AMENDMENT NO. 2

to the Summary Plan Description of the

ANVIL CORPORATION HEALTH BENEFIT PLAN
PPO and Traditional SPD's

The Summary Plan Description effective 01/01/2025 is amended effective 01/01/2026, as follows:

Throughout the **Traditional SPD** all references to **Traditional** will be revised to show **PPO-AK.**

Within the **PPO Schedule of Benefits,** revise the **Deductibles and Out of Pocket Maximums** as follows:

	Preferred Network	Participating Network	Out-of-Network
INDIVIDUAL DEDUCTIBLE Per calendar year.	$1,000	$1,000	$2,000
FAMILY DEDUCTIBLE Per calendar year.	$2,500	$2,500	$5,000
INDIVIDUAL OUT-OF-POCKET MAXIMUM Per calendar year.	$3,000	$3,000	$5,000
FAMILY OUT-OF-POCKET MAXIMUM Per calendar year.	$6,000	$6,000	$10,000

Within the **PPO-AK Schedule of Benefits,** revise the **Deductibles and Out of Pocket Maximums** as follows:

	Preferred Network	Participating Network	Out-of-Network
INDIVIDUAL DEDUCTIBLE Per calendar year.	$1,000	$1,000	$1,000
FAMILY DEDUCTIBLE Per calendar year.	$2,500	$2,500	$2,500
INDIVIDUAL OUT-OF-POCKET MAXIMUM Per calendar year.	$3,000	$3,000	$5,000
FAMILY OUT-OF-POCKET MAXIMUM Per calendar year.	$6,000	$6,000	$10,000

Within the **PPO Schedule of Benefits,** revise the **Deductible Accumulation** as follows:

Delete:
Your deductibles accumulate as a single amount. This means that you have one deductible amount for Preferred, Participating, and Out-of-Network services combined.

Add:
Amounts credited to your deductibles are combined for Preferred and Participating Network, however, Out-of-Network is not combined with your Preferred and Participating eligible expenses. The Out-of-Network deductible must be satisfied separately.

Within the **PPO Schedule of Benefits,** revise the **Office Visit** benefit as follows:

PHYSICIAN SERVICES			
Office Visits – Primary Care Provider Included General Practice, OB/GYN, Internal Medicine, Pediatrics, Family Practice, Naturopathy, Nurse Practitioner, Nurse Midwife, Doctor of Osteopathic Medicine, and Physician's Assistants.	$25 copay, then 100% deductible waived	60%	60%
Office Visits – Specialist	$40 copay, then 100% deductible waived	60%	60%

Within the **PPO-AK Schedule of Benefits,** revise the **Office Visit** benefit as follows:

PHYSICIAN SERVICES			
Office Visits – Primary Care Provider Included General Practice, OB/GYN, Internal Medicine, Pediatrics, Family Practice, Naturopathy, Nurse Practitioner, Nurse Midwife, Doctor of Osteopathic Medicine, and Physician's Assistants.	$25 copay, then 100% deductible waived	$25 copay, then 100% deductible waived	$25 copay, then 100% deductible waived
Office Visits – Specialist	$40 copay, then 100% deductible waived	$40 copay, then 100% deductible waived	$40 copay, then 100% deductible waived

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Within the **PPO Schedule of Benefits,** revise the **Emergency Room** benefit as follows:

EMERGENCY ROOM & SERVICES Out-of-Network services are payable at 250% of the Medicare allowable. Services received from an Out-of-Network provider will be applied to the Preferred Network deductible and out-of-pocket maximum.	$250 Copay, then 80%	$250 Copay, then 80%	$250 Copay, then 80%

Within the **PPO-AK Schedule of Benefits,** revise the **Emergency Room** benefit as follows:

EMERGENCY ROOM & SERVICES Out-of-Network services are payable at 250% of the Medicare allowable. Services received from an Out-of-Network provider will be applied to the Preferred Network out-of-pocket maximum.	$250 Copay, then 80%	$250 Copay, then 80%	$250 Copay, then 80%

Within the **PPO Schedule of Benefits,** revise the **Outpatient Mental Health Services** benefit as follows:

MENTAL HEALTH SERVICES			
Outpatient	$25 copay, then 100% deductible waived	60%	60%
Applied Behavioral Analysis Services received from an Out-of-Network provider will be applied to the Preferred Network out-of-pocket maximum.	$25 copay, then 100% deductible waived	$25 copay, then 100% deductible waived	$25 copay, then 100% deductible waived

