that is not considered a "rescission" under the Patient Protection and Affordable Care Act or any regulations or other guidance issued with respect to such Act. When required by law or regulation, the Plan Administrator will provide written notice of a rescission. The Plan may recover from you amounts it paid for services provided to you or your covered dependents after the date coverage was terminated.

COBRA

COBRA continuation coverage is a temporary extension of group health coverage under the Plan under certain circumstances (called “qualifying events”) when coverage would otherwise end. The right to COBRA coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”). COBRA coverage can become available to you when you would otherwise lose your group health coverage under the Plan. It can also become available to your spouse and dependent children who lose coverage for certain specified situations. The following paragraphs generally explain COBRA coverage, when it may become available to you and your spouse and dependent children, and what you need to do to protect the right to receive it.

COBRA applies to the Medical Plan, Dental Plan, Vision Plan, Medical Plan for Puerto Rico, medical and dental benefits provided to expatriates under the Global Benefits Plan for Expatriates and Foreign Employees and to Health Care FSAs, the Right Choice Wellness Center and the Be Well Center. COBRA does not apply to any other Employer benefits (such as Life, LTD or AD&D benefits). The Plans provide no greater COBRA rights than what COBRA requires – nothing in this Summary Plan Description is intended to expand your rights beyond COBRA’s requirements.

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.

What is COBRA Coverage

COBRA coverage is temporary continuation of group health coverage under the Plan when coverage would otherwise end because of a “qualifying event.” After a qualifying event occurs and any required notice of that event is properly provided to the Culture & People Development Representative, COBRA coverage will be offered to each person losing group health coverage under the Plan who is a “qualified beneficiary.” You, your spouse and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if group health coverage under the Plan is lost because of the qualifying event.

COBRA coverage is the same coverage that the Plan provides to other participants or beneficiaries under the Plan who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA will have the same rights under the Plan as other participants or beneficiaries covered under the Plan’s group health coverage elected by the qualified beneficiaries, including open enrollment and special enrollment rights. Under the Plan, qualified beneficiaries who elect COBRA must pay the full cost for COBRA coverage.

The pronoun “you” in the following paragraphs regarding COBRA refers to each person covered under the Plan who is or may become a qualified beneficiary.

Who Is Covered

Employees

If you are an employee of the Employer, you will have the right to elect COBRA if you lose your group health coverage under the Plan because either one of the following qualified events:

- A reduction in your hours of employment; or
- The termination of your employment (for reasons other than gross misconduct on your part).

Spouse

If you are the spouse of an employee, you will have the right to elect COBRA if you lose your group health coverage under the Plan because of any of the following qualifying events:

- The death of your spouse;
- The termination of your spouse's employment (for reasons other than your spouse's gross misconduct) or reduction in your spouse's hours of employment with the Employer; or
- Divorce from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce, and a divorce later occurs, then the divorce may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce.

Dependent Children

If you are a dependent child of an employee, you will have the right to elect COBRA if you lose your group health coverage under the Plan because any of the following qualified events happen:

- The death of the parent-employee;
- The termination of the parent-employee's employment (for reasons other than the employee's gross misconduct) or reduction in the employee's hours of employment;
- The parent-employee's divorce; or
- You, the dependent child, cease to meet the definition of a "dependent child" under the Plan.

FMLA

If you take a leave of absence that qualified under the Family and Medical Leave Act ("FMLA") and do not return to work at the end of the leave, you (and your spouse and dependent children, if any) will have the right to elect COBRA if:

- you were covered by group health coverage under the Plan on the day before the FMLA leave began (or became covered by group health coverage under the Plan during the FMLA leave); and
- you lose group health coverage under the Plan because the employee does not return to work at the end of the leave.

COBRA coverage will begin on the earliest of the following to occur:

- when you definitively inform your Employer that you are not returning at the end of the leave; or
- the end of the leave, assuming you do not return to work.

Newly Eligible Child
If a former covered employee elects COBRA coverage and then has a child (either by birth, adoption or placement for adoption) during the period of COBRA coverage, the new child is also eligible to become a qualified beneficiary. In accordance with the terms of the Plan's eligibility and other requirements for group health coverage and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage by providing notice of the new child's birth, adoption or placement for adoption. This notice must be provided within 30 days of birth, adoption or placement for adoption. The notice must be in writing and must include the name of the new qualified beneficiary, date of birth or adoption of the new qualified beneficiary and the birth certificate or adoption decree. The notice must be given to the Culture & People Development Representative.

If you fail to give appropriate notice within the 30 days, you will *not* be offered the option to elect COBRA coverage for the newly acquired child. Newly acquired dependent child(ren) (other than children born to, adopted by or placed for adoption with the employee) will not be considered qualified beneficiaries, but may be added to the employee's continuation coverage, if enrolled in a timely fashion, subject to the Plan's rules for adding a new dependent.

QMCSO
A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order ("QMCSO") received by the Employer during the covered employee's period of employment with the Employer is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

When COBRA Coverage is Available

When the qualifying event is the end of employment, reduction of hours of employment or death of the covered employee, the Plan will offer COBRA coverage to the qualified beneficiaries. You do not need to notify the Plan Administrator of any of these three qualifying events.

For a qualifying event which is a divorce of the employee and spouse or a dependent child's losing eligibility for coverage, a COBRA election will be available to you only if you notify the Culture & People Development Representative in writing within 60 days of the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event. You or a representative acting on your behalf (such as a family member) are responsible for providing the required notice.

The notice must include the following information:

- The name of the employee who is or was covered under the Plan;
- The name(s) and address(es) of all qualified beneficiary(ies) who lost (or will lose) coverage under the Plan due to the qualifying event;
- The qualifying event giving rise to COBRA coverage;
- The date of the qualifying event;
- The signature, name and contact information of the individual sending the notice.

In addition, you must provide documentation supporting the occurrence of the qualifying event, if requested. Acceptable documentation includes a copy of the divorce decree or a dependent child's birth certificate, driver's license, marriage license or letter from a university or institution indicating a change in student status.

You must mail, hand deliver or fax this notice to the Culture & People Development Representative.

If the above procedures are not followed or if the notice is not provided as discussed above within the 60-day notice period, you will lose your right to elect COBRA. In addition, if any claims are mistakenly paid for expenses incurred after the date coverage would normally be lost because of the qualifying event, you will be required to reimburse the Plan for any claims mistakenly paid.

Health Care Flexible Spending Account

COBRA coverage under a Health Care FSA will be offered only to qualified beneficiaries with "underspent" accounts. A qualified beneficiary has an underspent account if the annual contribution elected by the covered employee, reduced by reimbursements up to the time of the qualifying event, is equal to or more than the amount of contributions that will be charged for COBRA coverage under the Health Care FSA for the remainder of the plan year. COBRA coverage will consist of the coverage in force at the time of the qualifying event (i.e., the elected annual contribution reduced by expenses reimbursed up to the time of the qualifying event). COBRA coverage will terminate at the end of the plan year. Unless otherwise elected, all qualified beneficiaries who were covered under the employee's Health Care FSA will be covered together for COBRA coverage. However, each qualified beneficiary could alternatively elect separate COBRA coverage to cover that beneficiary only, with a separate Health Care FSA annual elected amount and a separate contribution.

How to Elect COBRA

An election notice will be provided to qualified beneficiaries upon the occurrence of a qualifying event. To elect COBRA coverage, you must complete the election form that is part of the Plan's COBRA election notice and mail it to Taben Group, which is the "COBRA Administrator" for the Plan. The COBRA Administrator's contact information is as follows:

Taben Group
P.O. Box 7330
Overland Park, KS 66210
(855) 576-9816
https://www.taben.com

Under federal law, you must elect COBRA coverage within 60 days from the date you would lose coverage due to a qualifying event, or, if later, 60 days after the date you are provided with the COBRA election notice from the Plan.

Your election must be postmarked within the 60-day election period. If you do not submit a completed election form within the 60-day election period, you will lose your right to COBRA.

If you return your election form waiving your rights to COBRA and change your mind within the 60-day election period, you may revoke your waiver and still elect the COBRA coverage as long as it is within the original 60-day election period. However, your COBRA coverage will be effective as of the date you revoked your waiver of coverage.

Separate Elections
Each qualified beneficiary has an independent election right for COBRA coverage. For example, even if the employee does not elect COBRA coverage, other family members who are qualified beneficiaries may elect to be covered under COBRA. Also, if there is a choice among types of coverage, each qualified beneficiary who is eligible for COBRA continuation coverage is entitled to make a separate election among the types of coverage. Thus, a spouse or dependent child may elect different coverage than the employee elects.

