GrafTech International Holdings, Inc.

Health and Welfare Plan

Summary Plan Description

Amended and Restated: January 1, 2016

Important Information About This SPD

This booklet summarizes the main features of the welfare benefits programs under the GrafTech International Holdings, Inc. Health and Welfare Plan (referred to as the "Plan" in this booklet). The programs are provided for employees of GrafTech International Holdings, Inc. (referred to as "GrafTech International Holdings, Inc." or the "Company" in this booklet). The programs are offered on a self-insured and/or a fully insured basis as described within. Coverage is provided to all Eligible Employees as listed in Exhibit A.

The intent of this booklet is to satisfy the Employee Retirement Income Security Act of 1974 (ERISA) requirement for a Summary Plan Description (SPD). The plan document, not this SPD, will be determinative in all matters pertaining to rights and obligations with respect to the Plan. This SPD is incorporated as part of the formal Plan Document. The Plan Document is a separate document that controls and any terms or conditions stated in this SPD that contradict the terms of the Plan Document or are ambiguous, as determined in the sole discretion of the Plan Administrator, are superseded and the Plan Document shall control.

Although it is GrafTech International Holdings, Inc.'s present intent to continue this Plan indefinitely, you should be aware that the GrafTech International Holdings, Inc. retains the right to substitute other coverage, initiate employee contributions, or amend, change, modify, or completely terminate some or all of the programs under this Plan at any time. Neither this booklet nor any other writing regarding the Plan will grant or confer any vested or other rights to any employee, former employee or any other person for future benefits beyond amounts payable for periods of time while the Plan is in effect.

The effective date of this restatement of the Plan is January 1, 2016.

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THE PLAN - Introduction

This is the Summary Plan Description (hereinafter "SPD") for the GrafTech International Holdings, Inc. Health and Welfare Plan (which we will refer to as the "Plan") for the purpose of providing health and welfare benefits to Eligible Employees under a number of different benefit programs and arrangements that we refer to as the Constituent Benefit Programs.

This SPD is a reporting and disclosure document under the Employee Retirement Income Security Act of 1974, as amended (ERISA) and is intended as a basic overview of the terms of the Plan. As stated above in the section "Important Information About This SPD", the Plan Document, a separate document, controls.

ADMINISTRATION AND OTHER BASIC INFORMATION

Name and Type of Plan

Plan Name: GrafTech International Holdings, Inc. Health and Welfare Plan

Plan Type: Health and Welfare benefits as stated and referenced in Exhibit A

This booklet describes the health and welfare benefits programs for Eligible Employees under the GrafTech International Holdings, Inc. Health and Welfare Plan. The Constituent Benefit Programs, provided for in Exhibit A, describe the offered plans and programs. This booklet is a Summary Plan Description. For more details, refer to the Plan Document.

Employer, Plan Sponsor and Administrator

The Employer, Sponsor and Plan Administrator of the Plan is:

GrafTech International Holdings, Inc.
Suite 300 Park Center 1
6100 Oak Tree Boulevard
Independence, OH 44131
(216) 676-2002

The Employer Identification Number
of the Plan Sponsor is: 06-1249029

Employer also includes the Participating Employers listed at Exhibit B.

Plan Funding and Constituent Benefit Programs

The GrafTech International Holdings, Inc. Health and Welfare Plan is funded through self-insurance and/or the purchase of insurance, as so indicated on Exhibit A. The specific plans and programs, and policies and contracts of insurance are referred to as Constituent Benefit Programs and they are referenced and stated in Exhibit A to this Plan document.

Grandfathered Plan Status

The Constituent Benefit Program or Programs that are group health plans are not considered grandfathered.

Plan Number

The Plan Number for this Plan is: 501

Type of Administration and Discretionary Authority

The Plan is administered by the Plan Administrator in accordance with the provisions of the Plan as implemented by the Claims Administrators. The Claims Administrators are those insurers listed and provided for in Exhibit A to this Plan.

The benefits are payable under the contracts of insurance and certificates of coverage referenced in Exhibit A, which identifies each of the Constituent Benefit Programs that constitute this Plan. The insurance providers under the contracts and certificates of coverage are directly responsible and are the fiduciaries for claims and claim determinations under each of the respective insured Constituent Benefit Programs that are incorporated as part of the Plan and referenced as part of this Summary Plan Description.

The Plan Administrator is not the fiduciary with respect to certain claim determinations under any of the insured Constituent Benefit Programs. The Plan Administrator is otherwise responsible and is the fiduciary for all other determinations under the Plan. In such determinations, that are not specifically reserved to an insurer under the Constituent Benefit Programs reflected in Exhibit A, the Plan Administrator has full discretionary authority with respect to all determinations under this Plan, including the determination of facts, the interpretation of the Plan or its terms, and with respect to all decisions and determinations under this Plan. This discretionary authority is to be interpreted in the broadest sense permitted under law.

No Contract of Employment

The Plan does not in any way create or constitute a contract of employment.

Plan Amendment and Termination

The GrafTech International Holdings, Inc. may amend, alter or terminate the provisions of the Plan, or any Constituent Benefit Program at any time. There is no vested right to any benefit under this Plan to any benefit.

Claims Administrator

Claims Administrators are named under the separate Constituent Benefit Programs under the Plan, as incorporated in Exhibit A to this Plan document.

Agent for Service of Legal Process

Any necessary service of legal process may be made on the Plan Administrator:

GrafTech International Holdings, Inc.
Suite 300 Park Center 1
6100 Oak Tree Boulevard
Independence, OH 44131
(216) 676-2002

EIN: 06-1249029

Plan Year

The Plan Year is the twelve consecutive month period that begins on: January 1.

All Plan records are compiled on this Plan year, even though certain of the insurance contracts forming the Constituent Benefit Programs may be on a different contract cycle.

PROGRAMS OF BENEFITS

Constituent Benefit Programs

The benefits, rights and responsibilities are provided for under the various welfare benefit programs called "Constituent Benefit Programs". The Constituent Benefit Programs are incorporated in this Plan by reference and are stated in Exhibit A. The specific terms and conditions of each of the Constituent Benefit Programs are described in the documents listed in Exhibit A and attached hereto as part of this SPD. Insurance company coverage eligibility payment terms are dictated primarily by the insurance contract then in effect. The Plan Administrator's discretionary authority only applies to conflicting or ambiguous terms.

