



2026

BENEFITS GUIDE

OPEN ENROLLMENT
NOVEMBER 3-14, 2025

HOURLY EMPLOYEES

ORASCOM CONSTRUCTION | USA

WEITZ

CONTRACK WATTS

TABLE OF CONTENTS

This benefits guide describes the benefit plans available to you as an employee of The Weitz Company. The details of these plans are contained in the official plan documents that have been provided to you by your employer and include some insurance contacts. This guide is meant to cover only the highlights of each plan. It does not contain all the details that are included in your summary plan description as described by the Employee Retirement Income Security Act (ERISA).

If there is ever a question about one of these plans, or if there is a conflict between the information in this guide and the formal language of the plan documents, the formal wording in the plan documents will govern. Please note that the benefits described in this guide may be changed at any time and do not represent a contractual obligation on the part of The Weitz Company.

IMPORTANT CONTACTS 2
WELCOME! 3
HOW TO ENROLL 4
CHOOSE YOUR MEDICAL PLAN 5
UNDERSTANDING YOUR OPTIONS 5
MEDICAL PLAN COMPARISON 6
PHARMACY 7
DIATHRIVE DIABETES PROGRAM 8
TELEHEALTH BENEFITS 9
HEALTH SAVINGS ACCOUNT (HSA) 10
FLEXIBLE SPENDING ACCOUNT (FSA) 11
DENTAL PLAN 12
VISION PLAN 13
LIFE INSURANCE 14
VOLUNTARY BENEFITS 15
EMPLOYEE ASSISTANCE PROGRAM 19
401(K) 20
EMPLOYEE CONTRIBUTIONS 21
ANNUAL BENEFIT NOTICES 22

IMPORTANT CONTACTS

COVERAGE	CONTACT	PHONE	WEBSITE
Medical	Wellmark	800-524-9242	wellmark.com
Pharmacy	Vivid Clear Rx	877-848-4379	vividclearrx.com
Dental	Delta Dental of Iowa	800-544-0718	deltadentalia.com
Vision	VSP	800-877-7195	vsp.com
Telemedicine	Doctor On Demand	800-997-6196	doctorondemand.com
FSA	HealthEquity	866-889-8583	healthequity.com
HSA	HealthEquity	866-889-8583	healthequity.com
Life and Accidental Death and Disability (AD&D)	Mutual of Omaha	800-877-5176	mutualofomaha.com
Disability	Mutual of Omaha	800-877-5176	mutualofomaha.com
Accident & Critical Illness Insurance and Hospital Indemnity	Mutual of Omaha	800-755-6000	mutualofomaha.com
401(k) Retirement	Principal Retirement Service Center	800-547-7754	principal.com
Employee Assistance Program	SupportLinc	888-881-5462	supportlinc.com
Human Resources (HR)	Weitz HR		weitzHR@weitz.com

Additional information is available on the Company SharePoint Intranet. There you can find plan benefit summaries with specific benefit details. Contact your local HR resource for additional information. You may also contact HR at WeitzHR@weitz.com.

Please call 844-589-6900 to speak with a Benefit Counselor to elect or make benefit changes.



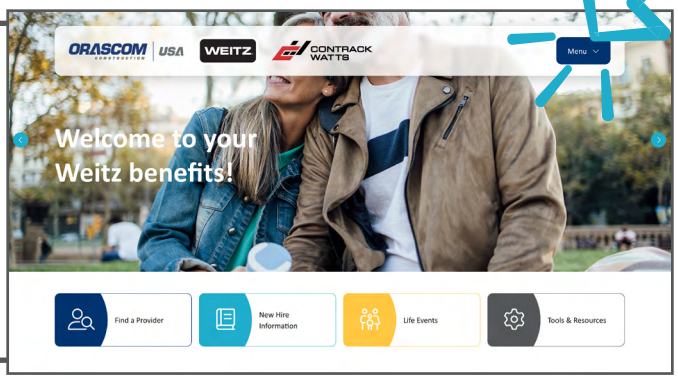
WELCOME!

Weitz is proud to offer a comprehensive benefits program designed to support your health, financial security, and overall well-being. Our benefits are built to be flexible—so you can choose the coverage that fits your lifestyle, your goals, and your family's needs.

This guide highlights the core benefits available to you as a Weitz employee and is a great place to start if you have questions or want to review your options. Please take time to read through the information and understand your choices, and be sure to enroll before the deadline.

Introducing WeitzBenefits.com

Weitz has a new, easy-to-use employee benefits website. Visit the site to access educational videos, plan details, FAQs, and tools to help you make informed decisions about your coverage. Whether you're comparing medical plans or learning how to use your HSA, everything you need is in one place—available 24/7 on your phone, tablet, or computer.



OPEN ENROLLMENT: TAKE ACTION!

November 3-14, 2025

This is a passive enrollment. If you do not enroll in benefits for 2026, most of your 2025 benefits will carry over automatically. However, you must actively re-elect your HSA or FSA contributions each year if you want to continue participating.

You will not be able to make changes to your benefits after Open Enrollment unless you experience a Qualifying Life Event (QLE).

QUALIFYING LIFE EVENTS

You may update your benefit elections mid-year only if you have a QLE, such as:

- Marriage, divorce, or legal separation
- Birth, adoption, or guardianship of a child
- Change in employment status for you or your spouse
- Your spouse's Open Enrollment at their employer

Important

If you have a QLE and need to make a change before the next Open Enrollment period, you must submit the required documentation WITHIN 30 DAYS of the event.

Contact WeitzHR for help initiating a change.

HOW TO ENROLL

You can enroll in your benefits either online or by calling the Benefits Call Center at 844-589-6900. During Open Enrollment, you'll have the opportunity to:

- Review your current benefit elections
- Learn about any plan updates
- Add or remove dependents
- Make new elections for 2026

ENROLL ONLINE

Follow these steps to complete your enrollment online:

1. Go to partners.benselect.com/weitz.
2. Log in using your full Social Security Number as your username.
3. Use the last four digits of your SSN + the last two digits of your birth year and your password. (Example: 123495).
4. After logging in, follow the prompts to select and confirm your benefits.
5. It will ask for the PIN/password again - make sure you input it again, hit enter, and you receive a confirmation email

WHEN TO ENROLL

You must complete your enrollment within 30 days of your hire date and coverage begins first of the month following 60 days of employment. You can enroll online or by calling the Benefits Call Center.

For example:

If your hire date is July 27, 2026, you have until August 27, 2026 to enroll. Your coverage would begin on October 1, 2026. Need help? Benefit Counselors are available through the Call Center to guide you through your options and ensure that your enrollment is complete. You can also enroll during the Annual Open Enrollment period each fall. Elections made during Open Enrollment take effect on January 1, 2026.