A covered employee or spouse can also make the COBRA election on behalf of all qualified beneficiaries and a parent or legal guardian may make the election on behalf of a minor child. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period will lose his or her right to elect COBRA coverage.

Coverage
If you elect COBRA continuation coverage, your coverage will generally be identical to coverage provided to "similarly situated" employees or family members at the time you lose coverage. However, if any changes are made to coverage for similarly situated employees or family members, your coverage will be modified as well. "Similarly situated" refers to a current employee or dependent child(ren) who has not had a qualifying event. Qualified beneficiaries on COBRA have the same enrollment and election change rights as active employees.

Medicare and Other Coverage
Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, as discussed in more detail below, a qualified beneficiary's COBRA coverage will terminate automatically if after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

When you complete the election form, you must indicate whether any qualified beneficiary has become entitled to Medicare (Part A, Part B or both) and, if so, the date of Medicare entitlement.

Cost of COBRA Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of COBRA coverage due to disability, 150 percent) of the cost to the group health plan

(including both employer and employee contributions) for coverage of a similarly-situated plan participant or beneficiary who is not receiving COBRA coverage.

The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

Your first premium is due within 45 days after you elect COBRA coverage. **If you do not make your first payment for COBRA coverage within the 45 days after the date of your timely election, you will lose all COBRA rights under the Plan.** Thereafter, payments are due by the first day of each month to which the payments apply (payments must be postmarked on or before the end of the 30-day grace period)**. If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan.**

All COBRA premiums must be paid by check or money order. Your first payment and all monthly payments for COBRA coverage must be mailed to the COBRA Administrator at the following address:

Taben Group
P.O. Box 7330
Overland Park, KS 66210
(855) 576-9816
https://www.taben.com

Your payment is considered to have been made on the date that it is postmarked. You will not be considered to have made any payment by mailing a check if your check is returned due to insufficient funds or otherwise.

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. You are responsible for making sure that the amount of your first payment is correct. You may contact the COBRA Administrator to confirm the correct amount of your first payment.

COBRA coverage is not effective until you elect it *and* make the required payment. Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

Duration of COBRA

If you lose Plan coverage because of termination of employment or reduction in hours, the law requires that you be given the opportunity to maintain COBRA coverage for a maximum of 18 months. For all other qualifying events, the law requires that you be given the opportunity to maintain COBRA coverage for a maximum of 36 months.

When Plan coverage is lost because of termination of employment or reduction in hours, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to a maximum of 36 months after the date of Medicare entitlement. This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months before termination or reduction of hours.

COBRA coverage can end before any of the above maximum periods for several reasons. See the *Early Termination of COBRA* section below for more information.

29-Month Qualifying Event (Due to Disability)

If the qualifying event that resulted in your COBRA election was the covered employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled. If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the COBRA Administrator in a timely fashion, all the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total of 29 months. The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction of hours and must last until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

To continue coverage for the additional 11 months, you or a representative acting on your behalf must give the COBRA Administrator written notice of the Social Security Administration's determination within 60 days after the latest of:

- The date of the Social Security Administration's disability determination;
- The date of the covered employee's termination of employment or reduction of hours; and
- The date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

You must also provide this notice within 18 months after the covered employee's termination or reduction of hours in order to be entitled to a disability extension. A "COBRA Event Notice" form is available from the COBRA Administrator. Your notice must include a copy of the Social Security Administration's determination of disability. You must mail this notice to the COBRA Administrator at the address listed below:

Taben Group
P.O. Box 7330
Overland Park, KS 66210
(855) 576-9816
https://www.taben.com

If the above procedures are not followed or if the notice is not provided to the COBRA Administrator within the 60-day notice period, there will be no disability extension of COBRA coverage.

If, during continued coverage, the Social Security Administration determines that the qualified beneficiary is no longer disabled, the individual must notify the COBRA Administrator of this determination within 30 days of the date it is made, and COBRA coverage will end no earlier than the first of the month that begins more than 30 days after the date of the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled. The notice must be provided in the same manner as described above for notice of disability.

Second Qualifying Event

An extension of coverage will be available to the spouse and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in case of a disability extension, the 29 months) following the covered employee's termination of employment or reduction in hours. Second qualifying events include an employee's death, divorce or a child losing dependent status (if such qualifying event would have resulted in a loss of coverage under the plan for an active employee or dependent). If you experience a second qualifying event, COBRA coverage for a spouse or dependent child can be extended from 18 months (or 29 months in case of a disability extension) to 36 months, but in no event will coverage last beyond 36 months from the initial qualifying event or the date coverage would have been lost due to the initial qualifying event.

This extension is only available if you or a representative acting on your behalf notify the COBRA Administrator in writing of the second qualifying event within 60 days after the later of: (1) the date of the second qualifying event; or (2) the date on which the qualified beneficiary would have lost coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the Plan as an active participant).

You may call the COBRA Administrator for a "COBRA Event Notice" form. You must mail this notice to the COBRA Administrator at the address listed below:

Taben Group
P.O. Box 7330
Overland Park, KS 66210
(855) 576-9816
https://www.taben.com

If the above procedures are not followed or if the notice is not provided to the COBRA Administrator within the 60-day notice period, there will be no extension of COBRA coverage due to a second qualifying event.

Trade Reform Act of 2002

The Trade Reform Act of 2002 created a special COBRA right applicable to certain employees who have been terminated or experienced a reduction of hours and who qualify for a "trade

readjustment allowance" or "alternative trade adjustment assistance." These individuals can either take a tax credit or get advance payment of a portion of the premiums paid for qualified health insurance coverage, including COBRA continuation coverage. These individuals are also entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage). This election must be made within the 60-day period that begins on the first day of the month in which the individual becomes eligible for assistance under the Trade Reform Act of 2002. However, this election may not be made more than six months after the date the individual's group health plan coverage ends. Although it is unlikely that employee of the Employer would qualify, you may contact the Employer for additional information, or you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. More information about the Trade Reform Act of 2002 is also available at http://www.doleta.gov/tradeact/2002act_index.asp

Early Termination of COBRA

The law provides that your COBRA continuation coverage may be cut short prior to the expiration of the 18-, 29-, or 36-month period for any of the following five reasons:

- The Employer no longer provides group health coverage to any of its employees;
- The premium for COBRA continuation coverage is not paid on time (within the applicable grace period);
- The qualified beneficiary first becomes covered — after the date COBRA is elected — under another group health plan (whether or not as an employee), but only after any preexisting condition exclusions of the other plan for a preexisting condition of a qualified beneficiary have been exhausted or satisfied;
- The qualified beneficiary first becomes entitled to Medicare (under Part A, Part B or both) after the date COBRA is elected; or
- Coverage has been extended for up to 29 months due to disability, and there has been a final determination made by the Social Security Administration that the individual is no longer disabled. Coverage will end no sooner than the first of the month that is more than 30 days from the date Social Security determines that the individual is no longer disabled.

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant not receiving COBRA coverage (e.g., for Cause). In addition, the Employer reserves the right to terminate your coverage retroactively in the event it determines you are not eligible for COBRA.

The Health Insurance Portability and Accountability Act (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated. However, if the other plan's pre-existing condition rule does not apply to you, the Plan may terminate your COBRA coverage.

You must notify the COBRA Administrator in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any preexisting condition exclusions have been exhausted or satisfied). COBRA coverage will terminate (retroactively, if applicable) as of the date of

Medicare entitlement or as of the beginning date of other group health coverage (after exhaustion or satisfaction of any pre-existing condition limitation). The Employer or the insurance carriers may require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide the required notice. In addition, you must notify the COBRA Administrator in writing if, during a disability extension of COBRA coverage, the Social Security Administration determines that the qualified beneficiary is no longer disabled. See *29-Month Qualifying Event (Due to Disability)* section above.

You may call the COBRA Administrator for a "COBRA Event Notice" form. You must mail this notice to the COBRA Administrator at the address listed below:

Taben Group
P.O. Box 7330
Overland Park, KS 66210
(855) 576-9816
https://www.taben.com

Contact Information

If you have any questions about COBRA coverage or the application of the law, you may contact the Culture & People Development Representative at the Employer or the COBRA Administrator.

Culture & People Development Representative at
Barry-Wehmiller Companies, Inc.:

Barry-Wehmiller Companies, Inc.
Benefits Plan Administrator
8020 Forsyth Blvd.
St. Louis, MO 63105
Phone: (314) 862-8000

COBRA Administrator:

Taben Group
P.O. Box 7330
Overland Park, KS 66210
(855) 576-9816
https://www.taben.com

You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA"). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep the COBRA Administrator and the Culture & People Development Representative informed of any changes in your and your family members' addresses. You should also keep a copy, for your records, of any notices (including a certificate of mailing) that you send to the COBRA Administrator or the Culture & People Development Representative.