Wellness Program. If a Constituent Benefit Program under the Plan, as listed on Exhibit A, is a wellness program, it will be reasonably designed to promote health and prevent disease. The wellness program may involve a reward or surcharge that applies to the amount that the Eligible Employee will have to pay for coverage under the Plan. When a wellness program involves a reward or surcharge that relates to any "health factor" as that term is used under ERISA ("Wellness Reward Program"), certain rules apply:

- The Employer and/or Plan Administrator may establish and administer any the Wellness Reward Program directly, or with the use of a third party provider or consultant as they may determine.
- The Eligible Employee's participation in the Wellness Reward Program will provide for an annual opportunity to qualify for the reward (or to avoid a surcharge as applicable), and the amount of such reward or surcharge will not exceed twenty percent (20%) (fifty percent (50%) in the case of a tobacco related Program) of the cost of employee only coverage (or employee and dependent coverage if the dependent is included in the Program) provided under the Plan.

- The reward or surcharge shall apply to all covered individuals in the Plan on an equivalent basis.
- The Wellness Reward Program will specifically provide for the availability of a reasonable alternative standard, including the possibility of a waiver of the otherwise applicable standard, in writing. In the event that any Wellness Reward Program materials do not so provide a reasonable alternative, this SPD is considered notice to each Eligible Employee and Dependent as applicable that a reasonable alternative will be provided to each such affected Eligible Employee (and Dependent as applicable) covered by the Plan, and such covered persons may contact the Plan Administrator for a specific reasonable alternative that applies, or that shall apply to such covered person to reasonably accommodate their specific circumstances.

ELIGIBILITY AND EFFECTIVE DATE

Who Is Eligible for Coverage

In General. The coverage described in this Plan is provided to the Employees of the Employer as detailed in the attached Exhibit A, along with their designated Spouses and their Dependents, as applicable. Certain Employees are not Eligible under the Plan. Employees are not Eligible, if they are not specifically designated as Eligible Employees in this description, or if they are subject to collective bargaining and such bargaining agreement does not provide for their inclusion in this Plan. Also, leased employees are not covered by this Plan, unless Exhibit A specifically provides for such Eligibility. Independent contractors are not Employees Eligible under this Plan.

Requirements. Employees may be required to satisfy certain requirements for eligibility and those are specified in Exhibit A. In addition, as a condition for coverage to apply, Employees are required to pay the Employee contribution amounts that may be required by the Employer, from time to time, with respect to each of the Constituent Benefit Programs, and must authorize such payments to be made. Also, coverage is conditional upon the Employee providing any required information or completing any required forms. For certain dates and times prior to the effective date of this Plan, Employees and former employees may be subject to entry dates and eligibility terms that are different and that apply to such prior periods of employment.

Spousal Coverage Limitation. Special rules apply to Spousal coverage under this Plan. This Plan generally excludes Spouses of Employees who have coverage available to them from some other source. This is called a Covered Spouse Limitation. If it applies to a Constituent Benefit Program under the Plan, it will be so indicated in Exhibit A. If your Spouse has "Other Coverage" which is coverage that is available to the Spouse from some other source, such as an employer, a retiree benefit program, certain governmental benefits, veterans' benefits, or otherwise (referred to as "Other Coverage"), your Spouse must be enrolled in those plans and they cannot be covered by the Constituent Benefit Programs with the Limitation, unless you pay a Covered Spouse Premium. The Covered Spouse Premium amount is an additional premium that applies to Spouses who have Other Coverage. Such Covered Spouse Premium amount is determined by the Employer.

If your Spouse coverage eligibility or participation status changes, you must notify Plan Administrator, in writing, of this change as soon as possible, but not later than 5 business days after its occurrence.

Part-time, Seasonal and Temporary Employees - Reasonable Determination Period. In the event that the Company cannot reasonably determine that a newly hired part-time, temporary, or seasonal Employee will satisfy the working full-time eligibility requirements under the Plan as stated herein and in Exhibit A, the Plan Administrator may take a reasonable period of time, not to exceed 12 months to determine if such Employee meets the full-time hours per week condition. This 12-month period is the "Measurement Period" and begins on the Employee's start date. During the Measurement Period, the Plan Administrator will determine whether the Employee meets the Plan's hours per week eligibility conditions. When the Plan Administrator determines that such Employee meets the Plan's hours per week eligibility conditions, the Employee will be eligible on the first day of the month coincident with, or that immediately follows the Measurement Period with such eligibility date being no later than 13 months from the first day of the month following the Employee's date of hire.

After Initial Period. With respect to Employees of the Company, after any initial reasonable determination period, or otherwise, the Company may use any reasonable and permitted measurement period and may evaluate those Employees who are not regularly scheduled to work at least the required number of hours, using any reasonable methodology permitted under the law. In the event an Employee's position changes to a position that involves regular work hours of at least the required amount, or using the measurement period, the Company determines that an Employee works the requisite number of hours, the Company shall permit such Employee to become eligible within a reasonable time, not to exceed ninety days.

Effective Date of Coverage

Your coverage will become effective as provided under each of the Plan's Constituent Benefit Programs, as long as you have provided any required information. No benefits are payable until you are Eligible and covered under the Plan. See Exhibit A.