Questions? Contact your local HR Coordinator or email WeitzHR@weitz.com.

WHO IS ELIGIBLE?

You are eligible to enroll in the Weitz benefits program if you are a regular full-time or part-time employee working at least 20 hours per week. Your benefits begin on the first day of the month following 60 days of employment.

Eligible Dependents

You may enroll the following family members in your benefits:

- Your legal spouse (*subject to the Working Spouse Provision—see page 5 for details*)
- Your children up to age 26, including:
  - Biological children
  - Stepchildren
  - Legally adopted children
  - Children for whom you have legal guardianship
- Children over age 26 if they are unmarried, totally disabled, and claimed as dependents on your federal tax return *(Documentation of disability may be required)*

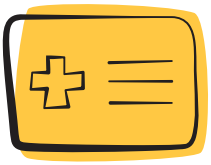
CHOOSE YOUR MEDICAL PLAN

Weitz offers three medical plans through Wellmark Blue Cross Blue Shield, all of which provide nationwide coverage through the Alliance Select PPO network.

You may visit any provider you choose, but you'll pay less when using in-network providers. These providers have agreed to discounted rates, which means lower out-of-pocket costs for you. If you go out of network, you may be billed for the difference between what the provider charges and what the plan considers Reasonable and Customary.

To find an in-network provider, visit wellmark.com and search within the Alliance Select network.

Note: You will receive separate ID cards for medical and pharmacy coverage.



UNDERSTANDING YOUR MEDICAL PLAN OPTIONS

All three plans cover preventive care at 100% in-network. Here's how they differ:

Plan 1: $1,500 PPO

- A traditional plan with copays for doctor visits and prescriptions
- You don't need to meet your deductible before using these copays
- Each family member has an individual deductible and out-of-pocket max
- Includes a separate out-of-pocket max for prescriptions:
  - $2,850 (individual) / $5,700 (family)

Plan 2: $3,000 HDHP

- A High Deductible Health Plan (HDHP) eligible for an HSA
- No copays—all expenses apply to the deductible and out-of-pocket maximum
- All family expenses count toward the family deductible, regardless of who incurs them
- Once you meet the deductible, the plan covers 100% of eligible in-network expenses. Because the deductible and out-of-pocket maximum are the same, you won't pay anything further after meeting the deductible.

Plan 3: $5,000 PPO

- Another traditional plan with copays and a higher deductible
- Same structure as the $1,500 PPO plan but with lower premiums
- You'll pay more out of pocket before coverage kicks in, but your paycheck deductions will be lower

Working Spouse Provision

If your spouse has access to affordable health coverage through their own employer and works full time, they are not eligible to enroll in Weitz's medical plan. However, they may still enroll in Weitz's dental and vision plans, and your children may remain enrolled in the medical plan.

Register Online

Your connection to great healthcare is only a click away. Register for an online account at wellmark.com so you can access time-saving tools and tips for healthy living, choose a doctor, manage your Explanations of Benefits, and more! Note: It may take up to two weeks after enrolling for your Wellmark account to be activated.

Download the Mobile App

With the **Wellmark mobile app**, you've got the tools you need to manage your healthcare, all from your smartphone. The mobile app is available in the Apple and Google Play stores.

Available on the App Store

GET IT ON Google Play

MEDICAL PLAN COMPARISON

WELLMARK BLUE CROSS BLUE SHIELD

	$1,500 PPO	$3,000 HDHP	$5,000 PPO
BENEFITS IN-NETWORK			
ANNUAL DEDUCTIBLE			
Individual	$1,500 Embedded	$3,000 Non-Embedded	$5,000 Embedded
Family	$3,000	$6,000	$10,000
OUT-OF-POCKET (OOP) MAXIMUM			
Individual	$4,000	$3,000	$6,850
Family	$8,000	$6,000	$13,700
BENEFIT HIGHLIGHTS			
Doctor on Demand Virtual Visits (Including Mental Health)	$0 copay	$0 copay	$0 copay
Preventive Care	Covered at 100%	Covered at 100%	Covered at 100%
Primary Care Physician / Chiropractic	$25 copay	Deductible	$20 copay
Specialist	$50 copay	Deductible	$20 copay
Mental Health Visits	$0 copay	Deductible	$0 copay
Emergency Room	Deductible, then 20%	Deductible	Deductible, then 50%
Inpatient Hospital	Deductible, then 20%	Deductible	Deductible, then 50%
Outpatient Hospital	Deductible, then 20%	Deductible	Deductible, then 50%
Urgent Care	$25 copay	Deductible	$20 copay
Outpatient Surgery	Deductible, then 20%	Deductible	Deductible, then 50%
Lab/X-Ray (Outpatient)	Deductible, then 20%	Deductible	Deductible, then 50%
BENEFITS OUT-OF-NETWORK			
Deductible – Single / Family	$1,500 / $3,000	$3,000 / $6,000	$6,850 / $13,700
Member Coinsurance	30%	0%	60%
OOP Maximum – Single / Family	$4,000 / $8,000	$3,000 / $6,000	$10,000 / $20,000
RATES – PER PAY PERIOD (WEEKLY)	WELLNESS/ NON-WELLNESS	WELLNESS/ NON-WELLNESS	WELLNESS/ NON-WELLNESS
Employee Only	$53.00 / $63.00	$24.00 / $29.00	$14.00 / $17.00
Employee/Spouse	$117.00 / $139.00	$56.00 / $66.00	$30.00 / $36.00
Employee/Child(ren)	$99.00 / $118.00	$48.00 / $57.00	$27.00 / $32.00
Family	$174.00 / $207.00	$84.00 / $99.00	$44.00 / 52.00

Please note: The medical plans do not require a referral to see a specialist, but the specialist may require a referral from a primary care physician. Please note: If you go to an out-of-network provider, your cost may be higher and your provider may ask you to pay the actual charge for your care at the time of your visit.

You will receive separate medical and pharmacy ID cards.

Embedded vs. Non-Embedded Deductibles

- **Embedded Deductible (PPO Plans):** Each family member has their own individual deductible. Once an individual meets their deductible, the plan begins paying benefits for that person—even if the full family deductible has not been met.
- **Non-Embedded Deductible (HDHP Plan):** There is only a family deductible. The plan does not begin paying benefits for any family member until the entire family deductible has been met.

This distinction is important when comparing how quickly benefits start for an individual versus the whole family.



