POWELL INDUSTRIES, INC.

HEALTH REIMBURSEMENT ARRANGEMENT

(Restated Effective January 1, 2024)

PURPOSE OF PLAN

Powell Industries, Inc. (sometime referred to as the "Employer") sponsors and maintains the Powell Industries, Inc. Health Reimbursement Arrangement (the "HRA") for the benefit of eligible employees.

The Plan is an integrated component of the Employer's group health plan (the "Medical Plan"), and reimburses eligible employees for certain expenses that are not otherwise reimbursed under the Medical Plan. The Plan will be interpreted and administered at all times in conformity with applicable provisions of the Employee Retirement Income Security Act of 1974, as amended ("ERISA") and the Internal Revenue Code (the "Code").

ELIGIBILITY

Which employees are eligible to participate in the HRA?

You are eligible if you meet the following three conditions:

1. You are classified as a common law W-2 employee on Employer's books and records;
2. You are employed as a regular employee working 20 or more hours per week; and
3. You are actively enrolled for coverage under the Premier CDHP Medical Plan or the Basic CDHP Medical Plan.

To the extent your eligible dependents are enrolled for coverage under the Premier CDHP Medical Plan or the Basic CDHP Medical Plan, your dependents will be automatically covered under the Health Reimbursement Plan.

PARTICIPATION

When do I begin to participate in the HRA?

Eligible employees begin participation on the same date they enroll for coverage under the Premier CDHP Medical Plan or the Basic CDHP Medical Plan.

When will my participation in the HRA terminate?

Your participation in the HRA will terminate on the same date your participation ends under the Premier CDHP Medical Plan or the Basic CDHP Medical Plan (subject to your right to elect to continue participation pursuant to COBRA, discussed below).

Dependent coverage ends on the earlier of the date your coverage ends, or the end of the month in which the person ceases to be a dependent or a dependent child reaches age 26.

BENEFITS

What benefits do I receive under the HRA?

The HRA provides reimbursements of all medical expenses allowed under Section 213(d) of the Code, excluding insurance premiums. Some examples of eligible expenses include co-payments, coinsurance and deductibles under the Premier CDHP Medical Plan or the Basic CDHP Medical Plan. Services or procedures solely for cosmetic reasons, or services merely beneficial to one's general health (for example, health spas, vacations) are not eligible for reimbursement under the HRA.

Eligible expenses are subject to an annual limit based on the medical plan elected and the coverage tier as follows:

	Premier CDHP	Basic CDHP
Employee Only	$750	$500
Employee + Spouse	$1,000	$750
Employee + Child(ren)	$1,000	$750
Employee + Family	$1,500	$1,000

The total amount credited to your HRA account is prorated depending on your effective date of coverage as follows:

	JANUARY		FEBRUARY		MARCH		APRIL	
	PREMIER	BASIC	PREMIER	BASIC	PREMIER	BASIC	PREMIER	BASIC
Employee Only	$750.00	$500.00	$687.50	$458.3	$625.00	$416.6	$562.50	$375.0
Employee + Spouse	$1,000.0	$750.00	$916.67	$687.5	$833.34	$625.0	$750.00	$562.5
Employee + Child(ren)	$1,000.0	$750.00	$916.67	$687.5	$833.34	$625.0	$750.00	$562.5
Employee + Family	$1,500.0	$1,000.0	$1,375.0	$916.6	$1,250.0	$833.3	$1,125.0	$750.0

	MAY		JUNE		JULY		AUGUST	
	PREMIER	BASIC	PREMIER	BASIC	PREMIER	BASIC	PREMIER	BASIC
Employee Only	$500.00	$333.32	$437.50	$291.6	$375.00	$250.0	$312.50	$208.3
Employee + Spouse	$666.67	$500.00	$583.34	$437.5	$500.00	$375.0	$416.67	$312.5
Employee + Child(ren)	$666.67	$500.00	$583.34	$437.5	$500.00	$375.0	$416.67	$312.5
Employee + Family	$1,000.0	$666.67	$875.00	$583.3	$750.00	$500.0	$625.00	$416.6

	SEPTEMBER		OCTOBER		NOVEMBER		DECEMBER	
	PREMIER	BASIC	PREMIER	BASIC	PREMIER	BASIC	PREMIER	BASIC
Employee Only	$250.00	$166.67	$187.50	$125.0	$125.00	$83.30	$62.50	$41.67
Employee + Spouse	$333.34	$250.00	$250.00	$187.5	$166.67	$125.0	$83.33	$62.50
Employee + Child(ren)	$333.34	$250.00	$250.00	$187.5	$166.67	$125.0	$83.33	$62.50
Employee + Family	$500.00	$333.33	$375.00	$250.0	$250.00	$166.7	$125.00	$83.33

How do I request reimbursement?

While the benefits under the HRA are technically considered a "reimbursement" of eligible expenses, your benefits normally will be automatically processed or adjudicated on your behalf to simplify the process. Automatic adjudication avoids the need for you to pay a provider directly and then seek reimbursement from the HRA. Any reference in this HRA to "reimbursement" includes the automatic adjudication process.