Within the **PPO-AK Schedule of Benefits,** revise the **Outpatient Mental Health Services** benefit as follows:

MENTAL HEALTH SERVICES			
Outpatient	$25 copay, then 100% deductible waived	$25 copay, then 100% deductible waived	$25 copay, then 100% deductible waived
Applied Behavioral Analysis Services received from an Out-of-Network provider will be applied to the Preferred Network out-of-pocket maximum.	$25 copay, then 100% deductible waived	$25 copay, then 100% deductible waived	$25 copay, then 100% deductible waived

Within the **PPO Schedule of Benefits,** revise the **Second Surgical Opinion** benefit as follows:

SECOND SURGICAL OPINION	$40 copay, then 100% deductible waived	60%	60%

Within the **PPO-AK Schedule of Benefits,** revise the **Second Surgical Opinion** benefit as follows:

SECOND SURGICAL OPINION	$40 copay, then 100% deductible waived	$40 copay, then 100% deductible waived	$40 copay, then 100% deductible waived

Within the **PPO Schedule of Benefits,** revise the **Outpatient Substance Use Disorder Services** benefit as follows:

SUBSTANCE USE DISORDER SERVICES			
Outpatient	$25 copay, then 100% deductible waived	60%	60%

Within the **PPO-AK Schedule of Benefits,** revise the **Outpatient Substance Use Disorder Services** benefit as follows:

SUBSTANCE USE DISORDER SERVICES			
Outpatient	$25 copay, then 100% deductible waived	$25 copay, then 100% deductible waived	$25 copay, then 100% deductible waived

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Within the **PPO Schedule of Benefits,** revise the **Urgent Care Facility** benefit as follows:

URGENT CARE FACILITY	$40 copay, then 100% deductible waived	$40 copay, then 100% deductible waived	60%

Within the **PPO-AK Schedule of Benefits,** revise the **Urgent Care Facility** benefit as follows:

URGENT CARE FACILITY	$40 copay, then 100% deductible waived	$40 copay, then 100% deductible waived	80%

Within the **Comprehensive Major Medical Benefits,** under **Maternity Services,** delete the bullet point for **Doula Support Services**:

Delete:
MATERNITY SERVICES

- Doula support services.

Within the **General Exclusions to the Medical Plan,** add an exclusion for **Doulas** as follows:

Doulas - Charges for services provided by a birth doula.

Within the **General Exclusions to the Medical Plan,** revise the **Cosmetic and Reconstructive Surgery** exclusion as follows:

Cosmetic and Reconstructive Surgery - Cosmetic surgery or related medical facility admissions are excluded, unless made necessary due to one or more of the following:

1. When authorized for an illness or injury that is a covered benefit under this Plan, except as excluded herein.
2. Except as specifically excluded by this Plan, for correction of congenital anomalies when medically necessary.
3. If you are receiving benefits for a medically necessary mastectomy and elect breast reconstruction after the mastectomy, you will also receive coverage for:
    - Reconstruction of the breast on which the mastectomy has been performed
    - Surgery and reconstruction of the other breast to produce a symmetrical appearance
    - Prostheses
    - Treatment of physical complications of all stages of mastectomy, including lymphedemas
    - Areola tattooing

    This reconstructive surgery coverage will be provided in consultation with your attending physician/provider and yourself, and will be subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

Within the **Comprehensive Major Medical Benefits,** revise the **Contraceptive Services** benefit as follows:

CONTRACEPTIVE SERVICES

Benefits will be provided for consultations, counseling, all contraceptive methods which require a prescription and have been approved by the United States Food and Drug Administration (FDA), software applications with FDA approval, and Participant education. Benefits are also provided for insertion and removal of intrauterine devices and implants.

This benefit does not cover contraceptives that can be purchased without a prescription, such as condoms, sponges, or contraceptive foam or jelly. All other FDA-approved contraceptive methods, including over-the-counter methods for which the method is both FDA-approved and prescribed for a woman by her health care provider, are covered under the Prescription Drug Benefits section of the Plan.