WHEN YOUR COVERAGE WILL END

Subject to continuation under COBRA (see below for full explanation of COBRA rights), your coverage under the Plan will end on the last day of coverage as provided under the Constituent Benefit Programs. If the Constituent Benefit Programs do not so provide, then your coverage will end on:

- . your last day of active work (with coverage provided through the close of your last day of active work);
- your last day of active work immediately preceding the day you are considered as laid off from the Employer;

- your last day of active work immediately preceding the day you are considered as retired from the Employer;

- the day you have a change in employment status that results in your ceasing to meet the then applicable eligibility requirements of one or more of the Constituent Benefit Programs, unless specific terms of leave provided by the Employer otherwise provide for continued eligibility;

- your last day of active work immediately preceding your transfer to an ineligible status;

- any day upon which you fail to authorize or make employee contribution or other payments required for coverage;

- the day of your death; or

- the day the Plan terminates

Notice of Conversion Rights. Certain of the Constituent Benefit Programs that are insured, may be subject to certain conversion rights. This means that you may have the right to convert your rights under the group insurance policy to an individual policy. These rights vary from policy to policy and may also vary from state to state. You are notified of such rights with respect to each such Constituent Benefit Program on behalf of the Employer and you should take action accordingly if you wish to exercise such rights.

CLAIMS FOR BENEFITS, BENEFIT DETERMINATION AND CLAIM APPEALS

Claims for Benefits and Benefit Determinations

Each Participant or beneficiary claiming a benefit under the Plan must follow the claim and appeal provisions in the Constituent Benefit Program under which a benefit is claimed. Claims for benefits are to be filed and/or submitted as provided for under the terms of the Constituent Benefit Programs. Appeals of any denial of benefits are also filed under the terms of the Constituent Benefit Programs. In the event that any of the Constituent Benefit Programs do not include a claim procedure, and an appeals procedure, or there are any questions or inconsistencies that exist in any of the Constituent Benefit Programs, then this claims procedure and procedure for appeals – or review on decision, will apply.

Important Terms

Adverse Benefit Determination. An "Adverse Benefit Determination" is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit. For purposes of this Claim Appeal Procedure, an "Adverse Benefit Determination" is sometimes referred to as a Claim "denial" (or the Claim for benefits is "denied"). Adverse Benefit Determinations are made in writing, and each Adverse Benefit Determination will explain the next step in the appeals process.

Claim. A "Claim" under the Plan is a request for benefits under a Constituent Benefit Program made by a Claimant in accordance with the procedure for filing benefit claims. All Claims must be filed as specified in this Plan. Claim appeals on Adverse Benefit Determinations must be in writing.

Claimant. A "Claimant" is the Plan participant filing a Claim. A personal representative may be authorized to act on behalf of a Claimant. This authorization must be in writing and signed by the Claimant.

Claims Administrator. The "Claims Administrator" for the Plan is the party designated in the Claims Appeal section of each Constituent Benefit Program's Plan as applicable.

Constituent Benefit Program. A "Constituent Benefit Program" is each separate health or welfare benefit program described in this Plan.

Plan Administrator. The "Plan Administrator" for the Plan is Employer.

Primary Contracts. The "Primary Contract" for a Constituent Benefit Program is the certificate of insurance, summary plan description, summary, plan or other document describing the benefits that are incorporated as part of this Plan as referenced in Exhibit A.

Claim and Appeal Procedures

If the Primary Contract for a Program **does not** provide a claim or appeal procedure or a means for determining a claim or appeal, then this default or "failsafe" procedure described below must be followed.

Initial Claim for Benefits

Filing of Claim. A claim for benefits under the Plan will be filed in writing with the Plan Administrator.

Notice of Denial. If a claim is for post service, or certain concurrent non-urgent service claims for benefits under the Plan is wholly or partially denied, except as otherwise provided herein, the Plan Administrator will, within 30 days after receipt of the claim, notify the Claimant of the denial of the claim. Such 30 day period may be extended for no more than an additional 15 days if Plan Administrator determines that an extension of time for processing the claim is necessary due to matters beyond the control of the Plan, in which case Plan Administrator will notify the Claimant of the extension in writing within the initial 30 day period, and such notice of extension will indicate the circumstances requiring the extension and the date by which Plan Administrator expects to render its decision.

Urgent Health Claims (Medical Claims Only). Urgent health claims will be decided as soon as possible within 72 hours rather than within 30 days. The 72 hour deadline may not be extended. An urgent health claim is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations: (a) could seriously jeopardize the life or health of the Claimant or the

ability of the Claimant to regain maximum function, or (b) in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Pre-Service Health Claims (Medical Claims Only). Pre-service health claims will be decided within 15 days rather than 30 days. The 15 day deadline may be extended by an additional 15 days. A pre-service health claim is any claim for a benefit with respect to which Plan terms condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

Disability and Other Claims. Disability claims will be decided within 45 days rather than 30 days. The 45 day deadline may be extended twice, each extension adding no more than 30 days to the prior deadline.

If an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded 45 days from receipt of the notice within which to provide the specified information.

Notice of Denial

A notice of denial will be (a) in writing (or in electronic form); (b) written in a way to be understood by the Claimant; and (c) contain:

- the specific reason or reasons for denial of the claim;
- references to the specific Plan provisions upon which the denial is based;
- a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
- an explanation of the claim review procedure and the time limits applicable to such procedures, in accordance with the provisions of this Claim and Appeal Procedure; and
- a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA if the claim is denied upon review.

Appeal of Decision

Request for Review of Denial. The Claimant may, within 180 days after receiving a written notice of denial of the claim, file a written request with the Plan Administrator that it conduct a full and fair review of the denial of the claim. The Plan Administrator will:

- provide the Claimant with the opportunity to submit written comments, documents, records and other information relating to the claim;

- provide the Claimant, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim;

- effect a review of the denial that takes 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 benefit determination;

- provide a review that (a) does not afford deference to the initial adverse benefit determination, (b) is conducted by a plan fiduciary, a reviewing fiduciary who did not make the adverse benefit determination and who is not the subordinate of the individual who made the adverse benefit determination;

- provide that the reviewing fiduciary will, before deciding an appeal based in whole or in part on a medical judgment, consult with a health care professional having appropriate training and experience, who was not involved with the adverse benefit determination and is not the subordinate of any such individual; and

- provide for the identification of any medical expert whose advice was obtained on behalf of the plan in connection with a Claimant's adverse benefit determination (regardless of whether the advice was relied upon).

Decision on Appeal

The Plan Administrator will deliver to the Claimant a decision in writing (or in electronic form) on the appeal within 60 days after the receipt of the Claimant's request for review, unless the claim category and type is described below.

