HOLLEY PERFORMANCE PRODUCTS
CAFETERIA PLAN

SUMMARY PLAN DESCRIPTION

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SUMMARY

HOLLEY PERFORMANCE PRODUCTS
CAFETERIA PLAN

INTRODUCTION

We are pleased to announce that we have amended and restated our Cafeteria Plan (also known as a "Flexible Benefit Plan") for you and other eligible employees. Under this Plan, you are able to choose among certain benefits that we make available. The benefits that you may choose are outlined in this Summary Plan Description("SPD"). This SPD also tells you about other important information concerning the Plan, such as the rules you must satisfy before you can join and the laws that protect your rights.

One of the most important features of our Plan is that the benefits being offered are generally ones that you are already paying for, but normally with money that has first been subject to income and Social Security taxes. Under our Plan, these same expenses are paid for with a portion of your pay before Federal income or Social Security taxes are withheld. This means that you will pay less tax and have more money to spend and save.

Read this Summary Plan Description carefully so that you understand the provisions of our Plan and the benefits you will receive. This SPD describes the Plan's benefits and obligations as contained in the legal Plan document, which governs the operation of the Plan. The Plan document is written in much more technical and precise language. If the non-technical language in this SPD and the technical, legal language of the Plan document conflict, the Plan document always governs. If you wish to receive a copy of the legal Plan document, please contact the Administrator.

This SPD describes the current provisions of the Plan, which are designed to comply with applicable legal requirements. The Plan is subject to federal laws, such as the Internal Revenue Code and other federal and state laws that may affect your rights. The Plan's provisions are subject to revision due to a change in laws or due to pronouncements by the Internal Revenue Service (IRS) or other federal agencies. We may also amend or terminate this Plan. If the provisions of the Plan that are described in this SPD change, we will notify you.

In this SPD, we have attempted to answer most of the questions you may have regarding your benefits, rights and obligations under the Plan. If this SPD does not answer all of your questions about the Plan, please contact the Administrator (or other Plan representative). The name and address of the Administrator can be found in the Article of this SPD entitled "General Information About the Plan."

I
ELIGIBILITY

1. When can I become a participant in the Plan?

Before you become a Plan member (referred to in this Summary Plan Description as a "Participant"), there are certain rules that you must satisfy. First, you must meet the Plan's eligibility requirements and be an active employee. After that, the next step is to actually join the Plan on the "entry date" that we have established for all employees. The "entry date" is defined in Question 3 below. You will also be required to complete an electronic application process to enroll in the Plan.

2. What are the eligibility requirements for our Plan?

You will be eligible to join the Plan as of your date of hire with us if you are a regular full-time employee on the U.S. payroll of Holley Performance Products, Inc. or one of its participating affiliates (collectively, the "Employer") and you are reasonably expected to work on average at least 30 hours per week. You are not considered a "regular employee" (and, therefore, are not eligible) if you are classified by the Employer as (a) a part-time employee generally expected to work on average fewer than 30 hours per week; (b) a leased employee; or (c) a temporary employee or an intern whose customary annual period of employment does not exceed six months. You are also not eligible if you work outside the U.S. and are not on a U.S. payroll

3. When is my entry date?

You can join the Plan on the day you meet the eligibility requirements, provided you make your initial election to participate in the Plan within 31 days of that initial eligibility date.

4. What must I do to enroll in the Plan?

Before you can join the Plan, you must complete an electronic application process to participate in the Plan. Through the electronic application process, you will make your personal choices for each of the benefits being offered under the Plan. Through that process you will also authorize us to set aside some of your pre-tax earnings in order to pay for the benefits you have elected.

