WORTHINGTON STEEL
HEALTH AND WELFARE PLAN

SUMMARY PLAN DESCRIPTION FOR MEDICAL, DENTAL & VISION PLANS

Effective as of January 1, 2026

This document is a Summary Plan Description ("SPD") as required by the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan provides benefits through the following component benefit programs:

- *Medical Plan(s);*
- *Dental Plan(s); and*
- *Vision Plan(s)*

When accompanied by the appropriate Benefits Booklet, Certificates of Coverage or Insurance Contracts (collectively referred to as Certificates), this document becomes the SPD. If the terms of this document conflict with the terms of the Certificate, then the terms of that document will control.

Section 1: General Plan Information

Plan Name:	Worthington Steel Health and Welfare Plan
Plan Number:	502
Employer/Plan Sponsor Name, Address and Phone Number:	Worthington Steel, Inc. 200 West Old Wilson Bridge Road Worthington, OH 43085 614-840-3002
Employer's EIN:	92-2632000
Plan Year:	January 1 – December 31
Effective Date:	The effective date of this SPD is January 1, 2026.
Plan Administrator:	Worthington Steel, Inc. Attn: Sr. Manager, Benefits 200 West Old Wilson Bridge Road Worthington, OH 43085 The Plan Administrator has authority to control and manage the operation and administration of the Plan, and complete discretion to interpret Plan terms.
Agent for Service of Legal Process:	Worthington Steel, Inc. Attn: General Counsel 200 West Old Wilson Bridge Road Worthington, OH 43085 Service of legal process may also be made on the Plan Administrator.

Plan Changes or Termination:	The Plan Administrator may terminate, suspend, withdraw, amend, or modify any Plan in whole or in part at any time, with or without notice.
Employee:	The term "Employee" means a common law employee of the Employer who otherwise meets eligibility criteria for each type of Plan benefit. The term "Employee" excludes individuals classified by the Employer as independent contractors, leased or agency employees (or the equivalent), regardless of whether or not such individuals are in fact common law employees of the Employer for tax or other purposes.
Claims Administrator Name, Address and Phone Number:	Medical Plan Anthem Blue Cross and Blue Shield P.O. Box 105187 Atlanta, GA 30348 1-888-641-5224
Insurers Name, Address and Phone Numbers:	Dental Plan Delta Dental of Ohio PO Box 9085 Farmington Hills, MI 48333-9085 800-282-0749 Vision Plan Vision Service Plan PO Box 495907 Cincinnati, OH 45249-5907 800-877-7195
Type of Plans:	Group health plan, dental plan, and vision plan
Funding Arrangement:	The Medical Plan is funded through the general assets of the Plan Sponsor and through contributions by participants where applicable. The Plan Sponsor has contracted with a Claims Administrator to process claims under the Medical Plan. The Claims Administrator does not serve as an insurer, but merely as a claims processor and administrator. Claims for benefits are sent to the Claims Administrator. The Claims Administrator processes the claims, then requests and receives funds from the Plan Sponsor to pay the claims and make payment on the claims to health care providers. The Plan Sponsor is ultimately responsible for providing plan benefits, not the Claims Administrator. However, the Claims Administrator and Plan Sponsor share the responsibilities for administration of the plan. The Dental and Vision Plans are provided through purchase of an

insurance contract with an insurer, which is solely responsible for payment of benefits and final determinations of benefit eligibility. Any refund, rebate, dividend, experience adjustment, or other similar payment under the group contract will be allocated, consistent with the fiduciary obligations imposed by ERISA, to first reimburse the Employer for premiums that it has paid, if any.

Section 2: Eligibility and Benefit Termination Specifications

A. Eligibility Requirements

You are eligible to participate in the Plans if you are classified as a Regular Employee whose base schedule is set for at least 40 hours per week, and if you are a Part Time, Seasonal or Temporary Employee. Eligible Regular Employees may enroll on their first day of employment. Part Time, Seasonal and Temporary Employee may enroll following 90 days of employment.