Converting Coverage After Termination

If you are eligible to convert your coverage to an individual policy, you will be sent a conversion notice within the last 180 days of COBRA coverage. Contact the applicable insurance company for information on converting to an individual policy. Insurance companies will sometimes permit you to continue membership or equivalent coverage under an individual policy. Conversion rights may also be available to your spouse and/or dependent child(ren). However, the cost of conversion coverage is usually high, and conversion coverage often will not offer the same comprehensive coverage as the Plan.

For more information about conversion rights, contact the applicable insurance company.

Certificates of Coverage

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you and your spouse and dependent child(ren) who lose group health coverage must receive certification of your coverage under the Plan. You may need this certification in the event you later become covered by a new plan under a different employer or under an individual policy.

You, your spouse and dependent child(ren) will receive a coverage certificate when your Plan coverage terminates, again when COBRA coverage terminates (if applicable and if you elected COBRA) and again upon your request (if the request is made within 24 months following either termination of coverage). To request a certificate of creditable coverage, contact either the Culture & People Development Representative or the applicable insurance company. Insurance company information is listed in the *Administrative Information* section of this SPD.

You should keep a copy of the coverage certificate(s) you receive, as you may need to prove you had prior coverage when you join a new health plan. For example, if you obtain new employment and your new employer's plan has a pre-existing condition limitation (which delays coverage for conditions treated before you were eligible for the new plan), the employer may be required to reduce the duration of the limitation by one day for each day you had prior coverage (subject to certain requirements). If you are purchasing individual coverage, you may need to present the coverage certificate to your insurer at that time as well.

Covered and Non-Covered Services

Refer to the EOCs provided by your applicable insurance company or service provider for a specific listing of covered and non-covered benefits.

Special Rights for Mothers and Newborn Children

For the mother or newborn child, the Medical Plan will not restrict benefits for any hospital length of stay in connection with childbirth to less than 48 hours following a vaginal delivery, or 96 hours following a Cesarean section. However, the mother's or newborn's attending provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours, as applicable) after the delivery. In any case, no authorization is required from the Plan or an insurance company for a length of stay that does not exceed 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

The Medical Plan will provide certain coverage for benefits received in connection with a mastectomy, including reconstructive surgery following a mastectomy. This benefit applies to any covered employee or dependent, including you, your spouse, and your dependent child(ren).

If the covered person receives benefits under the Medical Plan in connection with a mastectomy and elects breast reconstruction, the coverage will be provided in a manner determined in consultation with the attending physician and the covered person. Coverage may apply to:

- 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 at all stages of the mastectomy, including lymphedemas.

Benefits for breast reconstruction are subject to annual Medical Plan deductibles and coinsurance provisions that apply to other medical and surgical benefits covered under the Medical Plan.

Claims and Appeal Process

Filing a Claim

The Plan recognizes two broad types of claims: claims for Plan benefits and requests for eligibility determinations. Claims for Plan benefits are handled by the applicable Claims Administrator, while requests for eligibility determinations are handled by the Plan Administrator.

Filing a Claim for Plan Benefits with the Claims Administrator

In general, any participant or beneficiary under the Plan (or his or her authorized representative) may file a written claim for benefits using the proper form and procedure. The procedures for filing a claim for Plan benefits are set forth in the EOCs, which are listed in Appendix A. A claimant can obtain the necessary claim forms from the Claims Administrators. When the Claims Administrator receives your claim, it will be responsible for reviewing the claim and determining how to pay it on behalf of the Plan.

In general, when you need to file a claim use the addresses listed in the EOCs, on the applicable claims form or below. When your claim is received by the Claims Administrator, it will be reviewed and the Claims Administrator will determine how to pay your claim on behalf of the Plan. Claims forms are available from the Claims Administrator.

To ensure proper filing of claims, refer to the claims filing procedures that are set forth in the EOCs. In general, any participant or beneficiary under the Plan (or his or her authorized representative) may file a written claim for benefits using the proper form and procedure.

Claims Administrators – Fully Insured

Certain benefits under the Medical Plan and benefits under the Dental (CIGNA DHMO Option), Vision, Life, AD&D, LTD, EAP and Retiree Medical (Medicare Advantage) Plans are guaranteed under contracts of insurance with the insurance companies listed below. The insurance companies administer claims for those benefits and are solely responsible for providing benefits.

Medical Plan	Blue Cross Blue Shield of Arizona P.O. Box 2924 Phoenix, AZ 85062-2924 Customer Service: (800) 232-2345
Dental Plan (CIGNA DHMO Option)	CIGNA Dental Health Central Region 6600 Campus Circle Drive East Irving, TX 75063 Customer Service: (800) 244-6224

<table>
<tr><td>Vision Plan</td><td>EyeMed Vision Care
In Network Claims (by phone): 1-866-723-0514
Out of Network Claims (by mail):
EyeMed Vision Care
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111</td></tr>
<tr><td>Life & Accidental Death and Dismemberment (“AD&D”) Plan</td><td>Lincoln Life Assurance Company of Boston
Attn: Group Life Claims
P.O. Box 7212
London, KY 40742-7212
Phone: 1-888-787-2129
Fax #: 1-603-427-1888
www.MyLincolnPortal.com</td></tr>
<tr><td>Long-Term Disability (“LTD”) Plan</td><td>Lincoln Life Assurance Company of Boston
Attn: Group Disability Claims
P.O. Box 7206
London, KY 40742
Phone: (800) 210-0268
Fax: (603) 334-0401
www.MyLincolnPortal.com</td></tr>
<tr><td>Employee Assistance Plan (“EAP”)</td><td>ComPsych
P.O. Box 8379
Chicago, IL 60680-8379
Customer Service: (800) 272-7255
http://www.guidanceresources.com</td></tr>
<tr><td>Retiree Medical (Medicare Advantage)</td><td>HealthPartners
P.O. Box 1309
Minneapolis, MN 55440-1309
Customer Service: (800) 883-2177
www.healthpartners.com</td></tr>
<tr><td>Business Travel Accident</td><td>AIG/Chartis
(877) 244-6871
Outside U.S.: +1-715-346-0859
Website: aigbenefits.com/travelassist
Email: travelassist@aigbenefits.com</td></tr>
<tr><td>Medical Plan for Puerto Rico</td><td>MCS Life Insurance Company
1-888-758-1616
www.mcs.com.pr</td></tr>
<tr><td>Vision benefit (Select Network) for Puerto Rico</td><td>EyeMed Vision Discount: 1-866-955-9316 or www.humana.com
Lasik or PRK vision – correction Provider call: 1-877-5LASERS</td></tr>
</table>

Global Benefits Plan for Expatriates and Foreign Employees	CIGNA Global Health Benefits Customer Service: (800) 441-2668 or collect (302) 797-3100 Fax: (302) 797-3150 Website: www.CignaEnvoy.com

Claims Administrators – Self-Insured

Certain benefits under the Medical Plan, and benefits under the Dental Plan (Delta Dental PPO Option), FSAs, and STD Plan are self-insured. The Employer has the fiduciary responsibility for determining whether you are entitled to benefits under these Plans. These benefits are paid out of the Employer's general assets and are not guaranteed under a contract or policy of insurance.

Medical Plan	UMR/Quantum Health, Inc. 7450 Huntington Park Drive Columbus, OH 43235 https://www.mybwbenefits.com Wellmark, Inc. 1331 Grand Avenue Des Moines, IA 50309 Customer Service: (800) 524-9242
Dental Plan (Delta Dental PPO Option)	Delta Dental of Missouri Appeals Committee 12399 Gravois Road St. Louis, MO 63127-1702 Customer Service: (800) 335-8266
Flexible Spending Accounts	Taben Flex - Navia P.O. Box 7330 Overland Park, KS 66210 (855) 576-9816 https://www.taben.com
Short-Term Disability ("STD") Plan	Lincoln Life Assurance Company of Boston Attn: Group Disability Claims P.O. Box 7206 London, KY 40742 Phone: (800) 210-0268 Fax: (603) 334-0401 www.MyLincolnPortal.com

This section provides general information about the claims and appeals procedure applicable to the Plans under ERISA that is conducted by the Claims Administrators and the named fiduciaries for the Plans. Note that state insurance laws may provide additional protection to claimants under insured arrangements and if so, those rules will apply. In the case of the Medical Plan, the Patient Protection and Affordable Care Act of 2010 and the regulations thereunder require both an internal claims procedure that is conducted by the Claims Administrator and the named fiduciary for the Medical Plan and an external review process that is conducted by federal or state authorities, as applicable. See the EOCs for more information.