II
OPERATION

1. How does this Plan operate?

When you first become eligible for the Plan, and then again before the start of each Plan Year, you will be able to elect to have some of your upcoming pay contributed through the Plan to pay for the available benefits you wish to elect. These amounts will be used to pay for the benefits you have chosen. The portion of your pay that is contributed through the Plan is not subject to Federal income or Social Security taxes. In other words, this Plan allows you to use pre-tax dollars to pay for certain kinds of benefits and

expenses that you normally pay for with out-of-pocket, taxable dollars. However, if you receive a reimbursement for an expense under the Plan's Health Flexible Spending Account or Dependent Care Flexible Spending Account, you cannot claim a Federal income tax credit or deduction on your return. (See the Article entitled "General Information About Our Plan" for the definition of "Plan Year.") If you don't make an election through the electronic enrollment process within 31 days of the date you first become eligible for the Plan, you will be deemed to have elected not to purchase or participate in any of the benefits available under the Plan (that is, you will be deemed to have elected not to participate in any of the Employer's health plans and not to establish and contribute to a Health Flexible Spending Account, Dependent Care Flexible Spending Account or Health Savings Account for the Plan Year. If you fail to make an election from the electronic process during the election period for any subsequent Plan Year, you will be deemed to have elected the same health plan coverage (if any) that you elected for the previous Plan Year and to have elected not to contribute to a Health Flexible Spending Account, Dependent Care Flexible Spending Account or Health Savings Account for the upcoming Plan Year.

III
CONTRIBUTIONS

1. How much of my pay may the Employer redirect under the Plan?

Each year, you may elect to have us contribute on your behalf enough of your compensation to pay for the benefits that you elect under the Plan. These amounts will be deducted from your pay over the course of the year.

2. What happens to contributions made to the Plan?

Before each Plan Year begins, you will select the benefits you want and how much of the contributions should go toward each benefit. It is very important that you make these choices carefully based on what you expect to spend on each covered benefit or expense during the Plan Year. If you elect health plan coverage for a Plan Year, your contributions are applied toward the cost of that coverage. If you elect a Health Flexible Spending Account or a Dependent Care Flexible Spending Account, the amount you elect to contribute to benefit will be used to pay for the qualifying expenses as they arise during the Plan Year (provided you timely apply for reimbursement of the expenses). Amounts you elect to contribute to a Health Savings Account are contributed to that account.

3. When must I decide which benefits I want to elect?

Federal law requires you to make your elections for a Plan Year begins, during the applicable election period (defined below). As discussed below, your initial election must be made within a limited period after you first become eligible, and the election for each new Plan Year must be made within a limited period before the new Plan Year begins. Each time you make an election you must decide two things. First, which benefits you want and, second, how much should go toward each benefit. If you elect health coverage (under the Employer's medical, dental and/or vision plan), the amount you contribute will be equal to the employee portion of the cost for the health coverage you elect (which will be disclosed to you before you make your election). If you choose to contribute to a Health Flexible Spending Account, Dependent Care Flexible Spending Account or Health Savings Account, you get to decide how much to contribute to the account, subject to limitations set by Federal law.

4. When is the election period for our Plan?

You must make your initial election within 31 days after your entry date. (You should review Section I on Eligibility to better understand the eligibility requirements and entry date.) Then, for each following Plan Year, the election period is established by the Administrator and applied uniformly to all Participants. It will normally be a period of time prior to the beginning of each Plan Year. The Administrator will inform you each year about the election period. (See the Article entitled "General Information About Our Plan" for the definition of Plan Year.)

5. May I change my elections during the Plan Year?

Generally, you cannot change the elections you have made for a Plan Year after the beginning of the Plan Year. However, there are certain limited situations when you can prospectively change your elections. You are permitted to change elections if you have a "change in status" and you make an election change that is consistent with the change in status. Currently, Federal law considers the following events to be a change in status:

-- Marriage, divorce, death of a spouse, legal separation or annulment;

-- Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent;

-- Any of the following events for you, your spouse or dependent that affects eligibility for benefits: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that affects eligibility for benefits;

-- One of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or any similar circumstance; and

-- A change in the place of residence of you, your spouse or dependent that would lead to a change in status, such as moving out of a coverage area for insurance.