Within the **Schedule of Benefits,** following the **Deductible and Out-of-Pocket Maximum** section, add the following:

Please note: Member cost sharing, including deductibles and out-of-pocket maximums, may fluctuate throughout the calendar year due to various factors, including but not limited to, claim adjustments. The point in time satisfaction of a specific cost-share is not a guarantee that those amounts will remain satisfied for the duration of the plan year. If you have questions on your accumulators, please contact the RGA Customer Care team.

Within the **Schedule of Benefits,** replace the **Dental Accident** benefit with the following:

DENTAL SERVICES			
Dental Accident	Paid the same as any other condition	Paid the same as any other condition	Paid the same as any other condition
Dental Anesthesia and Surgery	Paid the same as any other condition	Paid the same as any other condition	Paid the same as any other condition
Dental Hospitalization	Paid the same as any other condition	Paid the same as any other condition	Paid the same as any other condition

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Within the **Comprehensive Major Medical Benefits,** add/revise **Dental Services** benefits as follows:

DENTAL SERVICES

Dental services provided by a dentist, oral surgeon, or physician/provider, including all related medical facility inpatient or outpatient charges, including an outpatient surgical center, for only the following:

- Treatment for accidental injuries to natural teeth. Treatment for up to 12 months from the date of the accident for accidental injuries is provided under this Plan. Injuries caused by biting or chewing are not covered under the medical plan.
- Treatment to excise and/or biopsy suspected lesions, excised confirmed tumors or malignancies of the oral cavity, tongue, or jaw; when performed by a provider who is acting within the scope of their license, whether done in a dental office or hospital.
- Benefits for anesthesia for dental services are covered the same as relevant services listed on your Schedule of Benefits. Services must be prior authorized by the Plan and are only provided for Participants with complicating medical conditions. Examples of these conditions include, but are not limited to:
    - Mental handicaps.
    - Physical disabilities.
    - A combination of medical conditions or disabilities that cannot be managed safely and efficiently in a dental office.
    - Emotionally unstable, uncooperative, combative Participants where treatment is extensive and impossible to accomplish in the office.

All other dental services are excluded.

Within the **General Exclusions to the Medical Plan,** revise the **Dental** exclusion as follows:

Dental - Dental services including treatment of the mouth, gums, teeth, mouth tissues, jawbones or attached muscle, orthodontic appliances, dentures and any service generally recognized as dental work. Hospital and physician services rendered in connection with dental procedures are only covered if adequate treatment cannot be rendered without the use of hospital facilities or if you have a medical condition besides the one requiring dental care that makes hospital care medically necessary. The only exceptions to this exclusion

are the services and supplies covered under the Dental Services Benefit or if treatment is necessary due to a malignant tumor.

Within the **General Exclusions to the Medical Plan,** revise the **Education or Training Services** exclusion as follows:

Education or Training Services - Education or training services or supplies for vocational assistance and outreach; job training or other education or training services; except as provided herein..

Within the **General Exclusions to the Medical Plan,** revise the **Mental Health and Substance Use Disorder Services** exclusion as follows:

Mental Health and Substance Use Disorder Services - Charges are not covered for the following:

1. Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
2. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act.
3. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Plan.
4. All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
5. Educational or correctional services or sheltered living provided by a school or halfway house, including any academic component of treatment; however, you may receive covered outpatient services while living temporarily in a sheltered living situation.
6. A court-required screening interview or treatment program unless determined to be medically necessary.
7. Support groups, including Alcoholics Anonymous or similar programs.
8. Personal items.
9. Custodial care or long-term care.
10. Investigational therapies, including wilderness or outdoor treatment programs.
11. Tobacco cessation programs are not covered under the Mental Health and Substance Use Disorder benefit, please see the Tobacco Cessation benefit for coverage. This exclusion does not apply to preventive and wellness services as specified by the Affordable Care Act (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations).
12. Treatment of gender dysphoria.

Within the **General Exclusions to the Medical Plan,** remove the **Training** exclusion:

Delete:
Training - Services or supplies for learning disabilities; vocational assistance and outreach; job training or other education or training services; except as provided herein.

Within the **Comprehensive Major Medical Benefits** section, under **Rehabilitative Services,** revise the **Exclusions** as follows:

No benefits will be provided for the following inpatient or outpatient services:

- Custodial care.
- Maintenance, non-medical self-help, recreational, educational, or vocational therapy.
- Psychiatric care *(see the Mental Health and Substance Use Disorder Services benefit for coverage)*.
- Chemical dependency/substance use rehabilitative treatment (see the Mental Health and Substance Use Disorder Services benefit for coverage).
- Gym therapy.