- Urgent health appeals will be decided within 72 hours rather than 60 days.

- Pre-service health appeals will be decided within 30 days rather than 60 days.

- Disability and other appeals will be decided within 45 days rather than 60 days. The 45 day deadline may be extended by an additional 45 days.

Final Determination

The Plan Administrator's written decision will:

- be written in a manner calculated to be understood by the Claimant;

- include the specific reason or reasons for the decision and contain references to the specific Plan provisions upon which the decision is based;

- state 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 Claimant's claim for benefits; and

- state the Claimant may have a right to bring a civil action under Section 502(a) of ERISA.

Authorized Representative. The Plan Administrator will permit an authorized representative of the Claimant to act on behalf of the Claimant under this claim and appeal procedure. The Plan Administrator may establish reasonable procedures for determining whether an individual who purports to be an authorized representative of a Claimant has in fact been authorized to act on behalf of such Claimant.

Administrative Processes and Safeguards. The Plan Administrator will develop such administrative processes and safeguards as it deems necessary to ensure and verify that claim determinations are made in accordance with the Plan and other governing documents, if any, and that where appropriate, the provisions of the Plan have been applied consistently with respect to similarly situated Claimants.

External Review (Applies to Non-Grandfathered Group Health Plans)

Voluntary External Review. This is a special default language for a procedure that applies only if the group health plan - medical plans - referenced in the Constituent Benefit Programs are non-grandfathered plans, or if they lose such status. In such a case, there is a voluntary external review process that applies, if after exhausting the two levels of appeal (when required), you are not satisfied with the final determination. Voluntary external review only applies to the denial of medical, mental health/substance abuse, prescription drug, certain dental, or vision claim denials if the denial is based on one of the following:

1. Clinical reasons based upon medical judgment, including medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or if a treatment is experimental or investigational; or

2. Rescission (retroactive termination) of care.

External review does not apply with respect to claims based upon the eligibility of a Participant or a Dependent, or with respect to whether a particular claim involves a covered product or service.

If you have any questions regarding the External Review, you may contact the Plan Administrator for more information about whether or not the voluntary external review program is available to you.

Request for External Review. A request for an external review generally must be made within four months following the day that you receive notice of the denial on appeal. Also, you can request an expedited external review as described Expedited External Review below.

Preliminary Review. Within five business days of receiving your request for external review, the Plan Administrator will complete a preliminary review, which determines:

1. if you were covered under the Plan at the time of service;
2. that the review does not relate to your eligibility to participate in the Plan;
3. that your review meets the criteria for external review stated above;
4. that you completed the Plan's internal appeals process to the extent required; and
5. that you have provided all necessary information and forms for processing an external review.

You are not eligible for an External Review if the Claims Administrator determines that you have not met all of the above requirements. Within one business day after the initial review of your request, the Plan Administrator may provide you with a notice that includes the reasons your request does not meet the requirements for an External Review and contact information for the Employee Benefits Security Administration. The notice will describe information or materials needed to complete your request, if applicable.

Your deadline to complete the request is the end of the four-month period described above or, if later, 48 hours after you receive the notice that the request was not complete. If your request is expedited, the Plan Administrator will immediately consider the above criteria and notify you of the determination as described in Expedited External Review below.

External Review by an Independent Review Organization (IRO). If your request qualifies for external review, it will be assigned to one of the qualified Independent Reviewer Organizations (IRO) with which the Plan Administrator has a contract. Within five business days after assigning the request to the IRO, the Plan Administrator will provide the IRO with the documents and information that were considered in the denial. If the Plan Administrator does not provide this information, the IRO may end the external review and reverse the Plan Administrator's decision. If this occurs, the IRO will notify you and the Plan Administrator within one business day of this action.

The IRO will give you written notice of the request's acceptance for external review. The notice will include a statement that you have 10 business days to submit additional written information. The IRO will consider this information in its review. The IRO also may agree to consider additional information submitted after 10 business days. Within one business day after receiving additional information from you, the IRO will forward the information to the Plan Administrator. The Plan Administrator may reconsider the denial on appeal based on this additional information. If the Plan Administrator decides to reverse the denial on appeal and provide coverage or payment, written notice will be provided to you and to the IRO within one business day of the decision. The IRO's external review will end if this notice is received.

If the Plan Administrator does not provide any notice of reversal of the decision, the IRO will review all information and documents submitted by the deadline. The IRO must review each claim without being bound by or subordinate to any decisions or conclusions reached during the entire prior claims and appeals process.

In addition to the documents and information provided by you and the Claims Administrator, the IRO will consider the following information or documents if they are available and the IRO considers them appropriate:

1. Your medical records;
2. Your attending health care professional's recommendation;
3. Reports from appropriate health care professionals and other documents submitted by the Claims Administrator, you or your treating provider;
4. Plan terms unless the terms are inconsistent with applicable law;
5. Appropriate practice guidelines, which include applicable evidence-based standards;
6. Any applicable clinical review criteria developed and used by the Claims Administrator, unless the criteria are inconsistent with Plan terms or applicable law; and
7. The opinion of the IRO's clinical reviewer(s) after considering the information described above to the extent the information or documents are available and the clinical reviewer(s) consider appropriate.

The IRO will provide written notice of the decision to you and the applicable Administrator within 45 days after the IRO receives your request. This notice may contain, if relevant:

1. A general description of the reason for the request and information that identifies the claim such as the date(s) of service, health care provider, claim amount (if applicable);
2. A statement describing the availability, upon request, of the diagnosis code and/or treatment code (and their corresponding meanings);
3. The reason of the prior denial;
4. The date the IRO received the request and the date of the decision;
5. References to the evidence or documents (including the specific coverage provisions and evidence-based standards) considered in reaching the decision;
6. A discussion of the principal reason(s) for the decision, including the rationale for the decision and any evidence-based standards that were relied on in making the decision;
7. A statement that the IRO’s determination is binding, unless other remedies are available under state of federal law;
8. A statement that judicial review may be available to you; and
9. The phone number and other current contact information for any applicable office of health insurance consumer assistance or ombudsmen.