In addition, if you are participating in the Dependent Care Flexible Spending Account, then there is a change in status if you change dependent care providers or your dependent no longer meets the qualifications to be eligible for dependent care.

However, with respect to the Health Savings Account, you may modify or revoke your elections without having to have a change in status.

There are detailed rules on when a change in election is deemed to be consistent with a change in status. In addition, there are laws that give you rights to change health coverage for you, your spouse, or your dependents. If you change coverage due to rights you have under the law, then you can make a corresponding change in your elections under the Plan. If any of these conditions apply to you, you should contact the Administrator.

You may not change your election under the Dependent Care Flexible Spending Account if the cost change is imposed by a dependent care provider who is your relative.

You may revoke your coverage under the employer's group health plan outside of our open enrollment period, if your employment status changes from working at least 30 hours per week to less than 30 hours. This is regardless of whether the reduction in hours has resulted in loss of eligibility. You must show intent to enroll in another health plan.

You may also revoke or modify your coverage (including change to self only from family/other-than-self coverage in certain cases) under our Employer sponsored group health plan if you (or individuals related to you in certain cases) are eligible to obtain coverage through the health exchanges.

6. May I make new elections in future Plan Years?

Yes, you may. For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming Plan Year. If you do not make new elections during the election period before a new Plan Year begins, we will consider that to mean you have elected the same health plan coverage (if any) that you elected for the previous Plan Year and to have elected not to contribute to a Health Flexible Spending Account, Dependent Care Flexible Spending Account or Health Savings Account for the upcoming Plan Year.

IV
BENEFITS

1. Health Flexible Spending Account

The Health Flexible Spending Account enables you to pay for expenses allowed under Sections 105 and 213(d) of the Internal Revenue Code that are not covered by our health plans (or any other health coverage that applies to you or your dependents)and save taxes at the same time. The Health Flexible Spending Account allows you to be reimbursed by the Employer for qualifying health care expenses incurred by you and your dependents.

Drug costs, including insulin, may be reimbursed, as long as they are not paid or reimbursed under the Employer’s group health plans or any other health coverage.

You may not be reimbursed for the cost of other health care coverage maintained outside of the Plan, or for long-term care expenses. A list of covered expenses is available from the Administrator and can also be found in IRS Publication 502.

You elect the amount of your pre-tax pay that you want credited to your Health Flexible Spending Account for a Plan Year, subject to IRS limits For 2027, the most you can elect to contribute to a Health Flexible Spending Account is $3400. After 2027, the dollar limit may increase for cost of living adjustments. The Administrator will provide participants with information about changes in the annual limit before the beginning of the annual Election Period. You may elect to establish a Health Flexible Spending Account for a Plan Year even if you do not elect to participate in the Employer’s group health plans. However, to preserve you eligibility for a Health Savings Account, **you may not elect a Health Flexible Spending Account for a Plan Year if you elect to participate in a high deductible health plan for the Plan Year** (but, as discussed below, participants in a high deductible health plan may elect to contribute on a pre-tax basis to a Health Savings Account under the Plan).

Generally, you must “use or lose” all amounts credited to your Health Flexible Spending Account for a particular Plan Year during that Plan Year. This means that you should be very careful to estimate as accurately as possible the qualifying health care expenses that you and your dependents are likely to incur during an upcoming Plan Year so that you don’t elect more than you can use. However, the Plan provides a exception to this “use it or lose it” rule by allowing you to carry over to the next Plan Year a limited amount (set by IRS rules) of unused Health Flexible Spending Account credits remaining at the end of a Plan Year. For 2026 you will be eligible to carry over amounts left in your Health Flexible Spending Account, up to $680. This “carryover” exception means that amounts you do not use during a Plan Year (up to the IRS carryover dollar limit) can be carried over to the next Plan Year and used for qualifying expenses incurred in the next Plan Year. After 2026, the carryover dollar limit may increase for cost of living adjustments.

