LAFAYETTE VENETIAN BLIND, INC.
HEALTH AND WELFARE PLAN

SUMMARY PLAN DESCRIPTION

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FOR THE
LAFAYETTE VENETIAN BLIND, INC.
HEALTH AND WELFARE PLAN

INTRODUCTION

This document is a summary of the LAFAYETTE VENETIAN BLIND, INC. HEALTH AND WELFARE PLAN (referred to as the "Plan"). The Plan is designed to provide self-funded benefits and insurance protection for the eligible employees of Lafayette Venetian Blind, Inc. (the "Company"). The purpose of this document is to acquaint you with the general provisions of the Plan and to advise you of your rights as a participant under the Plan. It is intended to be an easily understood explanation of the more important Plan provisions. However, the Plan itself is a detailed legal document, written in accordance with federal law. Should this summary differ in any way from the provisions of the Plan, the terms of the Plan will govern. All benefits under the Plan are provided pursuant to either self-funded arrangements or insurance contracts between the Company and the insurance companies. The rights and benefits of each self-funded arrangement and insurance policy are set forth in the insurance certificates, benefit schedules, summaries or booklets you received. Those certificates, schedules, summaries or booklets and this summary should be kept as part of your records. We encourage you to carefully review this summary and the insurance certificates, schedules, summaries or booklets and to ask the Plan Administrator any questions you have concerning the Plan. Copies of the Plan, insurance contracts and benefit schedules, summaries or booklets are on file at the Company's principal office and may be reviewed by any Plan participant, or any other person entitled to benefits under the Plan, upon request. To obtain a copy of the Plan document, please contact the Plan Administrator.

This summary reflects the provisions of the Plan effective as of January 1, 2021.

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GENERAL INFORMATION

Plan Name
LAFAYETTE VENETIAN BLIND, INC. HEALTH AND WELFARE PLAN

Plan Number (PN)
505

Name, Address, Telephone Number and Employer Identification Number (EIN) of the Plan Sponsor
Lafayette Venetian Blind, Inc.
P.O. Box 2838
3000 Klondike Road
West Lafayette, IN 47996-2838
(765) 464-2500
EIN: 35-1449682

Plan Type
The Plan described in this summary plan description is a "welfare benefit plan" providing self-funded and fully-insured benefits to eligible individuals as set forth in Appendix A to the Plan.

Plan Year
The Plan's records are kept on the basis of a "Plan-Year", which begins each January 1 and ends on the next following December 31.

Plan Administrator
The Company serves as the Plan Administrator. The Company, as the Plan "sponsor" and "named fiduciary," may designate a committee or a third party to serve as the Plan Administrator or to perform some or all of the Plan Administrator function.

Name, Address and Telephone Number of Plan Administrator
Lafayette Venetian Blind, Inc.
P.O. Box 2838
3000 Klondike Road
West Lafayette, IN 47996-2838
(765) 464-2500

Type of Administration and Source of Funding
The Plan provides self-funded and fully-insured benefits. Benefits are provided through self-funded benefit arrangements or through insurance policies issued by the insurance companies listed in Appendix A to the Plan. Claims for benefits must be sent to the applicable claims administrator or insurance company. The claims administrators and insurance companies are responsible (not the Company) for paying claims under the Plan. The Plan Administrator, claims administrators and insurance companies share responsibility for administering the Plan. Plan expenses and insurance premiums are paid in part by the Company and, if applicable, through contributions made by employees through the Section 125 plan maintained by the Company.

Service of Legal Process
Legal process may be served upon the Company or upon the person designated by the Company as its resident agent in the Office of the Secretary of State for the State of Indiana.

ELIGIBILITY AND PARTICIPATION

As an employee of the Company, you will become a Participant in the Plan when you become eligible for coverage under an arrangement or an insurance policy offered through the Plan in accordance with the terms and conditions specified in the arrangement or policy. You will be covered under the arrangement or policy at the time, for the period and under the conditions specified in that arrangement or policy. A copy of all the benefit schedules, summaries, insurance certificates or booklets describing the policies and arrangements, rules and benefits has been provided to you. Please review the eligibility information contained in the applicable insurance certificates, benefit schedules, summaries or booklets, and contact the Company if you have any questions.