Within the **General Exclusions to the Medical Plan,** revise the **Obesity (and Morbid Obesity)** exclusion as follows:

Obesity (and Morbid Obesity) - Treatment for obesity (excessive weight and morbid obesity) including surgery [or complications of such surgery, wiring of the jaw or procedures of similar nature, diet programs and/or other therapies, except as provided herein and as required by the Affordable Care Act. [Medically necessary treatment of complications (including but not limited to a hernia repair or treatment of iron deficiency), to a previous bariatric surgery obtained prior to enrollment on this Plan, are covered. Treatment of a complication resulting from a medical error are not covered nor are complications of a bariatric surgery performed outside of the United States. Cosmetic related procedures are not covered.

Within the **Comprehensive Major Medical Benefits,** revise the **Orthotics** language as follows:

ORTHOTICS

Medically necessary orthotic foot devices prescribed by a physician/provider to restore or improve function are covered at the coinsurance level indicated in the Schedule of Benefits.

Benefits are provided for medically necessary non-foot orthoses as follows: rigid and semi-rigid custom fabricated orthoses; semi-rigid prefabricated and flexible orthoses; rigid prefabricated orthoses.

Within the **Comprehensive Major Medical Benefits,** revise **Diabetic Equipment, Supplies, and Self-Management Training** benefit as follows:

DIABETIC EQUIPMENT, SUPPLIES, AND SELF-MANAGEMENT TRAINING

Covered expenses include charges for the following services, supplies, equipment, and training for the treatment of insulin and non-insulin dependent diabetes and elevated blood glucose levels during pregnancy based upon your medical needs. Pharmacy exclusive supplies and durable medical equipment (as determined by the manufacturer) are not covered under the medical benefits of the Plan. Coverage for these exclusive items may be available under your prescription drug plan. The following are covered under the medical benefits:

Services and Supplies:

- Foot care to minimize the risk of infection including routine and preventive foot care;
- Dilated retinal examinations;

- Diabetic needles and syringes;
- Injection aids for the blind;
- Diabetic test agents; urine test strips, ketone test strips;
- Lancets/lancing devices;
- Alcohol swabs;
- Injectable glucagon's; and
- Glucagon emergency kits.

Durable Medical Equipment:

- External insulin pumps;
- Blood glucose monitors; and
- Foot care appliances for prevention of complications associated with diabetes.

Training:

- Diabetes outpatient self-management training and medical nutrition therapy services must be ordered by a physician and provided by appropriately licensed or registered healthcare professionals. Services deemed preventive under the Affordable Care Act will be covered under the Diabetic and/or Dietary Education benefit.

Within the **Comprehensive Major Medical Benefits,** revise the **Durable Medical Equipment** benefit as follows:

DURABLE MEDICAL EQUIPMENT

Benefits are provided for rental or purchase (if more economical in the judgment of the Plan Supervisor's Care Management Department) of medically necessary durable medical equipment. Durable medical equipment is equipment able to withstand repeated use, is primarily and customarily used to serve a medical purpose, and is not generally used in the absence of illness or injury. The durable medical equipment must be prescribed by a physician/provider for therapeutic use, and include the length of time needed, the cost of rental and cost of purchase prior to any benefits being paid. Examples of durable medical equipment include: crutches; wheelchairs; kidney dialysis equipment; beds and mattresses; traction equipment; footwear (corrective shoes, diabetic shoes and orthopedic shoes); keyboard language or assistive communication devices; non-invasive positive pressure ventilation systems (CPAP, BiPAP) and equipment for administration of oxygen. Repairs or replacement of eligible equipment shall be covered when necessary to meet your medical needs and when necessary to make the equipment serviceable, but not where repairs suggest malicious damage or culpable neglect.

Benefits are not provided for certain equipment including, but not limited to, air conditioners, humidifiers, over-the-counter arch supports, orthopedic chairs, personal hygiene items, purifiers, heating pads, enuresis (bed-wetting) training equipment, exercise equipment, whirlpool baths, weights, or hot tubs. The fact that an item may serve a useful medical purpose will not ensure that benefits will be provided. Please see the sections covering Medical Supplies, Orthotics, and Prosthetics for further information. Pharmacy exclusive supplies and durable medical equipment (as determined by the manufacturer) are not covered under the medical benefits of the Plan. Coverage for these exclusive items may be available under your prescription drug plan.