Filing a Request for Eligibility Determination with the Plan Administrator

In general, any individual (or his or her authorized representative) may file a written request for eligibility determination using the proper form and procedure. A claimant can obtain the necessary forms from the Plan Administrator. When the Plan Administrator receives your request, it will be responsible for reviewing the reviewing the request and determining whether you are eligible for the Plan.

Contact the Plan Administrator as follows:

Barry-Wehmiller Companies, Inc.
Attn: Plan Administrator
8020 Forsyth Blvd.
St. Louis, MO 63105
(314) 862-8000

Claim-Related Definitions

Claim

Any request for Plan benefits made in accordance with the Plan's claims-filing procedures, including any request for a service that must be pre-approved. Either the Plan Administrator (for requests for eligibility determination) or the Claims Administrator (for claims for Plan benefits) must process each type of claim within the deadlines specific to each type of claim.

With respect to claims for Plan benefits, the Plan recognizes four categories of health benefit claims:

Urgent Care Claims

"Urgent care claims" are claims (other than post-service claims) for which the application of non-urgent care time frames could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function or, in the judgment of a physician, would subject the patient to severe pain that could not be adequately managed otherwise.

Pre-service Claims

"Pre-service claims" are claims for approval of a benefit if the approval is required to be obtained before a patient receives health care (for example, claims involving preauthorization or referral requirements).

Post-Service Claims

"Post-service claims" are claims involving the payment or reimbursement of costs for health care that has already been provided.

Concurrent Care Claims

"Concurrent care claims" are claims for which the Plan previously has approved a course of treatment over a period of time or for a specific number of treatments, and the Plan later reduces or terminates coverage for those treatments. A concurrent care claim may be treated as an "urgent care claim," "pre-service claim" or "post-service claim," depending on when during the course of your care you file the claim. However, the Plan must give you sufficient advance notice of the initial claims determination so that you may appeal the claim before a concurrent care claims determination takes effect.

Request for Eligibility Determination

A "Request for eligibility determination" is a claim whereby you ask Plan Administrator to determine whether you are in the class of individuals eligible for Plan coverage.

Adverse Benefit Determination

An "adverse benefit determination" is a denial, reduction or termination of a benefit, in whole or in part. With respect to the Medical Plan, an adverse benefit determination also includes a cancellation or discontinuance of coverage that has retroactive effect (other than a retroactive cancellation or discontinuance of coverage attributable to a failure to timely pay required premiums or contributions), whether or not there is an adverse effect on any particular benefit at the time of the rescission.

Initial Claim Determination by Claims Administrator

For each of the Plans, the Plan has a specific amount of time, by law, to evaluate and respond to claims for benefits covered by the Employee Retirement Income Security Act of 1974 ("ERISA"). The period of time the Plan has to evaluate and respond to a claim begins on the date the Plan receives the claim. If you have any questions regarding how to file or appeal a claim, contact the Claims Administrator for the benefit at issue.

The timeframes on the following pages apply to the various types of claims that you may make, and depend on the Plan and type of benefit.

In the event of an adverse benefit determination, the claimant will receive notice of the determination. The notice will include:

- The specific reasons for the adverse determination;
- The specific Plan provisions on which the determination is based;
- A request for any additional information needed to reconsider the claim and the reason this information is needed;
- A description of the Plan's review procedures (including, with respect to the Medical Plan, the external review process) and the time limits applicable to such procedures;
- A statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review;
- If any internal rules, guidelines, protocols or similar criteria were used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or

a statement that a copy of such information will be made available free of charge upon request;

- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request;
- For adverse determinations involving urgent care, a description of the expedited review process for such claims. This notice can be provided orally within the timeframe for the expedited process, as long as written notice is provided no later than 3 days after the oral notice;
- For adverse determinations involving the Medical Plan, you will be provided with sufficient information to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning; and
- For adverse determinations involving the Medical Plan, you will be provided with the denial code and its corresponding meaning, the treatment code and its corresponding meaning, and the Medical Plan's standard, if any, that was used in denying the claim.

Timeframes for Initial Claims Decisions by Claims Administrator

Timeframes generally start when the Plan receives a claim. (See the special rule for "concurrent care" decisions to limit previously-approved treatments.) Notices of benefit determinations generally may be provided through in-hand delivery, mail or electronic delivery, before the period expires, and oral notices may be permitted in limited cases. The references to "days" means calendar days.

	Medical, Dental and Flexible Spending Account Plans				**Short-Term and Long-Term Disability Plan**	**Vision, Life Insurance, AD&D and EAP Plans**
	Urgent Care Claims	***Non-Urgent "Pre-Service" Claims***	***Non-Urgent "Post-Service" Claims***	***"Concurrent Care" Decision to Reduce Benefits***		
Timeframe for Providing Notice	Notice of determination (*whether adverse or not*) must be provided by the Plan as soon as possible considering medical exigencies, but no later than 72 hours after receipt of claim (24 hours for the Medical Plan). If you request in advance to extend concurrent care, the Plan shall provide notice as soon as possible taking into account medical exigencies, but no later than 24 hours after receipt of the claim, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.	Notice of determination (*whether adverse or not*) must be provided by the Plan within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days after receipt of claim.	Notice of adverse determination must be provided within a reasonable period of time, but no later than 30 days after receipt of claim.	Notice of adverse determination must be provided by the Plan enough in advance to give you an opportunity to appeal and obtain a decision before the benefit at issue is reduced or terminated.	Notice of adverse determination must be provided by the Plan within a reasonable period of time, but no later than 45 days after receipt of claim.	Notice of adverse determination must be provided by the Plan within a reasonable period of time, but no later than 90 days after receipt of claim.

	Medical, Dental and Flexible Spending Account Plans				Short-Term and Long-Term Disability Plan	Vision, Life Insurance, AD&D, and EAP Plans
	Urgent Care Claims	*Non-Urgent Pre-Service Claims*	*Non-Urgent Post-Service Claims*	*Concurrent Care Decision to Reduce Benefits*		
Possible Extension Period to Respond to Claim	If your claim is missing information, the Plan has up to 48 hours (subject to decision being made as soon as possible) from the earlier of the Plan's receipt of the missing information, or the end of the period afforded to you to provide the missing information, to provide notice of determination.	The Plan has up to 15 days, if necessary due to matters beyond the Plan's control, and must provide extension notice before initial 15-day period ends.	The Plan has up to 15 days, if necessary due to matters beyond the Plan's control, and must provide extension notice before the initial 30-day period ends.	N/A	The Plan has up to 30 days, if necessary due to matters beyond the Plan's control. A second 30-day extension may also be permitted. The Plan must provide the extension notice before the period(s) ends.	The Plan has up to 90 days for special circumstances and must provide the extension notice before the period ends.
Period for Claimant to Complete Claim	You have a reasonable period of time to provide missing information (no less than 48 hours from when you are notified by the Plan that your claim is missing information).	You have 45 days to provide any missing information. The determination date will be tolled from the date notice of insufficiency is given, until you respond to such notice.	You have 45 days to provide any missing information. The determination date will be tolled from the date notice of insufficiency is given, until you respond to such notice.	N/A	You have 45 days to provide any missing information. The determination date will be tolled from the date notice of insufficiency is given, until you respond to such notice.	N/A
Other Related Notices	Notice that your claim is improperly filed or that information is missing must be provided by the Plan as soon as possible (no later than 24 hours after receipt of the claim by the Plan).	Notice that your claim is improperly filed must be provided by the Plan as soon as possible (no later than 5 days after receipt of the claim by the Plan).	N/A	N/A	N/A	

Appealing an Adverse Benefit Determination Issued by a Claims Administrator

If you receive notice of an adverse benefit determination and disagree with the decision, you are entitled to apply for a full and fair review of the claim and the adverse benefit determination. You (or an appointed representative) can appeal and request a claim review in accordance with the time frames described in the chart below. The request must be made in writing, except for urgent care claims which you may file orally or in writing, and should be filed with the appropriate Claims Administrator.

The Claims Administrator will forward the appeal request to the appropriate named fiduciary for review. The review will be conducted by the Claims Administrator (if serving as the reviewer for appeals) or other appropriate named fiduciary of the Plan. In either case, the reviewer will not be the same individual who made the initial adverse benefit determination that is the subject of the review, nor the subordinate of such individual (including any physicians involved in making the decision on appeal if medical judgment is involved). Where the adverse determination is based in whole or in part on a medical judgment, the reviewer will consult with an appropriate health care professional. No deference will be afforded to the initial adverse benefit determination.