PHARMACY

VIVID CLEAR RX

PHARMACY BENEFITS				
ANNUAL DEDUCTIBLE		$1,500 PPO	$3,000 HDHP	$5,000 PPO
Pharmacy OOP Maximum		$2,850 Single $5,700 Family	Combined with Medical	Combined with Medical
Retail 30-Day Supply	Tier 1	$15	Deductible	$15
	Tier 2	$35	Deductible	50% coinsurance
	Tier 3	$60	Deductible	Deductible, 50% coinsurance
	Specialty	20% coinsurance	Deductible	Deductible, 50% coinsurance
Mail Order 90-Day Supply	Tier 1	$30	Deductible	$45
	Tier 2	$70	Deductible	Deductible, 50% coinsurance
	Tier 3	$180	Deductible	Deductible, 50% coinsurance

You will receive separate medical and pharmacy ID cards.

Hy-Vee Mail Order

Save time by getting your prescriptions sent directly to your home! Follow the steps below to transfer your maintenance medication to Hy-Vee's mail order/home delivery service:

1. Visit vividclearrx.com and select "Prescription Mail Order" under the Members drop-down menu.
2. Under "Getting started is easy," click "Transfer Prescriptions."
3. Complete the Hy-Vee Mail Order online welcome packet. Review and scroll through "Patient Rights" and "Notice of Privacy" to mark the acknowledgement box.

For new mail order prescriptions, please have your physician e-prescribe it directly to Hy-Vee Mail Order.

New for 2026: In-Network Pharmacies

You may choose to fill prescriptions at any in-network retail or mail order pharmacy, including Hy-Vee and others. Your cost share will be the same at all participating pharmacies, giving you flexibility in where you fill your prescriptions.

To find a Hy-Vee retail location, click here.

Additional Mail Order Option: Mark Cuban Cost Plus Drugs

Mark Cuban Cost Plus Drugs is an independent online pharmacy that offers many generic medications at discounted prices. You may choose to use Cost Plus Drugs as another mail order option for certain prescriptions.

Important to know:

- Not all medications are available through Cost Plus Drugs.
- To explore pricing and availability, visit costplusdrugs.com.

Specialty Prescriptions

Specialty medications are covered only when the Vivid Clear Rx Specialty Pharmacy Program is used. If you currently fill a specialty medication at a specialty pharmacy, the prescription will need to be transferred to Amber Specialty Pharmacy.

Existing prescription: Call 888-370-1724.
New prescriptions: Call 888-370-1724 or have your physician e-prescribe to Amber Specialty.

DIATHRIVE

DIABETES SUPPORT PROGRAM

Managing diabetes doesn't have to be complicated—or expensive. Weitz partners with Diathrive Health to offer eligible employees and dependents access to a no-cost diabetes management program.

WHAT'S INCLUDED

The program provides comprehensive tools and support for individuals managing Type 1, Type 2, or gestational diabetes:

- Unlimited testing supplies shipped directly to your home
- Personalized coaching from certified diabetes care and education specialists
- Access to a user-friendly mobile app to track glucose, medications, nutrition, and activity
- Health tips and resources tailored to your lifestyle and goals

WHAT'S NOT INCLUDED

Some diabetes-related supplies and medications are covered under other parts of your benefits:

- **Continuous Glucose Monitors (CGMs):** Covered under the pharmacy plan through VividClearRx.
- **Insulin Pumps:** Covered under Durable Medical Equipment (DME) through your medical plan (Wellmark).
- **Insulin:** Covered under the pharmacy plan through VividClearRx.

For these items, your normal medical or pharmacy cost share will apply based on the plan you are enrolled in.

ELIGIBILITY

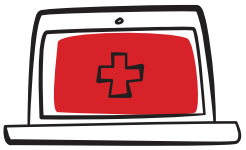
You must be enrolled in a Weitz medical plan to participate in the Diathrive Health program. Eligible participants will be contacted directly with instructions on how to enroll.

WHY IT MATTERS

This program helps you take control of your health with expert guidance and convenient tools—at no cost to you.

Call 866-878-7477 to get started today!





TELEHEALTH

CARE WHEN YOU NEED IT

Skip the waiting room and see a doctor from the comfort of home—day or night. **Doctor On Demand** provides 24/7 access to licensed, board-certified physicians via secure video visits. When you use Doctor On Demand, your cost is **$0 copay on all medical plans.**

WHAT YOU CAN USE IT FOR:

Telehealth is ideal for treating common, non-emergency conditions such as:

- Cold and flu symptoms
- Sinus infections
- Allergies
- Rashes and skin conditions
- Urinary tract infections
- Pink eye
- Headaches, joint pain, and more
- Mental health concerns such as stress, anxiety, and depression

Doctors can also prescribe medications or offer short-term refills, sent directly to a nearby pharmacy.

WHY USE TELEHEALTH?

- **Convenient:** Available anytime—including weekends and holidays
- **Affordable:** No out of pocket cost compared to urgent care or ER visits
- **Fast:** Skip the drive and get care in minutes

	$1,500 PPO	$3,000 HDHP	$5,000 PPO
Virtual Visits	$0 copay	$0 copay	$0 copay



Get Started

1. Download the **Doctor On Demand** app or visit doctorondemand.com.
2. Have your **Wellmark BCBS member ID** ready.
3. Create an account and log in.
4. Questions? Call **800-997-6196** anytime.

HEALTH SAVINGS ACCOUNT

ADMINISTERED BY HEALTHEQUITY

If you enroll in the $3,000 HDHP, you're eligible to open and contribute to an **(HSA)**. This account lets you set aside money **tax-free** to pay for qualified healthcare expenses.

WHAT CAN YOU USE IT FOR?

You can use HSA funds to pay for:

- Doctor visits, prescriptions, and hospital bills
- Dental and vision expenses
- Deductibles, copays, and coinsurance

KEY BENEFITS

- **Triple tax savings:** Contributions are tax-free, earnings grow tax-free, and withdrawals are tax-free when used for qualified expenses
- **Lower premiums** with the HDHP
- **Funds roll over** year to year: There's no "use it or lose it"
- **Portable:** You keep the money even if you change jobs or retire
- **Penalty-free access after age 65** (for any purpose, though non-medical expenses are taxed as income)

ELIGIBILITY REQUIREMENTS

You must:

- Be enrolled in the $3,000 HDHP
- Not be covered by any non-HDHP medical plan (including a spouse's plan)
- Not be enrolled in Medicare, Medicaid, Tricare, or a traditional healthcare FSA
- Not be claimed as a dependent on someone else's tax return
- Not have used VA services (except preventive care) in the past three months

HOW MUCH CAN I CONTRIBUTE TO AN HSA?

- Employee only coverage: $4,400 per calendar year
- Employee plus dependents coverage: $8,750
- If you are 55 or older, you can make an additional annual catch-up contribution of $1,000

*The Company contribution to your HSA will be prorated on a per-pay-period basis. A $2.50 monthly administrative fee will be taken out of the Company contribution and paid to HealthEquity.