If the applicable Administrator receives notice from the IRO that reverses a denial, the Administrator will immediately provide or authorize coverage for or payment of the claim. The IRO will maintain records of all claims and notices associated with the outside review process for six years and make these records available for examination by you, the Plan Administrator, the Claims Administrator, or a state or federal oversight

agency, upon request (except where disclosure would violate state or federal privacy laws).

Time Limit to Appeal Denial of a Claim Will Be Strictly Enforced

Regardless of whether the Constituent Benefit Program provides for time limits to appeal, this provision applies. The limits for a Claimant to file an appeal after an initial denial of a Claim for benefits and to file a final appeal will be strictly enforced. If a Claim is initially denied and the Claimant does not request a review within the time limit after receipt of that determination, the Claimant will forfeit his or her right to request a review of this determination.

If a Claimant does not make an appeal within the time limit after receipt of the determination on the mutual determination on the initial determination, the Claimant will forfeit his or her right to final appeal.

Also, if a Claimant does not make a final appeal within the time limit after a determination, the Claimant will lose his or her right to file an action in federal or state court because the Claimant will not have exhausted his or her administrative remedies.

One Year Limit to File a Legal Action

If the Plan Administrator denies a Claim on appeal, the Claimant has the right to file suit in federal court under ERISA Section 502(a). However, no legal action for recovery of benefits allegedly due under the Plan may be commenced by or on behalf of a Claimant against the Plan, the Plan Administrator or any other Plan fiduciary, Claims Administrator or other Third Party Administrator, unless it is filed within one year after the date of the final determination by the Plan Administrator under the Claims Appeal Procedure described herein.

RIGHTS OF REIMBURSEMENT AND SUBROGATION

If the Company pays benefits under a Program which is the result of an event: (a) caused by the act or omission of another party; or (b) sustained on the property of a third party which has premises liability insurance available, the Company, or the Claims Administrator on behalf of the Company, has the right to recover benefit payments made under the Plan. Reimbursement means the Employee must repay the Company at the time the employee makes any recovery. Recovery means all amounts received by the Employee from any persons, organizations, or insurers by way of settlement, judgment, award or otherwise on account of such injury or illness. The right of subrogation means that the Company, or the Plan or Claims Administrator or other third party acting on behalf of the Company, may make claim in the Employee's name or the Company's name against any persons, organizations or insurers on account of such injury or illness.

The rights of reimbursement and subrogation apply whether or not the Employee has been fully compensated for the Employee's losses or damages by any recovery of payments; in the event the Employee settles a claim against a third party, the Employee is deemed to have been made whole by such settlement and the Company, or the Plan or

Claims Administrator or other third party acting on behalf of the Company, will be entitled to immediately collect the present value of its subrogation rights as the first priority claim from said settlement or judgment. The Company is entitled to the first dollars recovered. No attorney's fees will be payable from any subrogation recovery unless the Company has been notified of the attorney's proposed representation in advance and the Company has agreed in writing to the representation of the Company's interests by that attorney.

Under certain circumstances, the Employee will be required to hold the Company harmless against future benefit payments due to the injury or illness for which a settlement is reached.

This right of reimbursement and subrogation applies to any type of recovery from any third party, including but not limited to recoveries from tortfeasors, underinsured motorist coverage, uninsured motorist coverage, other substitute coverage or any other right of recovery, whether based on tort, contract, equity or any other theory of recovery. Any amounts the Employee receives from such a recovery must be held in trust for the Company's benefit to the extent of the Company's subrogation claims.

By filing a Claim for benefits you agree to cooperate fully in every effort by the Company, or the Plan or Claims Administrator or other third party acting on behalf of the Company, to enforce the Company's rights of reimbursement and subrogation. You and your representatives must not do anything to interfere with those rights. The Company will have the right to discontinue the payment of benefits in the event that the Employee fails to cooperate and to seek reimbursement from the Employee for the amount of benefits paid due to that injury or illness. The Employee agrees to promptly inform the Plan or Claims Administrator in writing of any situation or circumstance which may allow it to invoke the Company's rights under this section.

ACCESS TO RECORDS

By filing a Claim for benefits under the Plan, you authorize the Company, the Plan and Claims Administrators, and their representatives (collectively the "Administrators") to access any records, health records or medical information held by any health care provider and employment information held by any employer. You also authorize the Administrators to use your health records, medical information and employment information for: claims evaluation and processing including, without limitation, claims by the Company for reimbursement or subrogation under the Plan; disability claims data evaluation; and evaluation of potential or actual claims against the Administrators.

RECOVERY OF BENEFITS

If any benefit payments are made in excess of the amount you are eligible to receive under the Plan, including but not limited to:

- erroneous payments,

- payments made for any periods or events for which you fail to satisfy Program requirements, and

- payments not reduced by amounts as specified in the applicable Program,

The Company has the right to recover the excess payments. Retroactive payments from any source listed as reducing Program benefit payments must be immediately disclosed to the Administrators. Excess payments will be recovered directly from you, or if necessary, from future benefit payments or from your estate, to the extent permitted by law.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1986 (COBRA)

If a "Qualified Beneficiary" (as defined below) loses his or her coverage under any of the benefit programs under the Plan that is a group health plan, as a result of a "Qualifying Event" (as defined below), he or she has the opportunity for continuation of health coverage for up to 18, 29, or 36 months (the time limit depends on the reason coverage ended). This extended health coverage is called "**COBRA coverage**." The benefit programs under the Plan that are "group health plans" for purposes of COBRA coverage are the Health Program, the Dental Program, the Health Care Spending Account Program, and the Employee Assistance Program.

Qualified Beneficiaries

You and any of your Eligible Dependents who are covered by a group health plan on the day before coverage would otherwise end are known as "**Qualified Beneficiaries**." A "Qualified Beneficiary" also includes (1) any child who is born to or placed for adoption with you during your COBRA coverage period and (2) any individual who is not covered by the group health plan on the day before coverage would otherwise end if such individual's lack of coverage is solely the result of a violation of applicable law.