In order to be reimbursed for a qualifying health care expense, you must submit to the Administrator an itemized bill from the service provider. The Administrator will also provide you with a debit or credit card to use to pay for health care expenses at the point of service. This allows immediate payment from your account and relieves you of having to file a claim for reimbursement, provided that you use the card only at qualifying merchant locations and follow the Plan’s established procedures to ensure adequate documentation of your purchases. If you use the debit or credit card to access your Health Flexible Spending Account, **it is important that you keep all itemized receipts and any provider invoices related to your card purchases for the entire calendar year,** so that you can provide them in the event that the Administrator or its agent needs them to comply with applicable tax law documentation requirements. The Administrator will provide you with further details about the debit or credit card.

Amounts reimbursed from the Plan may not be claimed as a deduction on your personal income tax return. Reimbursement from the Health Care Flexible Spending Account will be paid at least once a month. Expenses under the Plan’s Health Care Flexible

Spending Account arrangement are treated as being "incurred" when you are provided with the care that gives rise to the expenses, not when you are formally billed or charged or when you pay for the medical care.

You may be reimbursed for qualifying health care expenses incurred for any child until the end of the calendar year in which the child reaches age 26. For this purpose, a child is a natural child, stepchild, foster child, adopted child, or a child placed with you for adoption. If a child gains or regains eligibility due to these new rules, that qualifies as a change in status to make a corresponding mid-year change to your Health Flexible Spending Account election.

If you are a “qualifying reservist” and you elected a Health Flexible Spending Account, you may request a Qualified Reservist Distribution(“QRD”) as described in this paragraph, A “qualifying reservist” is a member of a reserve component of the U.S. military, specifically the Army and Air National Guard, the Ary, Air Force, Navy, Marine Corp and Coast Guard Reserves and the Reserve Corp of the National Public Health Service who is ordered to active duty for a period of 180 days or more or for an indefinite period. While an initial order to active duty for 179 days or less does not qualifying, an additional order(s_ that extend the period of the initial order to exceed 179 days will also make a reservist a qualifying reservist. If you are a qualifying reservist, taking a QRD may allow you to avoid forfeiting unused benefits under the “use it or lose it” rule described above. A qualifying reservist may receive a QRD subject to the following conditions:

- The amount of the QRD available will be limited to the amount of your contributions to the Health Flexible Spending Account as of the date you request a QRD that exceeds the amount of your claims reimbursed from the Health Flexible Spending Account as of that date.
- The QRD will not include any amount that you have elected to contribute to a Health Flexible Spending Account that has been withheld from your cash compensation as of the date you request a QRD.
- The Administrator will distribute the QRD in one lump sum distribution, and you will not receive any additional reimbursement from your Health Flexible Spending Account after the QRD during the same Plan Year.
- The Administrator must receive a written request for a QRD and a signed copy of your military orders no later than March 31 following the end of the Plan Year during which the period of active duty begins.
- The Administrator will make the QRD to you within 60 days after the date of your written request or the date the period of active duty actually begins, whichever is later.

2. Dependent Care Flexible Spending Account

The Dependent Care Flexible Spending Account enables you to pay for out-of-pocket, work-related dependent day-care cost with pre-tax dollars. If you are married, you can use the account if you and your spouse both work or, in some situations, if your spouse goes to school full-time. Single employees can also use the account.

An eligible dependent is someone for whom you can claim expenses on Federal Income Tax Form 2441 "Credit for Child and Dependent Care Expenses." Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. Dependent Care arrangements which qualify include:

(a) A Dependent (Day) Care Center, provided that if care is provided by the facility for more than six individuals, the facility complies with applicable state and local laws;

(b) An Educational Institution for pre-school children. For older children, only expenses for non-school care are eligible; and

(c) An "Individual" who provides care inside or outside your home: The "Individual" may not be a child of yours under age 19 or anyone you claim as a dependent for Federal tax purposes.