How long do I have to submit a claim for reimbursements?

If for whatever reason your reimbursement claim is not automatically processed or adjudicated as discussed in the preceding Q&A, you may submit a formal claim for reimbursement under the Plan.

A claim for reimbursement should be submitted as soon as possible after the expense is incurred and in no event later than 90 days following the last day of the Plan Year (as identified in the Plan Information section below) in which the expense was incurred. Any claims for reimbursement made after the 90-day period has expired will be denied. You may carry over unused amounts into the next plan year. The carry-over amount is limited to the employer contribution amount by tier and by plan for the preceding year.

How long will it take to be reimbursed?

The Claims Administrator will generally approve or deny your claim for reimbursement within 30 days of receiving the claim, but the period may be extended for up to an additional 15 days if necessary due to matters beyond the control of the Claims Administrator. If your claim is incomplete, you will be notified of any additional information required and given at least 45 days to provide the additional information.

If your claim for reimbursement under the Plan is denied, in whole or in part, you will receive a written notice explaining the specific reason the claim was denied and the steps you may take to appeal the decision. You must submit the appeal within 180 days after your claim is denied. Your appeal should explain the reason you believe the claim was not decided correctly. You may submit any additional information necessary to support your position.

A decision will be made on your appeal within no more than 60 days after the Plan Claims Administrator receives the request for review. If your appeal is denied, the notice of denial will include the specific reason for the denial and the specific Plan provisions on which the decision is based, a statement of your right to receive copies of all documents and records relevant to your claim, and a statement that you have the right to bring suit under ERISA if you are still not satisfied.

This appeal process applies only to requests for reimbursement from the Plan. Any claim for benefits under the Medical Plan will be decided and may be appealed in accordance with the claim and appeal procedures stated in the Medical Plan.

PLAN AMENDMENT OR TERMINATION

Can changes be made in the Plan after I join?

Yes. Powell Industries, Inc. reserves the right, without the consent of any person, to prospectively, or retroactively, amend or modify the Plan from time to time in any manner it deems appropriate. Further, the Employer reserves the right to terminate the Plan, in whole or in part, at any time, and may apply the termination to any or all participants.

PLAN ADMINISTRATION

How is the Plan administered?

The Plan Administrator has sole authority to control and manage the operation and administration of the Plan, and to interpret the provisions of the Plan, including but not limited to determinations regarding eligibility for participation in and coverage under the Plan and the types and amounts of benefits payable under the Plan, and to make all necessary findings of fact. Decisions by the Plan Administrator may not be overturned unless found by a court to be arbitrary and capricious.

The Plan Administrator may delegate responsibilities for the operation and administration of the Plan, may employ persons to assist in fulfilling its responsibilities under the Plan, may designate fiduciaries other than those named in the Plan, and may allocate or reallocate fiduciary responsibilities under the Plan.

Unless liability is otherwise provided under section 405 of ERISA, a fiduciary will not be liable for any act or omission of any other party to the extent that (i) such responsibility was properly allocated to such other party as a named fiduciary, or (ii) such other party has been properly designated to carry out such responsibility pursuant to the procedures set forth above.

FUNDING

How is the Plan funded?

Powell Industries, Inc. funds all contributions and can choose to do so through a benefits trust or through its general assets. Nothing in the Plan requires the Employer to maintain any fund or segregate any amount for the benefit of any participant. No participant or any other person or entity will have any right to, or interest in, the assets of the Employer with respect to the Plan.

COBRA CONTINUATION COVERAGE

Is the Plan subject to COBRA?

Yes. If you terminate employment or if you cease to be eligible for coverage under the Medical Plan for certain other reasons, you, your spouse, and/or your covered dependents may be entitled to continue your health care coverage for a limited period at your own expense. The Administrator of the Medical Plan will inform you of your right to enroll for continuation coverage, commonly called COBRA coverage. If you and/or your eligible spouse or dependent(s) elect COBRA coverage under the Medical Plan, your participation in the Medical Plan will automatically be continued. You may submit Eligible Expenses to the Claims Administrator for reimbursement as long as you have COBRA coverage under the Medical Plan. You will be required to pay a premium for COBRA coverage under the Medical Plan, but there is no additional cost for you to continue participation in the Plan.

HIPAA

How will my health information be kept private?

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), defines Protected Health Information (PHI) as information that is created or received by the Plan and relates to the past, present or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present or future payment of the provision of health care to a participant; and that

identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected health information includes information of persons living or deceased.

The HIPAA definition of PHI applies to the Plan. The Plan Administrator may use and disclose PHI from the Plan only as permitted by HIPAA. The Plan may disclose PHI to the Plan Administrator, provided that the Plan Administrator uses or discloses the PHI for Plan administration purposes only. Plan administration purposes include administrative functions performed by the Plan Administrator on behalf of the Plan, such as enrollment and termination, claims processing, claim appeals, auditing, and monitoring.