You will have the opportunity to submit written comments, documents, records, and other information relating to the claim, and you will be provided, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits. With respect to the Medical Plan, you will have the opportunity to review the claim file and present evidence and testimony. In addition, with respect to the Medical Plan, if the Claims Administrator (i) considers, relies upon, or generates any new evidence in connection with your claim, or (ii) bases an appeal decision on any new or additional rationale, the Claims Administrator will provide the evidence or rationale to you, free of charge, sufficiently in advance of its decision deadline to give you a reasonable opportunity to respond before that deadline. Whether a document, record or other information is relevant to the claim will be determined in accordance with the applicable Department of Labor (DOL) regulations. You also are entitled to the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination. The review will take into account all comments, documents, records and other information submitted by the claimant relating to the claim without regard to whether such information was submitted or considered in the initial benefit determination.

The time periods for providing notice of the benefit determination on review depends on the type of claim, as provided in the chart below.

The Claims Administrator will provide you with written notification of the Plan's determination on review, within the time frames described below. For urgent care, all necessary information, including the benefit determination on review, will be transmitted between the Plan and the claimant by telephone, fax or other available similarly expeditious method. In the case of an adverse benefit determination, such notice will indicate:

- The specific reason for the adverse determination on review;
- Reference to the specific provisions of the Plan on which the determination is based;

- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits;
- A description of your right to bring a civil action under ERISA following an adverse determination on review;
- If any internal rules, guidelines, protocols or similar criteria were used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request (for health and disability claims);
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request (for health and disability claims);
- For adverse determinations involving the Medical Plan, you will be provided with sufficient information to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning; and
- For adverse determinations involving the Medical Plan, you will be provided with the denial code and its corresponding meaning, the treatment code and its corresponding meaning, the Medical Plan's standard, if any, that was used in denying the claim, and a discussion of the decision.

All decisions are final and binding unless determined to be arbitrary and capricious by a court of competent jurisdiction.

Notwithstanding the foregoing, for adverse determinations related to the Medical Plan (other than adverse determinations relating to a determination that you fail to meet the requirements for eligibility under the terms of the Medical Plan), you have the right to an external review process. In general, you are entitled to this external review process once you have fully exhausted the internal claims and appeals procedures described herein and in the applicable EOC. You are deemed to have fully exhausted the internal claims and appeals process when the Claims Administrator fails to strictly adhere to the requirements for internal claims and appeals described herein and in the applicable EOC. Further, you may be entitled to an expedited external review process if: (i) the adverse benefit determination involves a medical condition for which the timeframe for internal appeal described herein (and in the applicable EOC) would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for expedited internal review as described herein; or (ii) you have received a final adverse benefit determination and the standard external review would seriously jeopardize your life or health, would jeopardize your ability to regain maximum function, or if the final adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which you have received emergency services, but have not been discharged from a facility. For more information on the external review process, please contact the Claims Administrator for the Medical Plan.

No action shall be brought against the Plan in any court unless the claims and appeals procedures described above have been fully exhausted. A participant, beneficiary or claimant asserting any action under 29 U.S.C. § 1132, 29 U.S.C. § 1140 or any other provision of the Employee Retirement Income Security Act of 1974, as amended, shall do so, if at all, within one year after

the cause of action accrued. A cause of action shall be deemed to have accrued the earliest of (i) when the participant, beneficiary or claimant has exhausted his administrative remedies under the Plan, (ii) when the Plan Administrator fails to produce documents in the time or manner required by ERISA in response to the participant's, beneficiary's or claimant's written request, (iii) when the claimant first was advised that he was an independent contractor, (iv) the date when a Plan fiduciary has clearly repudiated the claim (even if not yet filed) and the participant, beneficiary or claimant is aware of the repudiation, or (v)when the participant, beneficiary or claimant first knew or should have known of the action allegedly violating 29 U.S.C. § 1140. Failure to bring an action in court within this time frame shall preclude a participant, beneficiary or claimant from bringing any action in court.

Any action in connection with the Plan, whether brought under 29 U.S.C. § 1132 or any other provision of ERISA, by a covered individual or beneficiary or any other person, may only be brought in a federal district court sitting within the Eastern District of Missouri.

This Plan shall be construed, administered and enforced according to the laws of Missouri except as preempted by ERISA.

Timeframes for Appeal of Adverse Benefit Determination Issued by a Claims Administrator

The appeal procedures for each Plan are set forth in the EOCs for that Plan. Where not otherwise covered by the EOCs, the following procedures will apply.

The timeframe for filing an appeal starts when you receive written notice of adverse benefit determination. The timeframe for providing a determination regarding the appeal (a "notice of benefit determination on review") starts when the appeal is filed in accordance with the Plan's procedures. The notice of benefit determination on review may be provided through in-hand delivery, mail or electronic delivery before the period expires. Urgent care decisions may have to be delivered by telephone, facsimile or other available expeditious method. References to "days" mean calendar days. The Plan can require two levels of mandatory appeal review.

	Medical & Dental Plans and Flexible Spending Account Plan			Short-Term and Long-Term Disability Plans	Life Insurance, AD&D and EAP Plans
	Urgent Care Claims*	Non-Urgent Care Pre-Service Claims*	Non-Urgent Care Post-Service Claims*		
Period for Filing Appeal	You have 180 days.	You have 180 days.	You have 180 days.	You have 180 days.	You have 60 days.
Timeframe for Providing Notice of Benefit Determination on Review	As soon as possible taking into account medical exigencies, but not later than 72 hours after receipt of request for review.	Within a reasonable period of time appropriate to medical circumstances, but not later than 30 days after receipt of request for review. If two levels of mandatory appeal review are required, notice must be provided within 15 days of each appeal.	Within a reasonable period of time, but not later than 60 days after receipt of request for review. If two levels of mandatory appeal review are required, notice must be provided within 30 days of each appeal.	Within a reasonable period of time, but not later than 45 days after receipt of request for review.	Within a reasonable period, but not later than 60 days from receipt of request for review.
Extensions	None.	None.	None.	Additional 45 days if special circumstances require extension (with period "tolled" until you respond to any information request from the Plan).	Additional 60 days if special circumstances require extension.

** An appeal of a concurrent care decision to reduce or terminate previously-approved benefits may be an urgent care, pre-service or post-service claim, depending on the facts.*

External Review Process

In the case of the Medical Plan, the Patient Protection and Affordable Care Act of 2010 and the regulations thereunder require both an internal claims procedure that is conducted by the Claims Administrator and the named fiduciary for the Medical Plan and an external review process that is conducted by federal or state authorities, as applicable. See the EOCs for more information.

Requests for Eligibility Determinations by the Plan Administrator

If you believe that you are eligible to participate in the Plan, you may file a written request for eligibility determination with the Plan Administrator. The Benefits Administrator is authorized to make the initial determination for the Plan Administrator and will respond to your request within 90 days after it is received. If the Plan Administrator determines that you are not eligible for the Plan, the denial will include the following information:

- The specific reason or reasons for the denial;
- Specific reference to pertinent Plan provisions on which the denial is based;

- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; and
- An explanation of the claim review procedure and the time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA following an adverse benefit determination on review.

If special circumstances require an extension of time beyond the initial 90-day period, prior to the end of the initial 90-day period the Plan Administrator will give you written notice of the extension, the special circumstances requiring the extension, and the date by which the Plan Administrator expects to render a final decision. In no event will an extension exceed a period of 90 days from the end of the initial 90-day period. If the Plan Administrator does not respond within the initial 90-day period or extended period, you will be deemed to have exhausted the claims and review procedures and you will be entitled to file suit.

If your claim is denied in whole or in part, you or your duly authorized representative may, within 60 days after receiving the denial:

- Make written application to the Plan Administrator for a review of the decision. Such application shall be made on a form specified by the Plan Administrator and submitted with any documentation required by the Plan Administrator;
- Review, upon request and free of charge, all documents, records and other information in the possession of the Plan Administrator which are relevant to the claim; and
- Submit written comments, documents, records and other information relating to the claim.

The following are authorized to act for the Plan Administrator in reviewing the initial decision by the Benefits Administrator: Leader, Health and Well Being; Director, Culture and People Development; and Vice President, Culture and People Development. The Plan Administrator will review all comments, documents, records, and other information you submit, without regard to whether such information was submitted or considered in the initial determination of eligibility. If you do not file an appeal within 60 days after the claim is denied, you will be deemed to have waived any right to appeal the denial of the claim.