Eligibility Criteria. You are eligible to participate in the benefits provided under the Plan if you are an active full-time employee of the Company who works a minimum of 30 hours per week. Salaried employees are eligible to begin coverage under the Plan on the first day of the month following 30 days of employment. Drivers and hourly employees are eligible to begin coverage under the Plan on the first day following 84 days of employment. Your dependents are eligible if they meet the definition of dependent as described in the applicable certificate or benefit summary.

Please review the additional eligibility information contained in the benefit schedules, summaries, insurance certificates or booklets you have received, and contact the Company if you have any questions.

HIPAA SPECIAL ENROLLMENT RIGHTS

If you are an otherwise eligible employee and you decline to participate in the medical, dental or vision coverage provided under the Plan when first eligible or at open enrollment, you and/or your dependents may have the right to elect such coverage upon occurrence of a "special enrollment event" as provided by HIPAA. HIPAA special enrollment events generally occur when you or your dependents lose coverage under another employer's group health plan (unless due to failure to pay premiums), and when you gain a dependent through marriage, birth or adoption. You have 30 days from the occurrence of one of these events to notify the Company and enroll in the applicable arrangement or policy. You and/or your dependents may also have special enrollment rights if coverage is lost under Medicaid or a State Children's Health Insurance Program ("SCHIP"), or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the Company and enroll in the applicable arrangement or policy.

CONTRIBUTIONS AND FUNDING

The Company will provide for the Plan's funding through its general assets and the maintenance of insurance policies. The expenses for the self-funded arrangements and the premiums for the policies will be paid by the Company, and to the extent determined by the Company, by you. To the extent that you are eligible and elect to do so, you may pay your share of the cost of contributions and premiums on a pre-tax basis through your participation in the Company's Section 125 plan. The Company will determine and periodically communicate your share of the cost of the contributions and premiums. The Company may change the amount of the contributions and premiums you are required to pay at any time in its sole discretion.

SUMMARY OF PLAN BENEFITS

The Plan provides you and, for some benefits, your eligible dependents with welfare benefits as set forth in Appendix A to the Plan. As mentioned above, these benefits are provided under self-funded arrangements or group insurance contracts and are described in the benefit schedules, summaries, insurance certificates or booklets you have received and in Appendix A to the Plan.

The address and phone number of each claims administrator or insurance company is listed in the applicable insurance certificate, benefit schedule, summary or booklet.

All benefits under the Plan are provided in accordance with the terms and conditions of the self-funded arrangements or insurance policies.

GENERAL RULES

Qualified Medical Child Support Order

With respect to medical, dental and vision coverage, the Plan will provide benefits as required by any qualified medical child support order ("QMCSO"). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. You can obtain, without charge, a copy of the Plan's QMCSO procedures from the Plan Administrator.

Benefits for Adopted Children

With respect to the medical, dental and vision coverage, the Plan will provide benefits to dependent children placed with you or your spouse for adoption under the same terms and conditions as apply in the case of dependent children who are the natural children of you or your beneficiary. Please see the eligibility provisions described in the applicable insurance certificates or booklet for details regarding adding an adopted child to your coverage.

Special Rights on Childbirth

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

HIPAA Compliance

The Plan must comply with certain requirements under the Standards for *Privacy of Individually Identifiable Health Information* (the "Privacy Regulations") and the *Security Standards for the Protection of Electronic Protected Health Information*, (the "Security Regulations"), 45 CFR 160 and 164, as updated by the HITECH Act and regulations promulgated thereunder. The Plan will receive and handle PHI in accordance with its privacy and security procedures set forth in the Plan Document. In addition, the Plan may receive and disclose to the Plan sponsor information on whether the individual is participating in a policy or is enrolled in or has disenrolled from the medical, dental and vision coverage offered by the Plan. The Plan will also safeguard electronic protected information in accordance with the Security Regulations, including implementing or addressing, as reasonable in light of the limited electronic protected information received by the Plan, the administrative, technical and physical safeguards found in the Security Regulations. You have certain other rights that must be provided to you by the administrators and insurers offering the medical, dental and vision coverage under the Plan. Please contact each insurer, claims administrator or the Plan Administrator directly regarding your HIPAA Privacy and Security rights.