Plan participants must complete an enrollment application (provided by the Plan Administrator) in a timely fashion in order to receive benefits under the Dental and Vision Plan when first eligible. For the Medical Plan, if you fail to decline enrollment when first eligible, you will automatically be enrolled in single coverage into the lowest premium Medical Plan. Employees who decline enrollment in this Plan during the initial enrollment period will not be eligible for coverage until the first day of the next plan year unless the Employee qualifies for a mid-year election event. An Employee may add or change coverage if the Employee has a mid-year election event (see Section C below).

B. Coverage of Dependents

An eligible Employee may enroll his or her spouse for coverage in the Plans as long as the eligible Employee is enrolled. A Spouse is defined as an individual to whom you are legally married under the laws of any state or foreign jurisdiction.

An eligible Employee may also enroll his or her dependent children as long as the eligible Employee is enrolled. For purposes of coverage under the Plans a Child is your natural child, stepchild, a child legally adopted (or placed with you for adoption), a foster child or a child for whom you are a legal guardian who is under the age of 26, and a child for whom you are required to provide coverage under the terms of a Qualified Medical Child Support Order or a National Medical Support Notice, including a judgment, decree, or order issued by a court of competent jurisdiction, or an order issued through an administrative process that has the force and effect of law under applicable state law.

A Child's coverage under the Plans will terminate at the end of the month in which the Child attains age 26, but a Child's coverage may continue past the age limit for disabled dependents. This extended coverage is only for those already enrolled dependent children who are incapable of self-sustaining employment due to physical or intellectual disability. See the Certificate of Coverage for additional details on how to extend coverage. Extended coverage for the Child will end if the Child ceases to meet these conditions or the Child's coverage would cease under the Policy for a reason other than the limiting age.

Employees who have Spouses or dependent children who also work for the Plan Sponsor may enroll these individuals as dependents if they are eligible, but these individuals may only be covered as an employee or a dependent, not both.

C. Mid-Year Coverage Changes

The Plan may only allow mid-year enrollments in certain limited circumstances. The Plan will allow any mid-year election change that is permitted by the Plan's Section 125 Plan. The Plan will also allow mid-year changes to comply with a Qualified Medical Child Support Order.

If you, your spouse, or your dependent are entitled to special enrollment rights under the Plan, as required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), then you may revoke a prior election for coverage under the Plan and make a new election (including, when required by HIPAA, an election to enroll in another benefit package under a group health plan), provided that the election change corresponds with such HIPAA special enrollment rights.

It is your responsibility to notify the Plan of any mid-year changes (including if your spouse or dependent child no longer meets the Plan's eligibility requirements) within 30 days (or within 60 days for a change in Medicaid or CHIP coverage). If you do not timely notify the Plan of these changes, you may not be entitled to reimbursement of any additional premium payments you made after your spouse or dependent child lost eligibility but prior to you notifying the Plan Administrator of the change.

D. Leaves of Absence

If you are on a paid leave (e.g., STD or Parental Leave), benefits under the Plan are automatically continued with standard active employee premium deductions taken from your paychecks.

If you are on FMLA leave, your benefits under the Plan are automatically continued. Similarly, if you are on non-FMLA unpaid leave or a leave that is paid outside of payroll (e.g., approved unpaid LOA, Military Leave, or Workers Comp) and your leave is expected to be 30 days or less, benefits under the Plan are automatically continued. Upon return from your leave, premiums are doubled each paycheck following your return, until all past due premium payments are caught up.

If you are on an unpaid leave or a leave that is paid outside of payroll and your leave is expected to be more than 30 days, your benefits under the Plan can be continued but you must send in your portion of the premium timely each month. If you do not timely pay your premiums, your coverage will be terminated for the remainder of your leave. When you return to work, you may re-enroll in benefits within 30 days of returning to work.

Section 3: Termination or Modification

A. Right to Terminate/Modify/Amend

The Employer has the right to amend or terminate the Plan at any time, with or without notice to participants and beneficiaries. No consent of any participant or beneficiary is required to amend or terminate the Plan.

B. Loss or Termination of Coverage

Your individual coverage terminates as of the earliest of the following events:

1. The date in which you cease to satisfy the eligibility requirements for a particular Plan benefit. This may result from your death, reduction in hours, or termination of active employment;
2. The end of the period for which you paid your required contribution if the contribution for the next period is not paid when due;
3. When the Plan is amended to eliminate your coverage;
4. Upon the occurrence of any other event terminating coverage and described in the Insurance Contract or Certificate;
5. When you commit an act (or an omission to act) that is fraudulent or an intentional misrepresentation, or
6. When the Plan terminates.