Qualifying Events

If you are a Qualified Beneficiary and you lose coverage as a result of any of the following events, those events are considered "**Qualifying Events**" entitling you to COBRA coverage:

- Termination of your employment (other than by reason of gross misconduct, as determined by the Employer), including retirement; or

- Reduction in your scheduled work hours.

If your Eligible Dependent is a Qualified Beneficiary and loses coverage as a result of any of the following events, those events are considered "**Qualifying Events**" entitling that Qualified Beneficiary to COBRA coverage:

- Termination of your employment (other than by reason of gross misconduct, as determined by the Employer), including retirement;

- Reduction in your scheduled work hours;
- Your death while covered under the group health plan;
- Your divorce or legal separation from your spouse while covered under the group health plan;
- Your Eligible Child's termination of "Eligible Dependent" status under the terms of the group health plan (because of, for example, attainment of age or loss of student status); or
- Your becoming entitled to Medicare.

COBRA coverage may also be available if the Employer files for bankruptcy and you and your Eligible Dependents lose coverage under a retiree medical program maintained by the Employer. In the event of such a "Qualifying Event," the Plan Administrator will notify you of your election rights.

Required Notice of Qualifying Event

If the Qualifying Event is divorce, legal separation, or loss of dependent status, you or your Eligible Dependent must notify the Plan Administrator, in writing, within 60 days of the later of (1) such Qualifying Event or (2) the resulting loss of health coverage. ***If you or your Eligible Dependent fails to notify the Plan Administrator within this 60-day period, the right to COBRA coverage will be lost***.

If the Qualifying Event is your termination of employment, reduction in hours, death, or entitlement to Medicare, or if the Plan Administrator is notified of a Qualifying Event described in the previous paragraph, the Plan Administrator will notify each Qualified Beneficiary of the right to continue coverage. Your duty to elect COBRA coverage, if you desire such coverage, does not arise until the Plan Administrator sends such notice.

Election of COBRA Coverage

Once the Plan Administrator is notified regarding the Qualifying Event, an event notification letter and a COBRA enrollment form will be sent to the last known address of each Qualified Beneficiary. *Please notify the Plan Administrator of all address changes.* If you desire COBRA coverage, you must return the properly completed enrollment form to the Plan Administrator no later than 60 days from the later of (1) the date coverage is lost due to the Qualifying Event or (2) the date you received notification (the "60-day COBRA Election Period"). Each Qualified Beneficiary has a separate election right and may choose to continue single coverage for himself or herself. The Plan Administrator will not be responsible for the receipt of COBRA forms sent by regular U.S. mail. ***If you do not elect COBRA coverage within this 60-day period, your right to elect COBRA coverage will be lost, except as provided below with respect to certain individuals eligible for trade adjustment assistance.***

Rights and Obligations of COBRA-Covered Qualified Beneficiaries

A Qualified Beneficiary who elects COBRA coverage has the same rights and obligations under the terms of the Plan as those provided to participants, including the right to enroll family members who would qualify as Eligible Dependents.

Cost of COBRA Coverage

You will be charged a COBRA premium equal to the full cost of your COBRA coverage and a 2% administration fee if so determined by the Company. A disabled Qualified Beneficiary and his or her family members may be charged a 50% administration fee for any month of coverage beyond the initial 18-month COBRA coverage period. Since coverage is retroactive to the date of the Qualifying Event, you will be required to pay for coverage that is retroactive to the date of the Qualifying Event. This premium must be paid within 45 days after your COBRA enrollment form is received. Additionally, in accordance with normal insurance billing procedures, you will be required to pay the next month's premium. This initial payment and all subsequent monthly premium payments must be paid in a timely manner. ***If any COBRA premiums are not paid within the required time periods, coverage will be terminated. Once terminated, COBRA coverage cannot be reinstated***.

Maximum Length of COBRA Coverage

If the Qualifying Event is termination of your employment or reduction in your scheduled work hours, the maximum length of COBRA coverage for you and your dependent Qualified Beneficiaries is 18 months.

If the Qualifying Event is your death, divorce from your spouse, termination of an Eligible Child's Eligible Dependent status, or your becoming entitled to Medicare, the maximum length of COBRA coverage for your dependent Qualified Beneficiaries is 36 months.

If you become entitled to Medicare before your termination of employment or reduction of hours, your Eligible Dependents who are Qualified Beneficiaries, if any, may elect to continue coverage for the greater of 36 months from the date you become entitled to Medicare or 18 months from the date of your termination or reduction in hours.

Special Length of Coverage Rule for Disabled Qualified Beneficiaries

The maximum period of COBRA coverage available at termination of employment or reduction of work hours is increased from 18 months to 29 months with respect to individuals who are disabled at the time of such a Qualifying Event. The extended coverage period is available if the disabled Qualified Beneficiary:

- Is determined to have been disabled under Title II or XVI of the Social Security Act, for Social Security purposes, at any time during the first 60 days of COBRA coverage; and

- Gives the Plan Administrator notice of such determination, in writing, no later than 60 days after the date of the notice by Social Security of its determination of disability and before the end of the 18-month COBRA continuation period.

Family members who are Qualified Beneficiaries and are not disabled during the first 60 days of COBRA coverage, but who elect COBRA coverage along with the disabled Qualified Beneficiary, may also extend their periods of coverage from 18 months to 29 months.