Want help understanding your HSA or opening an account? Visit myhealthequity.com or call **866-889-8583**.

FLEXIBLE SPENDING ACCOUNTS

ADMINISTERED BY HEALTHEQUITY

FSAs help you save on healthcare and dependent care expenses by using **pre-tax dollars**. That means you reduce your taxable income and keep more of your paycheck.

HEALTH CARE FSA

Use this account to pay for eligible out-of-pocket medical, dental, and vision expenses such as:

- Copays, deductibles, and coinsurance
- Prescriptions
- Eyeglasses, contacts, dental cleanings, and more

2026 contribution limit: $3,400

DEPENDENT CARE FSA

Use this account to pay for qualified childcare or elder care expenses so you (and your spouse) can work, look for work, or attend school full-time. Eligible expenses include:

- Daycare, preschool, before-/after-school care
- Summer day camps
- In-home or adult day care for a dependent elder

2026 contribution limits:

- Up to $7,500 per household
- $3,750 if married and filing separately

Note: Funds are available only as they're deposited—unlike the Health Care FSA, which gives access to the full election amount up front.

Who Can Enroll?

- You do not need to be enrolled in a Weitz medical plan to participate.
- If you are enrolled in a traditional PPO plan ($1,500 or $5,000), you can elect a full Health Care FSA.
- If you are enrolled in the $3,000 HDHP, you are only eligible for a Limited Purpose FSA (for dental and vision expenses only).

Important: FSAs are "use it or lost it." Any unused funds will be forfeited at year-end. You will have until March 30, 2026 to submit a reimbursement for expenses incurred in 2025.

If you terminate mid-year and have contributed more to your FSA than you have spent, you will be eligible to elect COBRA coverage for your FSA.



Eligible Expenses

For full lists of eligible items, visit:

- IRS Publication 502 (Medical) [irs.gov/pub/irs-pdf/p502.pdf]
- IRS Publication 503 (Dependent Care) [irs.gov/pub/irs-pdf/p503.pdf]
- HealthEquity's qualified expenses tool [healthequity.com/hsa-qme]

Need help? Visit myhealthequity.com or call **866-889-8583**.



DENTAL PLAN

DELTA DENTAL

Find a provider:

deltadental.com/us/en/member/find-a-dentist.html

Two dental plans are available to you—a core plan and a buy-up plan. Both dental plans have a dual network option. The Delta Dental PPO network provides employees with the lowest out-of-pocket costs. More than 45% of dentists nationally participate in the PPO network. The Premier network is the largest dental network in the nation, with more than 80% of all dentists participating nationally. The Premier network gives you greater access while still keeping your out-of-pocket costs low.

CORE PLAN

IN-NETWORK PLAN FEATURES	PPO	PREMIER
Annual Deductible – Individual	$25	$50
Annual Deductible – Family	$75	$150
Annual Maximum	$1,000	$1,000
Preventive Care	Deductible waived, covered at 100%	Deductible waived, covered at 100%
Basic Services	Deductible, 10% coinsurance	Deductible, 20% coinsurance
Major Services	Deductible, 50% coinsurance	Deductible, 50% coinsurance
Orthodontia Services	$1,000 per lifetime for Orthodontia	
RATES PER PAY PERIOD	**WEEKLY**	
Employee	$2.50	
Employee & Spouse	$4.50	
Employee & Children	$5.25	
Family	$7.50	

BUY-UP PLAN

IN-NETWORK PLAN FEATURES	PPO	PREMIER
Annual Deductible – Individual	$25	$50
Annual Deductible – Family	$75	$75
Annual Maximum	$1,500	$1,500
Preventive Care	Deductible waived, covered at 100%	Deductible waived, covered at 100%
Basic Services	Deductible, 10% coinsurance	Deductible, 50% coinsurance
Major Services	Deductible, 20% coinsurance (some may be covered at 50% coinsurance)	Deductible, 50% coinsurance
Orthodontia Services	$1,500 per lifetime for Orthodontia	
RATES PER PAY PERIOD	**WEEKLY**	
Employee	$4.00	
Employee & Spouse	$9.00	
Employee & Children	$10.00	
Family	$14.00	

This dental plan includes a To Go Benefit, which allows you to carry over a portion of your unused annual maximum year to year. Your maximum annual benefit will never be greater than two times the annual benefit maximum. To receive the To Go benefit, you must have one claim during the calendar year.



VISION PLAN

VSP

Find a provider:
vsp.com

Driving to work, reading a news article, and watching TV are activities you likely perform every day. Your ability to do all of these, though, depends on your vision and eye health. Vision insurance can help you maintain your vision as well as detect various health problems.

Your vision insurance is provided by VSP and entitles you to specific eyecare benefits. Our policy covers routine eye exams and other procedures and provides specified dollar amounts or discounts for the purchase of eyeglasses and contact lenses.

You will not receive a benefit ID card. You will provide your Social Security Number to your provider to verify benefits.

	IN NETWORK	OUT OF NETWORK
OFFICE VISIT		
Routine Vision Exam	$20 copay	Reimbursed up to $50
EYEGLASS LENSES, MATERIALS, AND FRAMES		
Single Vision Lenses	Paid in full after $35 copayment	Reimbursed up to $50
Standard Lined Bifocal Lenses	Paid in full after copay	Reimbursed up to $75
Standard Trifocal Lenses	Paid in full after copay	Reimbursed up to $100
Lenticular	Paid in full after copay	Reimbursed up to $125
Frames	Plan pays for $200 after copay	Reimbursed up to $70
Scratch Resistant Coating	$0 copay	Members pay 100% of Cost
Contact Lenses Elect Medically Necessary	 $130 allowance Paid in full after copay	 Reimbursed up to $105 Reimbursed up to $210
FREQUENCY OF SERVICES		
Comprehensive Eye Exam	Every 12 months	
Lenses	Every 12 months	
Frames	Every 24 months	
Contact Lenses	Every 12 months	
RATES PER PAY PERIOD	**WEEKLY**	
Employee	$1.00	
Employee & Spouse	$2.00	
Employee & Children	$1.50	
Family	$2.50	

EXCLUSIVE MEMBER SAVINGS

- 30% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses (same day, same provider as your WellVision Exam).
- Average of 15% off Laser Vision Correction at contracted facilities.
- Access to Eyeconic®, VSP's preferred online retailer for glasses, sunglasses, and contacts.

Important:
You may choose either lenses or contact lenses during a single benefit period, but not both.