Services for manual and electronic breastfeeding equipment or supplies will be covered under the Breast Pump benefit as outlined in the Schedule of Benefits. Hospital grade equipment is covered under the Durable Medical Equipment benefit and is subject to all applicable plan provisions.

Purchase or rental of durable medical equipment that is over $2,000 must be reviewed by Plan Supervisor's Care Management Department. Failure by your provider to pre-authorize services may result in the denial of the claim.

Within the **PPO and PPO-AK Schedule of Benefits,** under **Medical Travel/Transportation Benefits,** revise the **Travel for Medical Steerage Subheading** as follows:

MEDICAL TRAVEL/ TRANSPORTATION BENEFIT -			
Travel For Steerage Includes travel, meals and lodging. Lodging is limited to $200 per night. Meals are limited to $100 per person per day.	100% deductible waived	100% deductible waived	100% deductible waived

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Within the **Comprehensive Major Medical Benefits,** revise the **Medical Travel/Transportation Benefits,** as follows:

MEDICAL TRAVEL/TRANSPORTATION BENEFIT

Travel for Steerage

This is a travel reimbursement benefit which may be available when travel is needed to obtain higher value medical care for the best outcome, as determined by the RGA Care Management Department. If approved medical services would be best provided outside of your local community, as determined in advance by the RGA Care Management Department, travel is allowed to an approved facility or health care provider within the Preferred Network service area. Approved methods of transportation do not include ground ambulance, air ambulance, Cabulance, limo rental, private jet, helicopter, or first class commercial airline tickets. This travel benefit is not intended for emergency transportation.

This travel benefit must be approved by the Care Management Department prior to use. Medical services may require preauthorization in advance by the Care Management Department. Benefits are available when travel is required to receive:

- Higher value medical care for non-emergency surgeries and procedures; and
- Services are provided by a Preferred Network facility and provider within the RGA/BlueCard Network.

This benefit includes reimbursement for transportation meals and lodging, for you, the patient and one travel companion/caregiver, and is limited as shown in the Schedule of Benefits. If services are for your covered dependent child under the age of 18 or a disabled adult in need of caregiver assistance, round trip airfare will be paid for one additional accompanying parent, guardian, or caregiver for each trip, up to the limit shown in the Schedule of Benefits. Once approved, RGA will provide you with a travel reimbursement form. You will need to submit this form once travel is completed. You must include copies of legible receipts that clearly show proof of payment to substantiate the reimbursement requested.

If you have been guided to receive healthcare services by the Care Management Department, in collaboration with your provider(s), and require travel, this Travel for Steerage benefit will apply. Any additional travel benefit that may be covered under this Plan, will not be available for the same condition.

Within the **General Exclusions to the Medical Plan,** revise the **Vision Care** exclusion as follows:

Vision Care - Eyeglasses, contact lenses, eye refractions or examinations for prescriptions or fitting of eyeglasses, contact lenses or charges for refractive eye surgery, except as provided herein. Charges for vision analysis, therapy, or training relating to muscular imbalance of the eye, and orthoptics are not covered under the Plan.

Within the **Comprehensive Major Medical Benefits,** revise the **Immunizations** benefit as follows:

IMMUNIZATIONS

Immunizations for routine use in children, adolescents, and adults if ordered by your physician/provider and are medically necessary, based upon shared clinical decision making, are recommended by the Federal Drug Administration (FDA) or Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) and listed on the Immunization Schedules of the CDC for children and adults, or are recommended by other science based organizations, are covered as shown in the Schedule of Benefits.

Throughout the **Summary Plan Description,** revise the name of the **Retail Pharmacy Benefit Manager** as follows:

Delete Retail PBM:
Costco Health Solutions
www.costcohealthsolutions.com
877/908-6024

Add Retail PBM:
Navitus
855/847-1025
https://Navitus.com

Within the **PPO and PPO-AK Schedule of Benefits,** replace the **Prescription Benefits** with the following:

PRESCRIPTION BENEFITS

INDIVIDUAL OUT-OF-POCKET MAXIMUM Per calendar year.	$3,000
FAMILY OUT-OF-POCKET MAXIMUM Per calendar year.	$6,000

Your individual and family out-of-pocket maximum includes eligible Medical and Prescription Drug expenses.