The Employer may enter into contracts with a Contract Administrator to provide administration, or with an Insurer to provide coverages. The Employer has the right to amend, terminate, modify, or change any element of the Plan, or any relationship with a Contract Administrator or Insurer, at any time, with or without prior written notice to you or your beneficiaries.

Section 4: Claims Procedures

For how claims are determined and the details of the appeals process, please see your Certificates.

Except for claims decisions that it delegates to a Claims Administrator, the Plan Administrator has the authority, in its complete discretion, to interpret the terms of the Plan, including any insurance policies, to decide questions of eligibility for coverage or benefits under the Plan, and to make any related findings of fact. All decisions made by the Plan Administrator shall be final and binding on the Claimant to the fullest extent permitted by law.

The Insurer has exclusive responsibility for determining claims under the Dental and Vision Plans.

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Section 5: Not an Employment Contract

The Plan is not to be considered a contract for employment between the Employee and the Employer. The Plan does not guarantee the Employee the right of continued employment, nor does it limit the Employer's right to discharge any Employee.

Section 6: Plan Provisions Relating to Acts of Third Parties

If a participant or beneficiary is sick or injured as a result of the act or omission of another person or party, the participant or beneficiary, as a condition of receiving benefits under the Plan, must agree to reimburse the Plan for those benefits from all recoveries from a third party or parties, whether the recovery occurs by lawsuit, settlement, or otherwise. Further, the participant or beneficiary (or anyone acting on his or her behalf) shall hold all such amounts owed to the Plan in

trust for the Plan upon receipt, and the Plan shall be entitled to a constructive trust and an equitable lien on any such proceeds as soon as the third party agrees to pay such amounts, or as soon as they are received by the participant, beneficiary, or anyone acting on his or her behalf. The participant and/or beneficiary agrees to cooperate in any way with the Plan in order to perfect such trust or equitable lien. The Plan's share of the recovery shall not be reduced by any attorney fees or court costs of the participant or beneficiary, or because the participant or beneficiary has not received the full damages claimed, unless the Plan agrees in writing to a reduction. In particular, any state "make whole" or "full recovery" laws or similar laws shall not apply to the Plan or its rights hereunder.

Section 7: Compliance with the Law

The Plan is intended to comply with the applicable provisions of the Internal Revenue Code and ERISA, and the Plan shall be interpreted and administered consistently with such provisions and with the applicable regulations and rulings thereunder.

With respect to benefits and benefits programs, the Plan will provide benefits in accordance with the requirements of all applicable laws, including the following, as amended, Patient Protection and Affordable Care Act of 2010, Consolidated Omnibus Budget Reconciliation Act of 1985, Family and Medical Leave Act of 1993, Genetic Information Nondiscrimination Act of 2008, Health Insurance Accountability and Portability Act of 1996, Health Information Technology for Economic and Clinical Health Act, Mental Health Parity Addiction Equity Act, Michelle's Law, Newborns' and Mothers' Health Protection Act of 1996, Uniformed Services Employment and Reemployment Rights Act of 1994, and Women's Health and Cancer Rights Act of 1998.

Section 8: Insurance

In its sole, absolute, and uncontrolled discretion, the Plan Sponsor shall have the right to enter into a contract with one or more insurance companies, claims administrators and health maintenance organizations for the purposes of administering the Plan and/or providing benefits under the Plan and to replace any of such insurance companies, health maintenance organizations or contracts.

Section 9: Statement of Your Rights Under ERISA

As a participant in the Plan, you are entitled to certain rights and protection under 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 and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, 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 ("EBSA").

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts 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. The Plan Administrator is required by law to furnish each Participant with a copy of the summary annual report for a Plan Year.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

You may receive a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare 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, in writing, 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 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 requested materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a State or Federal court. No action at law or in equity may be brought to recover under the Plan until the appeal rights herein provided have been exercised and the Plan benefits requested in such appeal have been denied in whole or in part. 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 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 ("EBSA), U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquires, 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.