Extension of Period of Coverage for Secondary Qualifying Events

If your Eligible Dependent is covered under COBRA due to your termination of employment or reduction in hours and a second Qualifying Event occurs that is a death, divorce or legal separation, loss of dependent status, or entitlement to Medicare, that Eligible Dependent may receive up to an additional 18 months of coverage (for a total of 36 months). You or your Eligible Dependent must notify the Plan Administrator within 60 days of the second event. ***If you or your Eligible Dependent fails to notify the Plan Administrator within this 60-day period, the right to extend coverage for an additional 18 months will be lost.***

Termination of COBRA Coverage

The COBRA coverage period ends when the *first* of the following events occurs:

- The last day of the 18-, 29-, or 36-month maximum period (described above), as applicable;

- The Employer and its controlled group members cease to maintain any group health plan;

- The Qualified Beneficiary's COBRA premium is not paid in a timely manner (COBRA coverage ends the last day of the month for which a timely payment is made);

- After electing COBRA coverage, the Qualified Beneficiary becomes covered under another group health plan, which does not contain an exclusion or limitation for any pre-existing condition that affects the Qualified Beneficiary or his or her dependent after taking into account any creditable coverage of the Qualified Beneficiary;

- The Qualified Beneficiary becomes entitled to Medicare benefits after electing COBRA coverage; or

- If coverage was extended due to disability, a determination that the disabled Qualified Beneficiary is no longer disabled (such disabled Qualified Beneficiary must notify the Plan Administrator within 30 days of such determination, and COBRA coverage ends as of the later of (1) the month that begins more than 30

days after a final determination is made or (2) the end of the original 18-month COBRA coverage period).

As soon as administratively practicable after a Qualified Beneficiary's COBRA coverage terminates, the Plan Administrator will provide such Qualified Beneficiary with notice of such termination and the effective date thereof.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

If you must provide health care coverage to a dependent child under a QMSCO from a court, then you must request coverage for the child in writing within 31 days of the date of the order. Other court orders may also be covered by this Plan. If you have questions, see the Plan Administrator.

NOTICE INFORMATION

Newborn and Mothers' Care

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

Women's Health and Cancer Rights Act (WHCRA) of 1998

As required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, notwithstanding anything herein to the contrary, the Plan provides coverage for: 1) all stages of reconstruction of the breast on which the mastectomy has been performed; 2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3) prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter. Contact the Plan Administrator for more information.

Medicaid and Children's Health Insurance Program – ("CHIP")

Free or Low-Cost Health Coverage for Children and Families. For Eligible Employees who are Participants and are eligible for health coverage under the Plan, but are unable to afford the employee portion of the total cost (sometimes referred to as the employee premium), some states have premium assistance programs that Participants may access to

help pay for coverage. Certain states use funds from their Medicaid or CHIP programs to help people who are eligible for health coverage provided by employers, but need assistance in paying their health premiums.

For those employees who are already enrolled in Medicaid or CHIP, or have dependents so enrolled, they can contact the applicable State Medicaid or CHIP office to find out if premium assistance is available. If covered Dependents are not currently enrolled in Medicaid or CHIP, they can contact the State Medicaid or CHIP office, or dial 1-877-KIDS-NOW, or go to www.insurekidsnow.gov to find out how to apply for this premium assistance. If one qualifies, the program in the your state where the individual resides will provide information as to whether it has a program that might help pay the premiums toward the employee portion payable for coverage under the Plan. Once it is determined that the Eligible Employee or Dependent is eligible for premium assistance under Medicaid or CHIP, this Plan will permit such Eligible Employee or Dependent to enroll, as long as such persons are eligible, and not already enrolled. This is a special enrollment period for such individuals. Such individuals must request coverage within sixty (60) days of being determined eligible for premium assistance.

Additional Notices

There are a number of related and additional notices that apply to the Plan, that are contained in the Plan's Notice Packet. These notices are incorporated by reference herein. If you do not have access to the Packet that was distributed, see the Plan Administrator, or human resources representative for a copy.

GENERAL COMPLIANCE AND OTHER INFORMATION

Benefits Are Not Subject to Vesting and Are Not Vested. As stated in the Plan, there are no vested rights to benefits. The Plan or any Program under the Plan may be amended or terminated at any time.

Health Insurance Portability and Accountability Act. It is intended that this Plan comply with the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") and the regulations issued thereunder. The Plan and Plan Administrator will not have regular access to any Protected Health Information (PHI) as that term is described under HIPAA. In the event that any PHI is provided to the Plan Administrator, it will be disclosed or obtained with the required consent in order to assist you in your access to benefits, or some other function under the Plan. Any such information obtained will be protected from dissemination and will be used only for purposes under the Plan. All HIPAA protections within the Constituent Benefit Programs shall apply.

Leave Under the Uniformed Services Employment and Re-employment Rights Act ("USERRA"). If you leave your job to perform military service, you have the right to elect to continue your existing health plan coverage for up to 24 months while in the military. See the Plan for more details.

Family and Medical Leave Act ("FMLA"). The FMLA entitles eligible employees to take up to 12 weeks of unpaid, job protected leave each year for specified family and medical reasons. For a medical leave, any period for which you are paid short term disability or workers' compensation benefits will count against any period of available FMLA leave. See your Human Resources Department for additional information on the FMLA.

No Right of Employment. This Plan does not confer upon anyone a right or contract of employment in any way.

Fraud or Concealment. By participating in this Plan, and any of the Constituent Benefit Programs, you agree to provide accurate and truthful information concerning any of your benefits or any subject matter for which you need to provide information in connection with your Participation in the Plan. This also applies to your dependents and beneficiaries. In the event of any fraud, or concealment or any untruthful information provided by any participant or beneficiary or dependent, any of the rights and remedies under the applicable Constituent Benefit Programs shall apply and the Employer may undertake any act or remedy available to it in this regard.

Compromise of Claims. The Employer and any of the insurers of any Constituent Benefit Program may compromise any claim filed under the Plan, in accordance with the terms of the Constituent Benefit Programs, or otherwise, as long as they satisfy obligations to the participants, beneficiaries and dependents hereunder.

References and Inconsistencies. This SPD is informational only. The Terms of the Plan control.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as applicable. ERISA provides that all participants in Programs subject to ERISA will be entitled to:

(1) Examine, without charge, at the Company, all plan documents, including all documents filed by the plan with the U.S. Department of Labor, such as annual reports and plan descriptions. These documents will be made available to you at your Human Resources Department within 10 calendar days following the day on which your request to examine the documents is made.

(2) Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report within 210 days after the close of the Plan Year.

(3) Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. A reasonable charge for the copies will be made. Your Human Resources Department will answer any questions you may have about requesting copies of the documents and the charge that will be made.

In addition to creating rights for plan participants, ERISA imposes obligations upon the persons who are responsible for the operation of this plan. These persons are referred to as "fiduciaries" in the law. Fiduciaries must act solely in the interest of the Plan participants and they must exercise prudence in the performance of the Plan duties.