LIFE INSURANCE

MUTUAL OF OMAHA

BASIC LIFE AND (AD&D)

The Basic Life and AD&D plan provides a benefit in the event of your death, dismemberment, or paralysis. This benefit is sponsored by The Weitz Company, so you will automatically be enrolled at no cost to you. Your coverage will be **a flat benefit of $20,000.**

SUPPLEMENTAL LIFE INSURANCE

You may purchase additional life insurance at group rates:

- Choose from $10,000 up to $500,000 in $10,000 increments, or five times your earnings. You can elect up to $250,000 at your new hire enrollment without having to go through medical underwriting.
- You pay the full cost of this plan, and the amount deducted depends on the age of the employee and the amount of coverage elected.
- If you do not elect this coverage when first becoming eligible, you are subject to medical underwriting by the carrier.
- Rates can be found by logging into Benselect.
- Benefits will be reduced to 65% of face amount at age 65, 50% of face amount at age 70, and 35% of face amount at age 75.

SPOUSAL AND CHILD LIFE INSURANCE

You may also purchase additional dependent life insurance at group rates:

- Spousal life insurance is available in increments of $5,000 up to a max of $250,000 (or 50% of employee election).
- As a new hire, you can elect up to $50,000 without medical underwriting.
- Spouse benefit will be reduced to 65% of face amount at age 65, 50% of face amount at age 70, and 35% of face amount at age 75.
- Child life insurance is available from birth to age 26 and is a flat benefit amount of $10,000.
- Children are not subject to medical underwriting.
  - The cost remains the same regardless of the number of children you have

Guaranteed Issue and Evidence of Insurability

Employees and spouses who elect Voluntary Life and AD&D coverage when they are first eligible can elect up to the Guaranteed Issue (GI) amount without Evidence of Insurability (EOI). If the amount requested is more than GI, you will need to provide EOI before the amount over GI becomes effective.

Imputed Income

Under current tax laws, imputed income is the value of your Basic Life insurance that exceeds $50,000 and is subject to federal income, Social Security, and state income taxes, if applicable. This imputed income amount will be included in your paycheck and shown on your W-2 statement.

Please ensure that your beneficiary remains up to date in Benselect.



VOLUNTARY BENEFITS

MUTUAL OF OMAHA

SHORT-TERM DISABILITY (STD)

The voluntary STD plan provides full-time employees with income replacement while disabled and unable to work due to a non-occupational illness or injury, including pregnancy.

When you become disabled, you must complete a waiting period before benefits are payable. When benefit payments begin, you will receive 60% of your weekly earnings, up to a maximum of $700 per week.

For disabilities caused by both accidental injury and sickness, you will have a waiting period of 7 days, which means benefits will be payable beginning on Day 8.

The maximum amount of time that you are able to receive Short-Term Disability payments is 26 weeks, or as long as you meet the definition of disability (whichever is shorter).

AGE	WEEKLY RATE PER $10 OF WEEKLY BENEFIT — 7-DAY WAITING PERIOD
Under 50	$0.67
51-59	$0.93
60+	$1.48

Rates are calculated based on the employee's current age on the effective date of the plan and are adjusted once per year on January 1st. The rate shown reflects the premium per $10 of covered weekly benefit.



The voluntary STD coverage is guarantee issue, which means you do not have to answer medical questions to be approved for coverage.

There is a pre-existing condition exclusion that applies if you become disabled during the first 12 months following the effective date of your coverage. A pre-existing condition is any condition for which you have done any of the following at any time during the 12 months immediately prior to your effective date of coverage (whether or not the condition is diagnosed, undiagnosed, or misdiagnosed):

- Received medical treatment or consultation
- Taken or were prescribed drugs or medicine
- Receive care or services, including diagnostic measures.

VOLUNTARY BENEFITS

MUTUAL OF OMAHA

HOSPITAL INDEMNITY INSURANCE

Hospital Indemnity insurance is designed to pay for the costs of a hospital admission. The plan covers employees who are admitted to a hospital for a covered sickness or injury. Even if your Medical insurance covers most of your hospitalization, you can still receive payments from your Hospital Indemnity insurance plan to cover extra expenses while you recover.

How Does Hospital Indemnity Insurance Work?

When you or a covered family member is hospitalized, this plan pays a cash benefit directly to you. You can use the money to help cover medical bills or everyday expenses while you recover.

Here's what's included:

- **ICU Admission Benefit:** $2,000, paid once per ICU admission
- **Regular Admission Benefit:** $1,000
- **Daily Hospital Stay Benefit:** $100 per day you are admitted to the hospital
- **Daily ICU Stay Benefit:** $200 per day you are admitted to the ICU
- **Newborn Nursery Care Benefit:** $75 per day, up to 2 days per policy year
- **Health Screening Benefit:** $50 per covered person, once per year (up to 6 per family)

The policy is portable, meaning you can continue it if you leave employment.

RATES PER PAY PERIOD	WEEKLY
Employee	$3.17
Employee & Spouse	$7.70
Employee & Children	$6.32
Family	$10.84

To learn more, please refer to the plan summaries that are posted at WeitzBenefits.com.



VOLUNTARY BENEFITS

ACCIDENT INSURANCE

Accident insurance pays out based on a schedule of benefits if you become injured because of an accident—even if the injuries you incur do not keep you out of work. While health insurance companies pay your provider or facility, Accident insurance pays you directly.

How Does Accident Insurance Work?

Accident insurance policies can pay a lump sum directly to you that will help you pay for a wide range of situations, including initial care, surgery, transportation and lodging, and follow-up care. Here's how it works:

- A set amount is payable based on the injury you suffer and the treatment you receive,
- Benefits are payable directly to you (unless you specify otherwise) and can be used as you see fit.
- A benefit is also included for accidental death and dismemberment.
- Coverage is available for you, your spouse, and eligible dependent children.
- You do not need to answer medical questions or have a physical exam to get basic coverage.
- Benefit payments are not reduced by any other insurance you may have with other companies.
- Coverage is portable in the event that you terminate employment.

Covered expenses typically include:

- Emergency room visits
- Hospital stays
- Fractures and dislocations
- Medical exams
- Physical therapy
- Transportation and lodging

Wellness Benefit

- This plan contains a $50 annual wellness benefit. Complete an eligible health screening, and you will receive a $50 payment.

RATES PER PAY PERIOD	WEEKLY
Employee	$2.03
Employee & Spouse	$2.88
Employee & Children	$4.18
Family	$5.03

To learn more, please refer to the plan summaries that are posted at WeitzBenefits.com.

VOLUNTARY BENEFITS

CRITICAL ILLNESS INSURANCE

While Medical insurance is vital, it doesn't cover everything. If you suffer from a serious illness, such as cancer, stroke, or heart attack, you will still be subject to the applicable deductible, coinsurance amounts, and OOP maximum. Critical Illness insurance will ease the financial strain and help you focus on your recovery.