The Plan Administrator will respond to your appeal no later than 60 days after you file your appeal. If special circumstances require an extension of time beyond the initial 60- day period, prior to the end of such initial 60-day period the Plan Administrator will provide you written notice of the extension, the special circumstances requiring the extension, and the date by which the Plan Administrator expects to render a final decision. In no event will an extension exceed a period of 60 days from the end of the initial 60-day period.

Any denial will include the specific reason or reasons for the denial, refer to the specific Plan provisions on which the denial is based, state that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim, and state that you have the right to bring a civil action under Section 502(a) of ERISA. All decisions are final and binding unless determined to be arbitrary and capricious by a court of competent jurisdiction.

No action shall be brought against the Plan in any court unless the claims and appeals procedures described above have been fully exhausted. A participant, beneficiary or claimant asserting any

action under 29 U.S.C. § 1132, 29 U.S.C. § 1140 or any other provision of the Employee Retirement Income Security Act of 1974, as amended, shall do so, if at all, within one year after the cause of action accrued. A cause of action shall be deemed to have accrued the earliest of when the participant, beneficiary or claimant has exhausted his administrative remedies under the Plan, when the Plan Administrator fails to produce documents in the time or manner required by ERISA in response to the participant's, beneficiary's or claimant's written request, when the claimant first was advised that he was an independent contractor or when the participant, beneficiary or claimant first knew or should have known of the action allegedly violating 29 U.S.C. § 1140. Failure to bring an action in court within this time frame shall preclude a participant, beneficiary or claimant from bringing any action in court.

Right of Recovery

If a covered person sustains a sickness or injury for which benefits are payable under the terms of the Plan, and a third party is or may be liable with respect to such injury or sickness (the "Third Party"), the Plan shall have the right of recovery (the "Right of Recovery"). The Plan shall have the Right of Recovery with respect to any recovery, right of recovery, claim, cause of action or other rights that any or all Interested Parties may have against a Third Party.

The term Third Party means any entity or person, including but not limited to, an insurance company (e.g., the covered person's own insurance company, in the case of uninsured or underinsured motorist coverage or no-fault automobile insurance). The term Interested Party means any person or entity who has or may have a right of recovery, claim, cause of action or other right arising out of or related to the sickness or injury (or any loss related thereto) sustained by the covered person; such term shall include, but not be limited to, the covered person's estate (or personal representative of the estate), guardian or other representative.

The Right of Recovery includes:

- the right to recover from any Interested Party all amounts the Interested Party may recover or receive from any Third Party with respect to the sickness or injury for which benefits are payable under the terms of the Plan;

- the right to reduce the amount of covered Plan benefits payable with respect to the sickness or injury, by any amount or amounts recovered by an Interested Party from a Third Party with respect to or as a result of the same sickness or injury; and

- the right of subrogation to stand in the shoes of an Interested Party and assert any right of recovery, claim or cause of action that the Interested Party may have against a Third Party arising from or related to the sickness or injury for which benefits are payable under the terms of the Plan; the Plan's right of subrogation includes the right to control absolutely the prosecution of the subrogated right of recovery, claim or cause of action, including, but not limited to, the selection of counsel.

The Plan's Right of Recovery shall be determined as follows:

- An Interested Party who receives a recovery from a Third Party shall hold the funds received in a constructive trust for the Plan and serve as a constructive trustee over the funds. The funds shall belong to the Plan and be Plan assets. Failure to hold such funds in trust will be deemed a breach of fiduciary duty to the Plan by the Interested Party. No disbursement of such funds shall be made until the Plan's Right of Recovery is fully satisfied.
- The Plan shall have a first priority lien on any full or partial recovery by an Interested Party from a Third Party. The Plan's Right of Recovery shall apply regardless of whether or not the Interested Party is made whole from the recovery against such Third Party. Any recovery amount that the Plan is entitled to shall not be reduced or prorated by or on account of the Interested Party's attorney's fees and costs. An equitable lien shall also attach to any recovery obtained by any party as a result of the Interested Party's rights resulting from the sickness or injury.

- Any full or partial recovery by an Interested Party against a Third Party shall be deemed to be recovery for Plan benefits with respect to the sickness or injury for which the Third Party is or may be liable, regardless of whether or not the judgment, award, formal or informal settlement, contract or any other payment of any kind itemizes or identifies an amount awarded for Plan benefits or is specifically limited to certain kinds of damages or payments; an Interested Party may not avoid or circumvent the Plan's Right of Recovery because of the way in which the recovery from a Third Party is characterized. By way of example, the Plan shall have a Right of Recovery even if an Interested Party's recovery from a Third Party is described as a recovery for pain and suffering, loss of consortium, emotional distress, punitive damages, damages for vexatious refusal to pay, attorneys' fees or medical expenses.

- The Plan Administrator, in its sole and absolute discretion, may agree to treat a lesser percentage of an Interested Party's recovery from a Third Party as attributable to Plan benefits. The amount so determined shall be binding on the Plan and the Interested Party as the amount of Plan benefits to which the Plan has the Right of Recovery.

The Plan Administrator, in its sole and absolute discretion, may agree to waive the Plan's Right of Recovery. The Plan's waiver of its Right of Recovery with respect to one claim shall not constitute a waiver of its Right of Recovery with respect to another claim; and the Plan's waiver of its Right of Recovery with respect to one Interested Party shall not constitute a waiver of its Right of Recovery with respect to another Interested Party.

If the Plan has a Right of Recovery, the Plan shall not be obligated to pay any Plan benefits with respect to the covered person's sickness or injury until all of the following conditions are fulfilled to the complete satisfaction of the Plan Administrator in its sole and absolute discretion.

- If the Plan Administrator desires to assert the Plan's right of subrogation, all Interested Parties (or someone legally qualified and authorized to act for an Interested Party) must sign all documents required by the Plan Administrator to assert such right.

- If the Plan Administrator, in its sole and absolute discretion, decides not to assert the Plan's right of subrogation, all Interested Parties (or someone legally qualified and authorized to act for an Interested Party) shall agree in writing to the following conditions:

  (i) The Interested Party shall agree to include Plan benefits in any claim or cause of action the Interested Party makes against a Third Party for the sickness or injury (or any loss related thereto);

  (ii) The Interested Party shall agree that the Plan has an absolute Right of Recovery and a first priority lien upon any recovery made by the Interested Party related to the sickness or injury for which Plan benefits have or will be paid; and

  (iii) The Interested Party shall agree not to settle a claim against a Third Party without prior written consent of the Plan Administrator.

- All Interested Parties (or someone legally qualified and authorized to act for an Interested Party) shall agree in writing to cooperate fully with the Plan in asserting and protecting its Right of Recovery, supply the Plan Administrator with any and all information necessary to assert and protect such Right of Recovery, and execute and deliver any and all instruments and papers in their original form.

The Plan Administrator, in its sole and absolute discretion, may suspend payment of Plan benefits if any Interested Party has not executed or is not in compliance with the terms of any required written agreement. Payment of benefits pursuant to the Plan before any required written agreement is obtained, or while an Interested Party is not in compliance with the terms of such a written agreement, shall not constitute a waiver by the Plan of its Right of Recovery. Violation of any required written agreement shall be a violation of the terms of the Plan document.

An Interested Party shall notify the Plan Administrator, in writing, whenever a sickness or injury arises that provides or may provide the Plan a Right of Recovery. The Plan shall be entitled to recover its attorney's fees and costs from an Interested Party if the Plan takes legal action against the Interested Party to enforce its reimbursement rights.

Recovery of Overpayment

Whenever payments have been made exceeding the amount necessary to satisfy the provisions of the Plan, the Plan has the right to recover overpayments from any individual (including you, an insurance company or any other organization receiving excess payments). The Plan may also withhold payment, if necessary, on future benefits until the overpayment is recovered. In addition, whenever payments have been made based on fraudulent information provided by you, the Plan will exercise the right to withhold payment on future benefits until the overpayment is recovered.

Non-assignment of Benefits

Plan participants cannot assign, pledge, borrow against or otherwise promise any benefit payable under the Plan before receipt of that benefit. Subject to the written direction of a Plan participant, all or a portion of benefits provided by the Plan may, at the option of the Plan, and unless a participant requests otherwise in writing, be paid directly to the person rendering such service. Any payment made by the Plan in good faith pursuant to this provision shall fully discharge the Plan and the Employer to the extent of such payment.