AMENDMENT OR TERMINATION OF THE PLAN

The Company, as the Plan sponsor, has the right to amend the Plan at any time, in any fashion, in its sole discretion. While the Company expects and intends to continue the Plan, it also has the right to terminate the Plan at any time in its sole discretion.

CLAIMS PROCEDURES

Each insurance company or claims administrator is responsible for evaluating all benefit claims under the insurance policy or benefit arrangement it issued under the Plan. The applicable insurance company or claims administrator will decide your claim in accordance with its reasonable claims procedures, as required by ERISA and the Patient Protection and Affordable Care Act (the "PPACA"), if applicable. The insurance companies and claims administrators have the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim.

You should review the appropriate insurance certificate, benefit schedule, summary or booklet for more information about how to file a claim and for details regarding the claims administrator or insurance company's claims procedures.

If your claim is denied, you may appeal to the insurance company named or claims administrator for a review of the denied claim. The insurance company or claims administrator will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA and the PPACA, if applicable. If you don't appeal on time, you may lose your right to file suit in a state or federal court, as you may have exhausted your internal administrative appeal rights (which is generally a prerequisite to bringing a suit in state or federal court).

You should review the appropriate insurance certificate, benefit schedule, summary or booklet for more information about how to appeal a denied claim and for details regarding the claims administrators' or insurance companies' claims procedures.

Information for disability claims

The disability benefits provided under this Plan are subject to Department of Labor regulations governing the adjudication and review of disability claims set forth in 29 CFR § 2560.503. These adjudication and review procedures are set forth in the applicable policy, certificate, arrangement or supplement. To the extent the insurer's policy is inconsistent or incomplete, the Plan will comply with those regulations.

You have specific rights under the disability claims regulations. These are fully set forth in the applicable policy, certificate, or supplement. The following is a summary of those rights. If the Plan denies your claim in whole or in part, written notification of the claims decision (called an "adverse benefit determination") will be provided in writing or electronically. It will include all of the following that pertain to the determination: 1) the specific reason(s) for denial; 2) the specific plan provision(s) on which denial is based; 3) a description of any additional information needed to further decide the claim and an explanation of why the information is needed (if applicable); 4) a description of the Plan's review procedures and the time limits applicable to such procedures, and 5) a discussion of the decision, including an explanation of the basis for disagreeing with the views of your medical or vocational professionals, medical or vocational professionals hired by the Plan, or a disability determination by the Social Security Administration. If a claim is denied on appeal, you will receive a final written decision stating why the appealed claim is denied, reference any specific plan provision(s) on which denial is based, and the calendar date by which you have a right to file suit. Any specific internal rules, protocols, standards or other similar criteria relied upon in making the adverse benefit determination will be provided or made available to you. You may request, free of charge, copies of documents, records, and other information relevant to your claim. In addition, the term "adverse benefit determination" includes not only a claim denial, but any rescission of disability coverage. A rescission in this context includes any retroactive cancellation or discontinuation of coverage, unless the cancellation or discontinuation is due to failure to timely pay premiums.

NO ENLARGEMENT OF EMPLOYMENT RIGHTS

Nothing contained in the Plan, the self-funded arrangements, insurance policies or this summary is to be construed as a contract of employment between the Company and you, nor can the Plan be deemed to give you the right to be retained in the employ of the Company, or limit the right of the Company to employ or discharge any person or to discipline any employee.