Generally, you must “use or lose” all amounts credited to your Dependent Care Flexible Spending Account for a particular calendar year during that calendar year, so you should be careful to estimate as accurately as possible the qualifying dependent care expenses you and your family are likely to incur during a calendar year so that you do not elect more than you can use. You should also make sure that the dependent care expenses you are currently paying for or expect to incur will qualify for reimbursement under our Plan.

The law places limits on the amount of money that you can elect to contribute to a Dependent Care Flexible Spending Account for a calendar year. Generally, that amount may not exceed the least of: (a) $7,500 (if you are married filing a joint return or you are head of a household) or $3,750 (if you are married filing separate returns); (b) your taxable compensation; (c) your spouse's actual or deemed earned income (a spouse who is a full time student or incapable of caring for himself/herself has a monthly earned income of $250 for one dependent or $500 for two or more dependents).

Also, in order to have the reimbursements made to you from this account be excludable from your income, you must provide a statement from the service provider including the name, address, and in most cases, the taxpayer identification number of the service provider on your tax form for the year, as well as the amount of such expense as proof that the expense has been incurred. The Administrator will also provide you with a debit or credit card to use to pay for dependent care expenses at the point of service. This allows immediate payment from your account and relieves you of having to file a claim for reimbursement, provided that you use the card only for qualifying dependent care expenses and follow the Plan’s established procedures to ensure adequate documentation of your purchases. If you use the debit or credit card to access your Dependent Care Flexible Spending Account, it is important that you keep all itemized receipts and any provider invoices related to your card purchases for the entire calendar year, so that you can provide them in the event that the Administrator or its agent needs them to comply with applicable tax law documentation requirements. The Administrator will provide you with further details about the debit or credit card.

In addition, you should keep in mind that Federal tax laws permit a tax credit for certain dependent care expenses you may be paying for even if you are not a Participant in the Plan's Dependent Care Flexible Spending Account arrangement. You may save more money if you take advantage of this tax credit rather than using the Dependent Care Flexible Spending Account under our Plan. Ask your tax adviser which is better for you.

3. May I direct Plan contributions to my Health Savings Account?

Yes. If you are enrolled in a qualifying high deductible health plan (and you are not enrolled in any part of Medicare or any other disqualifying health coverage), you may elect to make pre-tax contributions to a Health Savings Account ("HSA") Any election to contribute a portion of your compensation to your HSA on a pre-tax basis provided a tax-favored way to accumulate funds to pay eligible medical expenses that are not covered by our medical plan and save taxes at the same time.

Federal tax law limits the total contributions to your HSA for a Plan Year, and the IRS generally updates the limits each year. The limits are higher for employees enrolled in family coverage (coverage for the employee and one or more eligible dependents) under a high deductible health plan than for employees enrolled in employee-only coverage. Also, if you are age 55 or older (and otherwise eligible to contribute to an HSA,you may elect to make additional "catch-up" contributions to your HSA for a Plan Year.

Elective pre-tax contributions to your HSA are not included in your taxable income in the year in which they are made and are not taxable upon withdrawal from your HSA to the extent you use your HSA only to pay eligible health care expenses. In addition, investment earnings on those contributions accumulated tax-free in the HSA, and those earnings will not be taxable upon withdrawal to the extent you use for eligible health care expenses.

To make pre-tax HSA contributions under the Plan, you must establish an HSA with the HSA custodian selected by the Employer. Your HSA will be governed by the terms and conditions outlined in the HSA application and agreement with the HSA custodian. If you wish to use funds in your HSA to pay eligible health care expenses, you will not submit a claim for payment to the Administrator or the HSA custodian. Instead, you will pay any eligible health care expenses from your HSA with a check or the check card or debit card provided to you by the HSA Custodian Please see the Administrator for further details about the process for opening and using an HSA.

V
BENEFIT PAYMENTS FROM FLEXIBLE SPENDING ACCOUNTS

1. When will I receive payments from my Flexible Spending Accounts?

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. The Administrator will provide you with acceptable forms for submitting these requests for reimbursement. If the request qualifies as a benefit or expense that can be paid or reimbursed from your Health Flexible Spending Account or Dependent Care Flexible Spending Account, you will receive a reimbursement payment soon thereafter. Remember, these reimbursements that are made from the Plan are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes. You will only be reimbursed from the Dependent Care Flexible Spending Account to the extent that there are sufficient funds in the Account to cover your request.