Misstatement of Fact

In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

Administrative Information

Below is key information you need to know about your benefit plans:

Plan Name	Barry-Wehmiller Companies, Inc. Welfare Benefit Plan

Plan Number	501
Plan Sponsor	Barry-Wehmiller Companies, Inc. 8020 Forsyth Blvd. St. Louis, MO 63105 (314) 862-8000
Employer Identification Number	43-0172560
Plan Administrator	Barry-Wehmiller Companies, Inc. 8020 Forsyth Blvd. St. Louis, MO 63105 (314) 862-8000 Except for requests for eligibility determinations, the Plan Administrator for the insured benefits is the Claims Administrator listed below for each such benefit.
Agent for Service of Legal Process	Plan Administrator
Plan Year	January 1 through December 31
Plan Type and Funding	Welfare benefit plan providing the following types of benefits: ▪ Medical-Self-Insured & Insurance ▪ Dental–Self-Insured & Insurance ▪ Vision- Insurance ▪ Short-Term Disability (“STD”)- Self-Funded ▪ Long-Term Disability (“LTD”)- Insurance ▪ Life Insurance ▪ Accidental Death and Dismemberment (“AD&D”) Insurance ▪ Health Care Flexible Spending Accounts and Dependent Care Flexible Spending Accounts ▪ Employee Assistance Plan (“EAP”) Insurance ▪ Business Travel Accident-Insurance ▪ Medical (Puerto Rico)-Insurance ▪ Medical, Dental, Life and Disability for Expatriates and Foreign Employees-Insurance ▪ Right Choice Wellness Center – Self-Insured ▪ Be Well Center – Self-Insured ▪ Best Doctors – Self-Insured
Source of Contributions	The Employer and employees will share the cost of coverage, and current employees will pay their share of that cost on a pre-tax basis under a cafeteria plan.

	Employees who participate in a Medical Plan option with a Health Savings Account ("HSA") may make contributions to the HSA in addition to any contributions made by the Employer. Employees who elect FSAs are responsible for the full cost of such coverage. The Employer makes no contributions to FSAs. The Employer reserves the right to require or increase employee contributions at any time and for any reason.
Claims Administrators	**Medical Plan (Self-Funded)** UMR/Quantum Health, Inc. 7450 Huntington Park Drive Columbus, OH 43235 https://www.mybwbenefits.com Wellmark, Inc. 1331 Grand Avenue Des Moines, IA 50309 Customer Service: (800) 524-9242 **Medical Plan (Insurance)** Blue Cross Blue Shield of Arizona P.O. Box 2924 Phoenix, AZ 85062-2924 Customer Service: (800) 232-2345 **Retiree Medical (Medicare Advantage)** HealthPartners P.O. Box 1309 Minneapolis, MN 55440-1309 Customer Service: (800) 883-2177 www.healthpartners.com **Dental Plan – Delta Dental PPO Option** Delta Dental of Missouri Appeals Committee 12399 Gravois Road St. Louis, MO 63127-1702 Customer Service: (800) 335-8266 **Dental Plan – CIGNA DHMO Option** CIGNA Dental Health Central Region

	6600 Campus Circle Drive East Irving, TX 75063 Customer Service: (800) 244-6224 **Vision Plan Insurance** EyeMed Vision Care P.O. Box 8504 Mason, OH 45040-7111 Call Center: (866) 723-0514 **Short-Term Disability (Self-Funded)** Lincoln Life Assurance Company of Boston Attn: Group Disability Claims P.O. Box 7206 London, KY 40742 Phone: (800) 210-0268 Fax: (603) 334-0401 www.MyLincolnPortal.com **Long-Term Disability Insurance** Lincoln Life Assurance Company of Boston Attn: Group Disability Claims P.O. Box 7206 London, KY 40742 Phone: (800) 210-0268 Fax: (603) 334-0401 www.MyLincolnPortal.com **Life & AD&D Insurance** Lincoln Life Assurance Company of Boston Attn: Group Life Claims P.O. Box 7212 London, KY 40742-7212 Phone: 1-888-787-2129 Fax #: 1-603-427-1888 www.MyLincolnPortal.com **Flexible Spending Accounts** Taben Flex - Navia P.O. Box 7330 Overland Park, KS 66210 (855) 576-9816 https://www.taben.com

	Business Travel Accident AIG/Chartis (877) 244-6871 Outside U.S.: +1-715-346-0859 Website: aigbenefits.com/travelassist Email: travelassist@aigbenefits.com **Medical (Puerto Rico)** MCS Life Insurance Company 1-888-758-1616 www.mcs.com.pr **Medical, Dental, Life and LTD for Expatriates and Foreign Employees** CIGNA Global Health Benefits Customer Service: (800) 441-2668 or collect (302) 797-3100 Fax: (302) 797-3150 Website: www.CignaEnvoy.com
COBRA Administrator	Taben Group P.O. Box 7330 Overland Park, KS 66210 (855) 576-9816 https://www.taben.com

Plan Document

This document is intended merely as a summary of the official Plan document(s). In the event of any disagreement between this summary and the official Plan document(s), as they may be amended from time to time, the provisions of the Plan document(s) will govern.

Plan Amendment and Termination

The Employer reserves the right to amend or terminate the Plan, in whole or in part, for any purpose and at any time. For example, the Employer reserves the right to amend or terminate benefits, covered expenses, benefit copays lifetime maximums, and reserves the right to amend the Plan to require or increase employee contributions. The Employer also reserves the right to amend the Plan to implement any cost control measures that it may deem advisable. Any amendment, termination or other action by the Employer will be done in accordance with the Employer's normal operating procedures.

Plan Administration

The Sponsor is responsible for the general administration of the Plan, and will be the fiduciary to the extent not otherwise specified in this SPD, the Plan document or in an EOC.

The Sponsor may designate other organizations or persons to carry out specific fiduciary responsibilities for the Sponsor in administering the Plan including, but not limited to, the following:

- Pursuant to an administrative services or claims administration agreement, if any, the responsibility for administering and managing the Plan, including the processing and payment of claims under the Plan and the related recordkeeping,
- The responsibility to prepare, report, file and disclose any forms, documents and other information required to be reported and filed by law with any governmental agency, or to be prepared and disclosed to employees or other persons entitled to benefits under the Plan, and
- The responsibility to act as Claims Administrator and to review claims and claim denials under the Plan to the extent an insurer or administrator is not empowered with such responsibility.

The Plan Administrator will administer the Plan on a reasonable and nondiscriminatory basis and shall apply uniform rules to all persons similarly situated.

The Plan Administrator shall perform its duties as the Plan Administrator in its sole discretion, and shall determine what is appropriate in light of the reason and purpose for which the Plan is established and maintained. In particular, the interpretation of all Plan provisions, and the determination of whether a Participant or Beneficiary is entitled to any benefit pursuant to the terms of the Plan, shall be exercised by the Plan Administrator in its sole discretion. Any construction of the terms of the Plan for which there is a rational basis that is adopted by the Plan Administrator shall be final and legally binding on all parties.

Any interpretation of the Plan or other action of the Plan Administrator made in good faith in its sole discretion shall be subject to review only if such an interpretation or other action is without a rational basis. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of the review. Any employer that adopts and maintains the Plan, and any employee who performs services for an employer that are or may be compensated for in part by benefits payable pursuant to the Plan, hereby consents to actions of the Plan Administrator made in its sole discretion and agrees to this narrow standard of review.

Power and Authority of the Insurance Company

As described above, some Plan benefit options under a component plan are fully insured. Benefits may be provided under a group insurance contract entered into between the Sponsor and an insurance company. With respect to fully insured benefits, claims for benefits are sent to the insurance company. The insurance company is the fiduciary with respect to these claims and responsible for paying claims, not the Sponsor.

The insurance company is responsible for:

- Determining eligibility for and the amount of any benefits payable under the Plan.
- Prescribing claims procedures to be followed and the claim forms to be used by employees and beneficiaries pursuant to the Plan.

The insurance company also has the authority to require employees and beneficiaries to furnish it with such information as it determines is necessary for the proper administration of the Plan.

Questions

If you have general questions regarding the Plan, please contact the Plan Administrator. However, if you have questions concerning eligibility for and/or the amount of benefits payable under the Plan, please refer to your EOCs or contact the applicable Claims Administrator. If you have an ID card for a Plan, you may also use the contact information on the back of that card.

Statement of ERISA Rights

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 you, and all other participants, shall be entitled to:

Receive Information about Your Plan and Benefits

You can:

- Review at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, insurance contracts, EOCs and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, on written request to the Plan Administrator, copies of documents governing the operation of the Plan, including EOCs and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if any is required to be prepared under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of any required summary annual report (SAR).