SUBROGATION

If you or your covered dependents have medical expenses attributable to injuries suffered in an accident and the accident was caused by the negligence or misconduct of another person, the Plan has the right to seek payment of those medical expenses from that person. The Plan may also recover any amount it paid to you to the extent you receive payment for the expenses from another party.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

COBRA continuation coverage is a continuation of Plan coverage when coverage (including the medical arrangement and the dental and vision policies) would otherwise end due to a "qualifying event." Specific qualifying events are listed below. Upon the occurrence of a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent-children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage with after-tax dollars.

Who is entitled to elect COBRA Continuation Coverage?

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct; or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct; or
- The child stops being eligible for coverage under the Plan as a dependent child.

Special qualifying event for Retirees

- Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed by the Company, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse and dependent-children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. You and/or your dependents will be provided a notice of your right to elect COBRA continuation coverage within forty-four days after the Company's Plan Administrator receives your notice of a qualifying event. If, after the Plan Administrator receives your notice of a qualifying event, he or she determines that you and/or your dependents are not eligible for COBRA continuation coverage, the Plan Administrator will provide an explanation containing the reasons you or your dependents are not eligible for coverage. The Plan Administrator will also notify you or your dependents if you are enrolled in COBRA continuation coverage if your COBRA continuation coverage terminates prior to the end of the maximum applicable coverage period.

Sometimes, the Company Must Notify the Plan Administrator:

The Company will notify the Plan Administrator of you or your dependent's qualifying event when the qualifying event is the end of employment or reduction of hours of employment, or death of the employee. You need not notify the Company of any of these three qualifying events.

Sometimes, You Must Notify the Plan Administrator:

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent-child's losing eligibility for coverage as a dependent-child), you must notify the Plan Administrator. The Plan requires you to provide written notification of the qualifying event to the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to the address provided below. IF YOU DO NOT NOTIFY THE PLAN ADMINISTRATOR OF THE QUALIFYING EVENT WITHIN 60 DAYS AFTER THE QUALIFYING EVENT OCCURS, YOU WILL NOT BE ABLE TO ELECT TO RECEIVE COBRA CONTINUATION COVERAGE.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. You may elect COBRA continuation coverage on behalf of your spouse, and you or your spouse may elect COBRA continuation coverage on behalf of your children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time before the 61st day of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the initial 18-month period of COBRA continuation coverage. You should send such notice of disability to the address provided below.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can obtain additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the address provided below.

Please send Notices, in writing, to the COBRA Administrator designated below:

UMR, Inc.
P.O. Box 1206
Wausau, WI 54402-1206

If you have questions about your COBRA continuation coverage, you can write: Lafayette Venetian Blind, Inc., Attn: Plan Administrator, P.O. Box 2838, 3000 Klondike Road, West Lafayette, IN 47996-2838 or call the Human Resources Department at (765) 464-2500. You may also contact the COBRA administrator listed above. 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 family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

USERRA

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted. If the absence is for more than 31 days and not more than 12 weeks, you may continue to maintain your coverage under the Plan by paying premiums.

If you do not elect to continue to participate in the Plan during an absence for military duty that is more than 31 days, or if you revoke a prior election to continue to participate for up to 12 weeks after your military leave began, you and your covered family members will have the opportunity to elect COBRA Continuation Coverage only under the Company's medical arrangement for the 24-month period that begins on the first day of your leave of absence. You must pay the premiums for Continuation Coverage with after-tax funds, subject to the rules that are set out in that plan.

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 all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if required to be filed, and an 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. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report, if a Form 5500 Series is required to be filed.

COBRA and HIPAA Rights

If you are covered under the Plan's medical arrangement or dental or vision policies, you may be eligible to continue coverage for yourself, spouse or dependents if there is a loss of coverage under that policy as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description, the applicable plan arrangements, insurance certificates, booklets or summaries and other documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Action by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the 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 the Company, may terminate you or otherwise discriminate against you in any way to prevent you from obtaining your 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 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 Plan 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 domestic relations order or a medical child support order, you may file suit in a Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration. Employee Benefits Security Administration addresses and telephone numbers are available through the EBSA website at www.dol.gov/ebsa.