Navitus - Preferred Retail Prescriptions

Generic Drugs	$10 Copay
Brand Name Drugs	
On Formulary Drug List	$40 Copay

Not On Formulary Drug List	Not Covered
Dispensing limit	90 days
Navitus - All Other Retail Prescriptions	
Generic Drugs	$20 Copay
Brand Name Drugs	
On Formulary Drug List	$80 Copay
Not On Formulary Drug List	Not Covered
Dispensing limit	34 days 35 - 90 days for 1.5x Copay
Specialty Medications	20% Coinsurance up to a $100 Maximum Copay
Dispensing limit	30 days
Costco Health Solutions - Mail Order Prescriptions	
Generic Drugs	$10 Copay
Brand Name Drugs	
On Formulary Drug List	$40 Copay
Not On Formulary Drug List	Not Covered
Dispensing limit	90 days

This Plan requires your pharmacist to fill the prescription with a generic product whenever it is available. If the prescription is filled with a name brand prescription at the request of either your provider or yourself, then the copay **plus** the difference between the ingredient cost of the generic drug and the brand name drug will be charged.

Over the Counter COVID-19 Tests

Over the Counter (OTC) COVID-19 Tests can be purchased point-of-sale at retail pharmacy locations and are eligible for coverage under the pharmacy benefits of this Plan with no up-front out-of-pocket cost to you. Coverage will be limited to 8 tests per person every 30 days, based upon the purchase date of the test. If you paid up front for an OTC COVID-19 test and need to submit for reimbursement you must contact the Pharmacy Benefit Manager (PBM) for claim submission instructions.

Within the **Prescription Drug Card Program** provisions, replace the **Specialty Pharmacy** benefit with the following:

SPECIALTY PHARMACY

Specialty pharmacy services include treatment of Participants with narrow-niche, high-cost, chronic conditions such as multiple sclerosis, hepatitis C, rheumatoid arthritis, hemophilia, growth hormone deficiency, alpha 1-antitrypsin disorder, and other special medical conditions. Products provided are typically injectable drugs but may also include infusion drug products. The Plan has established a specialty pharmacy program whereby certain pharmaceutical products that are generally biotechnological in nature and given by

injection or otherwise require special handling (specialty medications), are provided by Lumicera specialty pharmacies.

In the event that you are prescribed a specialty medication, regardless of your diagnosis, you must participate in the Plan's specialty program for the medication to be covered under the Plan and therefore, the specialty medication must be dispensed by a Costco Health Solutions specialty pharmacy. To inquire about or begin specialty pharmacy services, please call or have your healthcare provider call Lumicera at 855/847-3553. Additional information may be obtained via: https://Navitus.com.

If you would like to know more information about the drug coverage policies under this program, or if you have a question or concern about your specialty pharmacy benefit, please contact Lumicera at 855/847-3553.

Within the **Prescription Drug Card Program** provisions, revise the **Retail Prescription Drug Program, Dispensing Limitations** as follows:

The amount normally prescribed by a physician or other lawful prescriber, but not to exceed a 34-day supply (35–90-day supply for 1.5 Copay).

Within the **Prescription Drug Card Program** provisions, revise the **Mail Order Prescription Drug Program, Dispensing Limitations** as follows:

The amount normally prescribed by a physician or other lawful prescriber, but not to exceed a 90-day supply.

Throughout the **COBRA** provisions, revise the **COBRA Administrator** information as follows:

Delete:
Accrue Solutions
P.O. Box 2167
Omaha, NE 68103
888/882-1498 (phone)
469/732-3271 (fax)
cobrasupport@accruecms.com

Add:
Wex
P.O. Box 2926
Fargo, ND 58108
866/451-3399
cobraemployerservices@wexhealth.com

Summary Plan Description Amendment Approval Notification

It is agreed by, **Anvil Corporation** that the provisions in the Summary Plan Description are amended and that these amendments are acceptable and will be the basis for the administration of the Plan as described herein.

Signed at **Bellingham**, WA, this _____ day of _____ 2026, for an effective date of January 1, 2026.

Plan Representative

_____ _____

Signature Title

_____

Print Name