You may not be discharged, suspended or discriminated against in any manner by any person for the purpose of preventing you from obtaining a welfare benefit or exercising your rights under ERISA.

If you believe you are improperly denied a welfare benefit in full or in part, you must receive a written explanation of the reason for denial. The Plan provides an appeal procedure for resolving your Claim.

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 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a Claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that the 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 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 Plan Administrator. If you have any questions about this statement or your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210.

PLAN INTERPRETATION

The Plan Administrator has complete discretionary authority to determine eligibility for benefits and to construe any and all terms of the Plan, including, but not limited to, any disputed or doubtful terms, to the extent that this right is not specifically reserved to any insurer under any Constituent Benefit Program. The Plan Administrator also has the power and discretion to determine all questions of fact and law arising in connection with the administration, interpretation and application of the Plan, unless such right is specifically reserved to any insurer under the Constituent Benefit Programs. Any and all determinations by the Plan Administrator with respect to any aspect of the Plan not otherwise reserved to the insurer under the Constituent Benefit Programs, is and will be conclusive and binding on all persons, except to the extent reviewable by a court with jurisdiction under ERISA after giving effect to the time limits described in the "Benefit Determination and Claims Appeal Procedure" section of this Plan.

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Exhibit A

GrafTech International Holdings, Inc.
Constituent Benefit Programs and Eligible Employees
(as of January 1, 2016)

CONSTITUENT BENEFIT PROGRAMS	POLICY OR BOOKLET NUMBER	TYPES OF BENEFITS PROVIDED	ELIGIBLE EMPLOYEES	ELIGIBILITY ENTRY DATES
Cigna PPO Open Access Plus Plan Standard OAP1 $600 Individual $1,800 Family Network Deductible	334857	Medical	Employees Who Are Regularly Scheduled to Work at Least Thirty (30) Hours Per Week (Spousal Limitation Applies)	Date Of Hire
Cigna Choice Fund Open Access Plus HSA Plan Standard HSAF $3,000 Individual $6,000 Family Network Deductible	334857	Medical Health Savings Account (HSA)	Employees Who Are Regularly Scheduled to Work at Least Thirty (30) Hours Per Week (Spousal Limitation Applies)	Date Of Hire
Cigna Dental PPO	334857 05264A	Dental	Employees Who Are Regularly Scheduled to Work at Least Thirty (30) Hours Per Week	Date Of Hire
Combined Insurance Company of America Group Vision	9820416 9820417	Vision	Employees Who Are Regularly Scheduled to Work at Least Thirty (30) Hours Per Week	Date Of Hire

CONSTITUENT BENEFIT PROGRAMS	POLICY OR BOOKLET NUMBER	TYPES OF BENEFITS PROVIDED	ELIGIBLE EMPLOYEES	ELIGIBILITY ENTRY DATES
Cigna Life Insurance Company of North America Group Life Insurance	FLX-964122 C01	Life Insurance	All Active Full Time Employees and International Assignees, as That Term is Defined by Employer, Who Are Regularly Scheduled to Work at Least Thirty (30) Hours Per Week	Date of Hire
Cigna Life Insurance Company of North America Group Life Insurance	FLX-964122 C02	Life Insurance	All Retirees Who Were Age 50 or Older on 7/1/09, With at Least Ten (10) Years of Service and Were Insured Under the Employer-Sponsored Life Ins. Policy in Effect at That Time	Grandfathered as of 7/1/09
Cigna Life Insurance Company of North America Group Life Insurance	FLX-964122 C03	Life Insurance	Disabled Employees Under the Age of 65 as of 1/1/02 Who Were Insured Under Principal Policy P26497, Excluding Employees Insured as of 7/31/11 Under a Waiver of Premium Provision Policy P26497 and Whose Names are on File With the Employer and Ins. Company	Grandfathered Class

CONSTITUENT BENEFIT PROGRAMS	POLICY OR BOOKLET NUMBER	TYPES OF BENEFITS PROVIDED	ELIGIBLE EMPLOYEES	ELIGIBILITY ENTRY DATES
Cigna Life Insurance Company of North America Group Disability Insurance Long Term Disability	LK-962905	Long Term Disability Insurance	All Active Full Time Employees and International Assignees, as That Term is Defined by Employer, Who Are Regularly Scheduled to Work at Least Thirty (30) Hours Per Week	Date of Hire
Cigna Life Insurance Company of North America Group Accident Insurance	OK 965741	Accidental Death and Dismemberment Insurance	All Active Full Time Employees and International Assignees, as That Term is Defined by Employer, Who Are Regularly Scheduled to Work at Least Thirty (30) Hours Per Week	Date of Hire
Pre-Tax Premium Cafeteria Plan with FSA, HSA & DCAP	N/A	Pre-Tax Premium Cafeteria Plan with FSA, HSA & DCAP	Employees Who Are Regularly Scheduled to Work at Least Thirty (30) Hours Per Week	Date Of Hire
GrafTech GraFit Wellness Program	N/A	Wellness Program	Employees Who Are Regularly Scheduled to Work at Least Thirty (30) Hours Per Week	Date Of Hire

CONSTITUENT BENEFIT PROGRAMS	POLICY OR BOOKLET NUMBER	TYPES OF BENEFITS PROVIDED	ELIGIBLE EMPLOYEES	ELIGIBILITY ENTRY DATES
Health Advocate Employee Assistance Program	N/A	Employee Assistance Program	Employees Who Are Regularly Scheduled to Work at Least Thirty (30) Hours Per Week	Date Of Hire

Exhibit B

GrafTech International Holdings, Inc.
Controlled Group Members

The term "GrafTech International Holdings, Inc." or "Company" refer to the following Controlled Group Members:

GrafTech International Holdings, Inc.	EIN # 06-1249029
Fiber Materials, Inc.	EIN # 37-1650609
Intermat	EIN # 01-0504952
Seadrift Coke LP	EIN # 20-2692750
GrafTech USA LLC	EIN # 04-3583868