How Will a Critical Illness Claim Get Paid?

The payment will go directly to you instead of to a medical provider. The payment can be used for whatever you would like. You can purchase a benefit of $10,000, $20,000, or $30,000. Coverage is also available for spouses and dependent children (up to $10,000). Children are eligible from birth to age 26, with no limit to the number of children per family.

Covered Expenses Include Things Like:

- Heart attack and stroke
- Cancer
- Type 1 diabetes
- Severe burns
- Paralysis and loss of sight, hearing, or speech
- Kidney failure
- Coronary artery bypass
- MS, ALS, Parkinson's, Alzheimer's, Huntington's

Refer to the benefit summary for a full list of covered conditions.

Wellness Benefit

- This plan contains a $50 annual wellness benefit. Complete an eligible health screening, and you will receive a $50 payment.

The rates for the Critical Illness policy depend on the benefit you elect and your attained age. The spouse premium is based on the employee's attained age.

To learn more, please refer to the plan summaries that are posted at WeitzBenefits.com.

EMPLOYEE & SPOUSE – PER PAY PERIOD RATES			
Attained Age	$10,000	$20,000	$30,000
Under 25	$0.88	$1.75	$2.63
25-29	$0.95	$1.89	$2.84
30-34	$1.13	$2.26	$3.39
35-39	$1.43	$2.86	$4.29
40-44	$2.22	$4.43	$6.65
45-49	$3.00	$6.00	$9.00
50-54	$4.13	$8.26	$12.39
55-59	$5.61	$11.22	$16.82
60-64	$6.72	$13.43	$20.15
65-69	$8.82	$17.63	$26.45
70+	$12.14	$24.28	$36.42

Child insurance is automatic and does not require a separate premium.



EMPLOYEE ASSISTANCE PROGRAM (EAP)

PROVIDED BY SUPPORTLINC | AVAILABLE 24/7 | CONFIDENTIAL AND FREE

Life can be complicated—but you don't have to navigate it alone. The SupportLinc (EAP) is here to help you and your family manage personal, work, and life challenges.

This benefit is completely confidential, available at no cost, and open to you and your immediate household members.

Support Is Just a Call or Click Away

You can access licensed professionals and helpful resources for:

- Emotional well-being (stress, anxiety, depression, grief)
- Work-life balance (time management, burnout, return-to-work concerns)
- Family and relationships
- Financial coaching and legal consultations
- Substance use support and recovery resources

SupportLinc EAP app

supportlinc.com/mobile

Available on the App Store

GET IT ON Google Play

Get Started Anytime

- **Call:** 888-881-5462
- **Visit:** supportlinc.com
- **Company code:** *weitz* (if prompted)

The EAP is available 24 hours a day, 365 days a year.

Whether you're going through a tough time or just want to talk to someone, SupportLinc is here to help—with real solutions and real support.



PLAN FOR THE FUTURE: 401(K) RETIREMENT PLAN

PROVIDED BY PRINCIPAL®

Weitz is committed to helping you build long-term financial security. That's why we offer a 401(k) retirement plan with automatic enrollment, company matching, and flexible investment options.

ENROLLMENT

You are eligible to participate on your first day of employment if you are a regular employee of a sponsoring employer. You'll be automatically enrolled after 30 days of employment at an 8% pre-tax contribution rate—unless you choose a different amount or opt out.

CONTRIBUTIONS

- Contribute up to 80% of your eligible pay (subject to annual IRS limits).
- Choose between pre-tax, Roth (after-tax), or a combination of both.
- If you're age 50 or older, you're eligible for catch-up contributions.

Your contribution rate will automatically increase by 1% every April 1, up to a maximum of 12%, unless you make changes.

COMPANY MATCH

Weitz helps you save even more by matching 50% of the first 8% you contribute.

- Match is made each pay period when you contribute.
- That's up to 4% of your pay in company contributions.

VESTING SCHEDULE (COMPANY CONTRIBUTIONS ONLY)

Years of service	Vested amount
Less Than 2 Years	0%
2 Years	50%
3 Years	100%

You are always 100% vested in your own contributions and the earnings they generate.

INVESTMENT OPTIONS

Unless you choose otherwise, your contributions will go into a Fidelity Freedom Blend Target Date Fund based on your age and expected retirement year. You can change your investments anytime at principal.com.

TAKE CONTROL OF YOUR RETIREMENT

- Log in or register: principal.com/Welcome
- Download the app: Search "Principal" in the Apple App Store or Google Play.

Questions?

Visit principal.com or call Principal® at 800-547-7754. Retirement specialists are available Monday-Friday, 7 a.m.–9 p.m. CT.



WHAT WILL I PAY?

PLAN CONTRIBUTIONS

PER PAY PERIOD – WEEKLY

Your medical premiums are based on the plan you choose, your coverage level, and whether or not you qualify for the wellness discount.

MEDICAL	$1,500 PPO WELLNESS/NON-WELLNESS	$3,000 HDHP WELLNESS/NON-WELLNESS	$5,000 PPO WELLNESS/NON-WELLNESS
Employee	$53.00 / $63.00	$24.00 / $29.00	$14.00 / $17.00
Employee & Spouse	$117.00 / $139.00	$56.00 / $66.00	$30.00 / $36.00
Employee & Children	$99.00 / $118.00	$48.00 / $57.00	$27.00 / $32.00
Family	$174.00 / $207.00	$84.00 / $99.00	$44.00 / 52.00

DENTAL/VISION	DENTAL - CORE PLAN	DENTAL - BUY-UP PLAN	VISION
Employee	$2.50	$4.00	$1.00
Employee & Spouse	$4.50	$9.00	$2.00
Employee & Children	$5.25	$10.00	$1.50
Family	$7.50	$14.00	$2.50

VOLUNTARY COVERAGES	HOSPITAL INDEMNITY	ACCIDENT
Employee	$3.17	$2.03
Employee & Spouse	$7.70	$2.88
Employee & Children	$6.32	$4.18
Family	$10.84	$5.03

What's the Wellness Discount?

If you complete a physical exam and submit your Physician Form by November 30, you'll qualify for a discount on your medical premiums in the following plan year. New hires automatically receive the discount for their first calendar year.

Need help calculating your total costs or deciding which plan is right for you? Call a Benefit Counselor at **844-589-6900**.

REQUIRED NOTICES

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

PART A: GENERAL INFORMATION

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.96% of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.96% of the employee's household income.1 2

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility.

To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325

What about Alternatives to Marketplace Health Insurance Coverage?.