2. What happens if I don't spend all Plan contributions credited to my Flexible Spending Account during the Plan Year?

After all timely submitted reimbursement requests are processed after the end of a Plan year, any monies left in a Flexible Spending Account will be forfeited, except for amounts that can be carried over into the next Plan Year for the Health Flexible Spending Account. Obviously, qualifying expenses that you incur late in the Plan Year for which you timely seek reimbursement after the end of such Plan Year will be paid first before any amount is forfeited. For the Health Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. For the Dependent Care Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. Because it is possible that you might forfeit amounts in the Plan if you do not fully use the contributions that have been made, it is important that you decide how much to place in each account carefully and conservatively. Remember, you must decide which benefits you want to contribute to and how much to place in each account before the Plan Year begins. You want to be as certain as you can that the amount you decide to place in each account will be used up entirely. (As noted above, amounts contributed to your Health Savings Account are not subject to forfeiture).

3. Family and Medical Leave Act (FMLA)

If you take leave under the Family and Medical Leave Act, you may revoke or change your existing elections for the Health Flexible Spending Account. If your coverage under the Health Flexible Spending Account terminates, due to your revocation of the benefit while on leave or due to your non-payment of contributions, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return. For the Health Flexible Spending Account, you may continue your coverage or you may revoke your coverage and resume it when you return. You can resume your coverage at its original level and make payments for the time that you are on leave. For example, if you elect $1,200 for the year and are out on leave for 3 months, then return and elect to resume your coverage at that level, your remaining payments will be increased to cover the difference - from $100 per month to $150 per month. Alternatively your maximum amount will be reduced proportionately for the time that you were gone. For example, if you elect $1,200 for the year and are out on leave for 3 months, your amount will be reduced to $900. The expenses you incur during the time you are not in the Health Flexible Spending Account are not reimbursable.

If you continue your coverage during your unpaid leave, you may pre-pay for the coverage, you may pay for your coverage on an after-tax basis while you are on leave, or you and your Employer may arrange a schedule for you to "catch up" your payments when you return.

4. Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are going into or returning from military service, you may have special rights to health care coverage under your Health Flexible Spending Account under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended health care coverage. If you may be affected by this law, ask your Administrator for further details.

5. What happens if I terminate employment?

If you terminate employment during the Plan Year, your right to Flexible Spending Account benefits and Health Savings Account benefits will be determined in the following manner:

(a) You will still be able to request reimbursement for qualifying dependent care expenses incurred prior to your date of termination from the balance remaining in your dependent care account at the time of termination of employment. However, no further salary redirection contributions will be made on your behalf after you terminate. You must submit claims within 90 days after termination.

(b) Your Health Savings Account amounts will remain yours even after your termination of employment.

(c) Upon your termination of employment, your participation in the Health Flexible Spending Account will cease, and no further salary redirection contributions will be contributed on your behalf. However, you will be able to submit claims for health care expenses that were incurred before the end of the period for which payments to the Health Flexible Spending Account have already been made. Also, because the Health Flexible Spending Account is a type of health coverage, you may have the right to continue Health Savings Account participation for a limited period after termination of employment under certain circumstances under the federal law known as COBRA, which could allow you to use amounts remaining credited to your Health Flexible Spending Account for health care expenses incurred after your Health Flexible Spending Account coverage ended. Please see the Article below entitled "Continuation Coverage Rights Under COBRA" for more information.

(d) Group health plan coverage is governed by the plan documents and summary plan descriptions for the group health plans in which you participate. Please see those summary plan descriptions for an explanation of when health plan coverage ends upon a termination of employment and an explanation of the COBRA continuation coverage rights that may permit you to continue group health plan coverage, at your own cost, for a limited period after your coverage would otherwise end.