With respect to PHI disclosed by the Plan to the Plan Administrator, the Plan Administrator shall:

- Not use or disclose the PHI other than is permitted or required by the Plan or by law.
- Not use or disclose the PHI for employment-related actions and decisions.
- Ensure that any agents, or subcontractors to whom PHI is provided agree to the same privacy restrictions and conditions that apply to the employer and the Plan Administrator.
- Report to the Plan any use or disclosure of PHI that is in violation of the HIPAA privacy rules.
- Make available PHI to comply with the HIPAA right to access in accordance with the law.
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements.
- Return or destroy all PHI received from the Plan that the employer or Plan Administrator still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, if feasible.
- Satisfy the requirement of adequate separation between the Plan and the employer by limiting access to PHI to only those employees or classes of employees who have been given responsibility for performing the administrative duties the Plan Sponsor provides for the Plan.

The Plan Sponsor must also reasonably safeguard PHI transmitted or maintained in any electronic media (Electronic PHI). The Plan Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that the Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan, as follows.

- Plan Sponsor shall ensure that the adequate separation that is required by the HIPAA privacy regulation is supported by reasonable and appropriate security measures;
- Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic PHI agrees to implement reasonable and appropriate security measures to protect such information; and
- Plan Sponsor shall report to the Plan any security incidents of which it becomes aware that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic PHI within a reasonable period of time after learning of the security incident.

YOUR RIGHTS UNDER THE PLAN

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 will 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) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, 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 administrator may make a reasonable charge for the copies.

- Receive a summary of the plan's annual financial report. If the Plan is required to file an annual report (Form 5500 Series), the Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or 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.

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 benefit or exercising your rights under ERISA.

Enforce Your Rights

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.

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 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 Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, 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.

MISCELLANEOUS

Recovery of Ineligible Reimbursements

If the Plan makes payment for benefits that are in excess of expenses actually incurred or in excess of allowable reimbursement, due to error (including, for example, a clerical error) or fraud or for any other reason, the Plan reserves the right to recover any overpayment plus interest and costs, through whatever means are necessary, including, without limitation, legal action or by offsetting future benefit payments to you, your beneficiary, or you or your beneficiary's heirs, assigns or estate.

If you or your beneficiary fails to submit any information reasonably requested including proof of a claim, makes a false statement, or furnishes fraudulent or incorrect information, you or your beneficiary's benefits under the Plan (and participation in the Plan, even if you or your beneficiary would otherwise meet the eligibility requirements) may be denied, suspended or discontinued at any time and for any length of time (including permanently) by the Plan Administrator or its designees in its sole and absolute discretion.

Governing Law

The Plan will be construed, regulated and administered according to the laws of the State of Texas except to the extent preempted by ERISA.

Construction

The headings and subheadings in the Plan have been inserted for convenience of reference only and will not affect the construction of the provisions of the Plan. In any necessary construction of the Plan, the masculine gender will include the feminine gender and the singular will include the plural where applicable and vice versa.

Anti-Assignment

The right of any participant to receive any reimbursement under the Plan shall not be alienable by the participant by assignment or any other method and shall not be subject to claims by the participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

No Guarantee of Employment

The Plan will not be deemed to constitute a contract between the Employer and any employee or to be consideration or an inducement for the employment of any employee. No participant in the Plan will acquire any right to be retained in the Employer's employ by virtue of the Plan; nor upon his dismissal or upon his voluntary termination of employment, will he have any right or interest in the Plan other than as specifically provided in the Plan.

No Guarantee of Tax Treatment

The Plan Administrator and the Employer do not guarantee that any amounts paid for the benefit of any participant are excludable from the participant's income for federal, state, or local income tax purposes or from wages for FICA purposes.

Severability

If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability will not affect any other provisions of the Plan, and the Plan will be construed and enforced as if such provision had not been included.

Qualified Medical Child Support Orders

The Plan will comply with terms of a "qualified medical child support order" as defined in section 609(a) of ERISA, which recognizes the right of a child of a participant to receive benefits for which the participants and beneficiaries generally are eligible to receive under the group health plan. Participants and beneficiaries may obtain a copy of the Plan's procedures relating to qualified medical child support orders from the Plan Administrator.

Other Laws

Benefits shall be provided in compliance with ERISA, COBRA, HIPAA, FMLA, USERRA, and other group health plan laws to the extent required by such laws.

PLAN INFORMATION

Plan Name:	The Health Reimbursement Arrangement is a component benefit under a larger ERISA plan known as the Powell Industries, Inc. Welfare Benefit Plan.
ERISA Plan Number	501
Type of Plan:	Welfare benefit plan
Effective Date:	January 1, 2024
Plan Year:	12-month period beginning January 1 and ending December 31.
Plan Sponsor & Plan Administrator:	Powell Industries, Inc. 8550 Mosley Rd. Houston, TX 77057 713.948.4022
Plan Sponsor Tax Identification Number:	88-0106100
Claims Administrator:	TaxSaver Plan
Other participating employers:	None.
Sources of Contributions:	Employer contributions
Trustee:	None
Agent for Legal Process:	Service of legal process may be made upon Powell Industries, Inc., Attn: Vice President Human Resources

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