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit healthcare.gov/medicaid-chip/getting-medicaid-chip for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Human Resources. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

1. Indexed annually; see irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
2. An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

SPECIAL ENROLLMENT NOTICE

This notice is being provided to make certain that you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

LOSS OF OTHER COVERAGE

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

This notice is being provided to make certain that you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

MARRIAGE, BIRTH OR ADOPTION

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption.

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this Plan. However, you must apply within 30 days from the date of your marriage.

MEDICAID OR CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents.

You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

FOR MORE INFORMATION OR ASSISTANCE

To request special enrollment or obtain more information, please contact: Human Resources at WeitzHR@weitz.com

IMPORTANT NOTICE FROM THE WEITZ COMPANY ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with The Weitz Company and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Weitz Company has determined that the prescription drug coverage offered by the all plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current plan coverage will not be affected.

Your current coverage pays for other health expenses in addition to prescription drug. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits.

If you do decide to join a Medicare drug plan and drop your currentWeit Company coverage, be aware that you and your dependents may be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with The Weitz Company and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through The Weitz Company changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: 01/01/2026

Name of Entity/Sender: The Weitz Company

Contact--Position/Office: Krista Robinson

Address: 611 5th Ave, Suite 300, Des Moines, IA 50309

Phone Number: 515-698-4260

MICHELLE'S LAW ENROLLMENT NOTICE

Note: Pursuant to Michelle's Law, you are being provided with the following notice because the The Weitz Company's group health plan provides dependent coverage beyond age 26 and bases eligibility for such dependent coverage on student status. Please review the following information with respect to your dependent child's rights under the plan in the event student status is lost.

When a dependent child loses student status for purposes of The Weitz Company's group health plan coverage as a result of a medically necessary leave of absence from a post-secondary educational institution, the group health plan will continue to provide coverage during the leave of absence for up to one year, or until coverage would otherwise terminate under theThe Weitz Company's group health plan, whichever is earlier.

In order to be eligible to continue coverage as a dependent during such leave of absence:

The Weitz Company group health plan must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary; and

To obtain additional information, please contact: Human Resources at WeitzHR@weitz.com

WOMEN'S HEALTH AND CANCER RIGHTS ACT

ENROLLMENT NOTICE

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA).

For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- **All stages of reconstruction of the breast on which the mastectomy was performed;**
- **Surgery and reconstruction of the other breast to produce a symmetrical appearance;**
- **Prostheses; and**
- **Treatment of physical complications of the mastectomy, including lymphedema.**

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator at 800-887-1278.

ANNUAL NOTICE

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at 800-887-1278 for more information.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

The Newborns' and Mothers' Health Protection Act (the Newborns' Act) provides protections for mothers and their newborn children relating to the length of their hospital stays following childbirth.

Under the Newborns' Act, group health plans may not restrict benefits for mothers or newborns for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. The 48-hour (or 96-hour) period starts at the time of delivery, unless a woman delivers outside of the hospital. In that case, the period begins at the time of the hospital admission.

The attending provider may decide, after consulting with the mother, to discharge the mother and/or her newborn child earlier. The attending provider cannot receive incentives or disincentives to discharge the mother or her child earlier than 48 hours (or 96 hours).

Even if a plan offers benefits for hospital stays in connection with childbirth, the Newborns' Act only applies to certain coverage. Specifically, it depends on whether coverage is "insured" by an insurance company or HMO or "self-insured" by an employment-based plan. (Check the Summary Plan Description, the document that outlines benefits and rights under the plan, or contact the plan administrator to find out if coverage in connection with childbirth is "insured" or "self-insured.")

The Newborns' Act provisions always apply to coverage that is self-insured. If the plan provides benefits for hospital stays in connection with childbirth and is insured, whether the plan is subject to the Newborns' Act depends on state law. Many states have enacted their own version of the Newborns' Act for insured coverage. If your state has a law regulating coverage for newborns and mothers that meets specific criteria and coverage is provided by an insurance company or HMO, state law will apply.

All group health plans that provide maternity or newborn infant coverage must include in their Summary Plan Descriptions a statement describing the Federal or state law requirements applicable to the plan (or any health insurance coverage offered under the plan) relating to hospital length of stay in connection with childbirth for the mother or newborn child.

For more information, see the Frequently Asked Questions (FAQs) About the Newborns' and Mothers' Health Protection Act.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or

www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –

STATE	WEBSITE/EMAIL	PHONE
Alabama Medicaid	myalhipp.com	855-692-5447
Alaska Medicaid	Premium Payment Program: myakhipp.com Medicaid Eligibility: health.alaska.gov/dpa Email: customerservice@myakhipp.com	866-251-4861
Arkansas Medicaid	http://myarhipp.com/	855-MyARHIPP (855-692-7447)
California Medicaid	dhcs.ca.gov/hipp Email: hipp@dhcs.ca.gov	916-445-8322 916-440-5676 (fax)
Colorado Medicaid and CHIP	Medicaid: healthfirstcolorado.com CHIP: hcpf.colorado.gov/child-health-plan-plus HIBI: mycohibi.com	800-221-3943 Relay 711 800-359-1991 Relay 711 855-692-6442
Florida Medicaid	flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html	877-357-3268
Georgia Medicaid	HIPP: medicaid.georgia.gov/health-insurance-premium-payment-program-hipp CHIPRA: medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra	678-564-1162, press 1 678-564-1162, press 2
Indiana Medicaid	HIPP: https://www.in.gov/fssa/dfr/ All other Medicaid: in.gov/medicaid	800-403-0864 800-457-4584
Iowa Medicaid and CHIP	Medicaid: hhs.iowa.gov/programs/welcome-iowa-medicaid CHIP: hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki HIPP: hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp	800-338-8366 800-257-8563 888-346-9562
Kansas Medicaid	kancare.ks.gov	800-792-4884 HIPP: 800-967-4660
Kentucky Medicaid and CHIP	KI-HIPP: chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx KI-HIPP Email: KIHIPP.PROGRAM@ky.gov KCHIP: kynect.ky.gov Medicaid: chfs.ky.gov/agencies/dms	KI-HIPP: 855-459-6328 KCHIP: 877-524-4718
Louisiana Medicaid	ldh.la.gov/healthy-louisiana or www.ldh.la.gov/lahipp	Medicaid: 888-342-6207 LaHIPP: 855-618-5488
Maine Medicaid	Enrollment: mymaineconnection.gov/benefits Private health insurance premium: maine.gov/dhhs/ofi/applications-forms	Enroll: 800-442-6003 Private HIP: 800-977-6740 TTY/Relay: 711
Massachusetts Medicaid and CHIP	mass.gov/masshealth/pa Email: masspremassistance@accenture.com	800-862-4840 TTY/Relay: 711
Minnesota Medicaid	mn.gov/dhs/health-care-coverage	800-657-3672