6. Will my Social Security benefits be affected by my participation in the Plan?

Your Social Security benefits may be slightly reduced because when you make pre-tax salary redirection contribution under the Plan, it reduces the amount of contributions that you make to the Federal Social Security system as well as the Employer's contribution to Social Security on your behalf.

VI
HIGHLY COMPENSATED AND KEY EMPLOYEES

1. Do limitations apply to highly compensated employees?

Under the Internal Revenue Code, highly compensated employees and key employees generally are Participants who are officers, shareholders or considered highly paid under IRS rules. You will be notified by the Administrator each Plan Year whether you are a highly compensated employee or a key employee and that status affects your Plan benefits.

If you are within these categories, the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. Federal tax laws state that a plan will be considered to unfairly favor the key employees if they as a group receive more than 25% of all of the nontaxable benefits provided for under our Plan.

Plan experience will dictate whether contribution limitations on highly compensated employees or key employees will apply. You will be notified of these limitations if you are affected.

VII
PLAN ACCOUNTING

1. Periodic Statements

The Administrator will provide you with a statement of your Flexible Spending Account(s) periodically during the Plan Year that shows your account balance. It is important to read these statements carefully so you understand the balance remaining to pay for a benefit. Remember, you want to spend all the money you have designated for a particular benefit by the end of the Plan Year.

With respect to a Health Savings Account, statements will be provided in accordance with your agreement with the HSA custodian.

VIII
GENERAL INFORMATION ABOUT OUR PLAN

This Section contains certain general information which you may need to know about the Plan.

1. General Plan Information

Holley Performance Products Cafeteria Plan is the name of the Plan.

Your Employer has assigned Plan Number 501 to your Plan.

The provisions of the Plan as described in this Summary Plan Description became effective on January 1, 2026.

Your Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year begins on January 1 and ends on December 31.

2. Employer Information

Your Employer's name, address, and identification number are:

Holley Performance Products
2445 Nashville Rd. Suite B1
Bowling Green, Kentucky 42101
Employer Identification Number (EIN): 61-1291482

3. Plan Administrator Information

The name and address of your the Administrator are:

Holley Performance Products
2445 Nashville Rd. Suite B1
Bowling Green, Kentucky 42101

The Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator will also answer any questions you may have about the Plan. You may contact the Administrator for any further information about the Plan.

4. Service of Legal Process

The name and address of the Plan's agent for service of legal process are:

Holley Performance Products
2445 Nashville Rd. Suite B1
Bowling Green, Kentucky 42101

5. Type of Plan and Administration

The Plan is a type of fringe benefit known as a “cafeteria plan.” It permits eligible employees to purchase certain option benefits on a pre-tax basis. The Plan is administered by the Employer.

6. Claims Submission

Claims for expenses under the Health Flexible Spending Account and the Dependent Care Flexible Spending Account should be submitted to:

PNC Benefit Plus
PO BOX 2865
Fargo, ND 58108

IX
ADDITIONAL PLAN INFORMATION

1. Your Rights Under ERISA

Plan Participants, eligible employees and all other employees of the Employer may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code. For those benefits subject to ERISA, these laws provide that Participants, eligible employees and all other employees are entitled to:

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

(b) obtain copies of all Plan documents and other Plan information upon written request to the Administrator. The Administrator may charge a reasonable fee for the copies;

(c) continue health coverage for a Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Employees or dependents may have to pay for such coverage; and

(d) review this summary plan description and the documents governing the plan on the rules governing COBRA continuation rights.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the best interest of you and other Plan Participants.

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 benefit or exercising your rights under ERISA.

If your claim for a 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.

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.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may request the 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.

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.

If you have any questions about the Plan, you should contact the Administrator. If you have any questions about this statement, or about your rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA) or if you need assistance in obtaining documents from the Administrator, you should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

2. Claims Process

You should submit all reimbursement claims during the Plan Year. For the Health Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. However, if you terminate employment during the Plan Year, you must submit your Health Flexible Spending Account claims within 90 days after your termination of employment. For the Dependent Care Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. However, if you terminate employment during the Plan Year, you must submit your Dependent Care Flexible Spending Account claims within 90 days after your termination of employment. Any claims submitted after that time will not be considered.