Continue Group Health Plan Coverage

You may continue health care coverage for yourself, spouse and/or dependent child(ren) if there is a loss of coverage under the Plan because 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 for the rules governing your COBRA continuation coverage rights.

You may be eligible for a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan if you have creditable coverage from another plan. If you request one before losing coverage, or up to 24 months after losing coverage, the Plan should provide you with a certificate of creditable coverage, free of charge when:

- You lose coverage under the Plan,
- You become entitled to elect COBRA continuation coverage, or
- Your COBRA continuation coverage ceases.

Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after you enroll in a plan that imposes a pre-existing condition exclusion.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties on 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 welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (if any) 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 suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

If 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 (formerly the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or:

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 — Evidence of Coverage Documents

This summary should be read in combination with the insurance contracts, evidence of coverage documents (together and individually referred to as “EOCs”) provided by the insurance companies and service providers.

The EOCs are intended to describe the Employer benefits available to you and, when read in conjunction with this SPD, are intended to meet ERISA’s SPD requirements.

Please see the EOCs for details of Plan benefits.

For additional information or for copies of the EOCs, please contact the Plan Administrator.

Coverage	Evidence of Coverage Name
Medical	**Medical Plan (Self-Funded)** UMR/Quantum Health, Inc. Benefit/Certificate of Coverage Barry-Wehmiller Companies, Inc. Group ID ________ Wellmark, Inc. 1331 Grand Avenue Des Moines, IA 50309 Group ID ________ **Medical Plan (Insurance)** Blue Cross Blue Shield of Arizona P.O. Box 2924 Phoenix, AZ 85062-2924 Customer Service: (800) 232-2345 **Retiree Medical (Medicare Advantage)** Health Partners Freedom Group Plan Retiree Medicare Advantage Barry-Wehmiller Companies, Inc. Group ID: 60826
Dental	**Dental Plan (Self-Funded)** Delta Dental of Missouri Delta Dental PPO Dentacare M – ASC Barry-Wehmiller Companies, Inc. Group Number: 7698-0001 & all sub-locations **Dental Plan (Insurance)** Connecticut General Life Insurance Company CIGNA Dental Care Insurance Prepaid Dental Services Certificate Barry-Wehmiller Companies, Inc. Group ID: 3207784-DHMO1
Vision	EyeMed Vision Care

	Barry Wehmiller-Companies, Inc. Contract ID: 9793316
Short-Term Disability (STD)	Lincoln Life Assurance Company of Boston Barry-Wehmiller Companies, Inc. Group ID: 04-444087
Long-Term Disability (LTD)	Lincoln Life Assurance Company of Boston Barry-Wehmiller Companies, Inc. Group ID: 04-444087
Life Insurance **Accidental Death and Dismemberment (AD&D)** **Dependent Life Insurance**	Lincoln Life Assurance Company of Boston Barry-Wehmiller Companies, Inc. Group ID: 04-444087
Flexible Spending Accounts	Taben Flex - Navia Barry-Wehmiller Companies, Inc. Flexible Spending Account Plan Summary Plan Description Group ID: _____
Business Travel Accident	AIG/Chartis Barry-Wehmiller Companies Inc. Group ID: GTP 0009112715A
Medical Plan for Puerto Rico	MCS Life Insurance Company 1-888-758-1616 www.mcs.com.pr
Global Benefits for Expatriates and Foreign Employees	CIGNA Barry-Wehmiller Companies, Inc. Group ID: 05908A
Best Doctors	Best Doctors 1250 Hancock St. Suite 501N Quincy, MA 02169

Appendix B — Waiting Period

This summary should be read in combination with the insurance contracts, evidence of coverage documents (together and individually referred to as "EOCs") provided by the insurance companies and service providers.

Temporary Employees. If you are hired on or after January 1, 2015, you are classified as a temporary employee, and you are expected to work on average at least 30 hours or more per week, you are required to complete a ninety (90) day waiting period prior to becoming eligible to participate in the Plans. Once you have completed the ninety (90) day waiting period, you will remain eligible to participate in the Plans even if your average weekly work schedule falls below 30 hours per week.

A temporary employee who terminates employment with the Employer and resumes employment within three hundred sixty-five (365) days after such termination shall be eligible to participate in the Plans on his or her rehire date. A temporary employee who terminates employment with the Employer and resumes employment more than three hundred sixty-five (365) days after such termination will be treated as a new hire and will be required to satisfy the ninety (90) day waiting period prior to becoming eligible to participate in the Plans.

Appendix C — Be Well Center, Green Bay Wisconsin

Scope of Services. The services listed are available to eligible employees of Paper Converting Machine Company or the Hudson-Sharp location in Green Bay, Wisconsin at the Be Well Cent. All services are provided to eligible employees at the location and times periodically set for the Be Well Center

1. Nurse Practitioner Services. Nurse Practitioner Services will include the following:

    - Adult vaccinations for: tetanus, diphtheria, pertussis, Hepatitis B, and influenza
    - Routine screenings of blood sugars, lipids, weight, and blood pressure
    - Rapid screen diagnostic tests for strep, pregnancy, and urine
    - Routine diagnosis and treatment of non-trauma workplace and non-workplace illness and injuries
    - Department of Transportation (DOT) examinations
    - Non DOT drug and alcohol screening, including pre-employment, post-accident, random, and reasonable suspicion testing
    - Health Risk Appraisals
    - Early detection, treatment, and prevention
    - Healthcare counseling
    - Physical exams, including camp and school physicals
    - Audiometric Screenings
    - DOT Drug and Alcohol Testing (to be considered when feasible)
    - School physicals
    - First Aid Responder training assistance
    - Participate in Safety and Health Committee Meetings
    - Facilitate education sessions on-site
    - Pulmonary testing (if such testing may be performed on-site)
    - International travel exams and vaccinations
    - Patient advocacy assistance
    - Acute and Urgent Care for children ages two (2) and up.
    - Well-child checks for children ages seven (7) and up.

2. Medical Assistant (MA)/Patient Support Representative (PSR) Services. Medical Assistant Services will include the following:

    - Room patients
    - Assist with office procedures
    - Provide telephone advice to patients as directed
    - Communicate with providers regarding patient calls
    - Call in prescription refills as directed
    - Act as a liaison for nurse practitioners
    - Assist physicians and/or practitioners with scheduling
    - Facilitate completion of forms (ex. W/C, insurance, etc. by the physicians)
    - Blood draw (phlebotomy)

3. Laboratory Services. Laboratory Services as set forth in the Health and Wellness Healthcare Services Agreement by and between Prevea Health and Barry-Wehmiller Companies, Inc.

Appendix D — Right Choice Wellness Center, Sheboygan, Wisconsin

This summary should be read in combination with benefit summaries provided to employees with respect to the Be Well Center.

Scope of Services The services listed are available to eligible employees of Will-Pemco, Inc. at the Be Well Center in Sheboygan, Wisconsin. All services are provided to eligible employees at the location and times periodically set for the Right Choice Wellness Center

1. Preventive Care
2. Diagnosis & medical care
    - Treatment and management or chronic conditions, e.g. diabetes, hypertension.
    - Lab work including rapid screen diagnostic tests.
    - Diagnosis and treatment of non-trauma workplace injuries
3. Wellness Services
    - Physical exams
    - Health screenings
    - Skin screening
    - TB testing
    - Adult immunizations
    - Adult flu shots
    - Cholesterol screening
    - Diabetes screening

Appendix E — Special Component Plan Exclusion

This summary should be read in combination with the insurance contracts, evidence of coverage documents (together and individually referred to as "EOCs") provided by the insurance companies and service providers.

Medical Plan for Puerto Rico

Eligibility is limited to employees employed in Puerto Rico who otherwise satisfy the eligibility requirements. Such employees cannot participate in the Medical Plan covering U.S.-based employees.

Global Benefit Plan for Expatriates and Foreign Employees

Eligibility is limited to employees who are expatriates or third country nationals and who otherwise satisfy the eligibility requirements. Such employees cannot participate in the Medical Plan or any other welfare benefit plans covering U.S.-based employees.

Be Well Center, Green Bay, Wisconsin

Eligibility is limited to employees of the Paper Converting Machine Company and the Hudson-Sharp locations in Green Bay, Wisconsin, employees working at these locations, and eligible dependents of such employees. Only dependents aged 2 and over may receive services at the Be Well Center.

Right Choice Wellness Center.

Eligibility is limited to employees of Will-Pemco, Inc., employees working at this location, and eligible dependents of such employees.