If a dependent care claim under the Plan is denied in whole or in part, you or your beneficiary will receive written notification. The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure. Within 60 days after denial, you or your beneficiary may submit a written request for reconsideration of the denial to the Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The Administrator will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended an additional 60 days under certain circumstances.) In this response, the Administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The Administrator has the exclusive right to interpret the appropriate plan provisions. Decisions of the Administrator are conclusive and binding.

In the case of a claim for medical expenses under the Health Flexible Spending Account, the following timetable for claims applies:

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information to process the claim:	
Notification to Participant	15 days
Response by Participant	45 days
Review of claim denial	60 days

The Plan Administrator will provide written or electronic notification of any claim denial. The notice will state:

(a) The specific reason or reasons for the denial;

(b) Reference to the specific Plan provisions on which the denial was based;

(c) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(d) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under section 502 of ERISA following a denial on review;

(e) A statement that the claimant is 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

(f) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When you receive a denial, you will have 180 days following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a claim if it:

(a) was relied upon in making the claim determination;

(b) was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;

(c) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(d) constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

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 claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

3. Qualified Medical Child Support Order

A medical child support order is a judgment, decree or order (including approval of a property settlement) made under state law that provides for child support or health coverage for the child of a participant. The child becomes an "alternate recipient" and can receive benefits under the health plans of the Employer, if the order is determined to be "qualified." You may obtain, without charge, a copy of the procedures governing the determination of qualified medical child support orders from the Plan Administrator.

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CONTINUATION COVERAGE RIGHTS UNDER COBRA

Because the Plan’s Health Flexible Spending Account arrangement is a type of group health plan, it is subject to the continuation coverage requirements of a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA

requires that, under certain circumstances, you must be given the opportunity to continue your Health Flexible Spending Account coverage for the remainder of a Plan Year at your own, after-tax cost in certain instances in which your coverage would otherwise end. The COBRA continuation coverage rules are somewhat different for Health Flexible Spending Account arrangements than they are for other types of group health plans subject to COBRA. Specifically, if your Health Flexible Spending Account coverage would otherwise end during a Plan Year because of a "qualifying event" (your termination of employment with the Employer or a reduction in your hours of employment), and the amount you have contributed to your Health Flexible Spending Account as of your termination date exceeds the amount of health care expenses for which you have been reimbursed to that date, you may elect to continue your Health Flexible Spending Account participation up to the end of the Plan Year in which your qualifying event occurred. To continue your coverage pursuant to COBRA, you must timely elect continuation coverage, and you must pay a monthly COBRA premium, on an after-tax basis, equal to the monthly contribution amount you had elected to make for the plan year (plus an administrative fee of up to 2% of that amount. Timely electing and paying for COBRA coverage under your Health Flexible Spending Account will allow you to access unspent amounts in your account to pay for eligible health care expenses incurred after your qualifying event and during the period in which you maintain the COBRA continuation coverage.

If you become entitled to elect COBRA continuation coverage under your Health Flexible Spending Account during a Plan Year, the Administrator or its designee will provide you with a detailed written notice that explains COBRA continuation coverage and how to elect and pay for it. This notice is incorporated into the Plan by reference and constitutes part of the Plan. You may obtain additional copies of the notice by contacting the Administrator.

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SUMMARY

The money you earn is important to you and your family. You need it to pay your bills, enjoy recreational activities and save for the future. The Plan is designed to help you keep more of the money you earn by lowering the amount of taxes you pay. The Plan is the result of our continuing efforts to find ways to help you get the most for your earnings.

This document is designed to summarize and explain, as simply as possible, the key provisions of the Plan, If you have any questions about the Plan that have not been fully answered by this document, please contact the Administrator.