STATE	WEBSITE/EMAIL	PHONE
Missouri Medicaid	dss.mo.gov/mhd/participants/pages/hipp.htm	573-751-2005
Montana Medicaid	HIPP: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP HIPP Email: HHSHIPPProgram@mt.gov	800-694-3084
Nebraska Medicaid	ACCESSNebraska.ne.gov	800-992-0900
Nevada Medicaid	Medicaid: dhcfp.nv.gov	800-992-0900
New Hampshire Medicaid	dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	603-271-5218 or 800-852-3345, ext. 15218
New Jersey Medicaid and CHIP	Medicaid: state.nj.gov/humanservices/dmahs/clients/medicaid CHIP: njfamilycare.org/index.html	Medicaid: 800-356-1561 CHIP Premium Assist: 609-631-2392 CHIP: 800-701-0710 TTY/Relay: 711
New York Medicaid	health.ny.gov/health_care/medicaid	800-541-2831
North Carolina Medicaid	medicaid.ncdhhs.gov	919-855-4100
North Dakota Medicaid	hhs.nd.gov/healthcare	844-854-4825
Oklahoma Medicaid and CHIP	insureoklahoma.org	888-365-3742
Oregon Medicaid	healthcare.oregon.gov/Pages/index.aspx	800-699-9075
Pennsylvania Medicaid and CHIP	Medicaid: pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html CHIP: dhs.pa.gov/CHIP/Pages/CHIP.aspx	Medicaid: 800-692-7462 CHIP: 800-986-KIDS (5437)
Rhode Island Medicaid and CHIP	eohhs.ri.gov	855-697-4347 or 401-462-0311 (Direct RIte)
South Carolina Medicaid	scdhhs.gov	888-549-0820
South Dakota Medicaid	dss.sd.gov	888-828-0059
Texas Medicaid	hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program	800-440-0493
Utah Medicaid and CHIP	UPP: medicaid.utah.gov/upp/ UPP Email: upp@utah.gov Adult Expansion: medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program: medicaid.utah.gov/buyout-program/ CHIP: chip.utah.gov	UPP: 877-222-2542
Vermont Medicaid	dvha.vermont.gov/members/medicaid/hipp-program	800-250-8427
Virginia Medicaid and CHIP	coverva.dmas.virginia.gov/learn/premium-assistance/famis-select coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs	Medicaid/CHIP: 800-432-5924
Washington Medicaid	hca.wa.gov	800-562-3022
West Virginia Medicaid and CHIP	dhhr.wv.gov/bms/ mywvhipp.com/	Medicaid: 304-558-1700 CHIP: 855-699-8447

Wisconsin Medicaid and CHIP	dhs.wisconsin.gov/badgercareplus/p-10095.htm	800-362-3002
Wyoming Medicaid	health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility	800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
dol.gov/agencies/ebsa
866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
cms.hhs.gov
877-267-2323, Menu Option 4, ext. 61565

WELLNESS PROGRAM NOTICES

Build a Better You is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a preventive health exam with your Primary Care Provider. You are not required to complete the HRA or to participate in the medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of a premium discount on monthly medical premiums for completing your preventive exam. Although you are not required to complete the HRA or participate in the preventive exam, only employees who do so will receive the premium discount on monthly medical premiums.

Additional incentives of up to a $100 gift care may be available for employees who participate in certain health-related activities such as additional preventive exams and wellbeing activities such as group challenges. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Human Resources at WeitzHR@weitz.com.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and The Weitz Company may use aggregate information it collects to design a program based on identified health risks in the workplace, Build a Better You will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) the vendor that Weitz has obtained to collect data for purposes of tracking eligibility for the wellness incentive.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Human Resources at WeitzHR@weitz.com.

THE WEITZ GROUP, LLC

("PLAN SPONSOR") HIPAA NOTICE OF PRIVACY PRACTICES

UPDATED DATE: 1/1/2024

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW YOUR PLAN SPONSOR (YOUR EMPLOYER WHO SPONSORS YOUR GROUP HEALTH PLAN) CAN USE OR DISCLOSE YOUR MEDICAL INFORMATION AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH Act) place important restrictions on sharing your medical information and provide you with important privacy rights. This Notice of Privacy Practices (the "Notice") replaces all prior notices provided by the Plan Sponsor and is effective on the Date Distributed noted above. This Notice describes the legal obligations of the Plan Sponsor and your legal rights regarding your "protected health information" ("PHI") held by your Plan Sponsor and Group Health Plan. This Notice describes how your PHI may be used or disclosed to carry out treatment, payment, or health care operations, or other purposes permitted by law.

Generally, PHI includes your personal information collected from you or created by your Group Health Plan, or the Plan Sponsor on behalf of a Group Health Plan, that relates to your past, present, or future physical or mental health or condition; the provision of health care; or the past, present, or future payment for the provision of health care, and includes your elections to enroll in the Plan. If you have any questions about this Notice or about our privacy practices, please contact your Privacy Officer identified below.

The Plan Sponsor may retain agents, service providers and third-party administrators to administer all or part of your Group Health Plan such as claims payment and enrollment management. The term Plan Sponsor as used in this Notice includes all entities that provide services related to your Group Health Plan that have access to your PHI. The Plan Sponsor and contracted service providers are required by law to follow the terms of this Notice.

The Plan Sponsor is required by law to maintain the privacy of your PHI, provide you with certain rights with respect to your PHI, provide you with a copy of this Notice, and follow the terms of this Notice. The Plan Sponsor reserves the right to change the terms of this Notice and its practices regarding your PHI. If there is any material change to this Notice, the Plan Sponsor will provide you with a copy of the revised Notice of Privacy Practices.

Use and Disclosure

The Plan Sponsor may use or disclose your PHI under certain circumstances without your permission. All of these certain circumstances will fall within one of the categories listed below.

- **For Treatment,** to facilitate medical treatment or services by providers including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you.
- **For Payment,** to determine your eligibility for Plan benefits, to facilitate payment for the treatment or services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage.
- **For Health Care Operations,** uses and disclosures necessary to run the Plan.
- **Treatment Alternatives or Health-Related Benefits and Services** that might be of interest to you.

- **To Business Associates** to perform various functions on our behalf or to provide certain types of services. A Business Associate will receive, create, maintain, transmit, use, and/or disclose your PHI, but only after they agree in writing with the Plan Sponsor to implement appropriate safeguards regarding your PHI.
- **As Required by Law** when required to do so by federal, state, or local law.
- **To Avert a Serious Threat to Health or Safety** to you, or the health and safety of the public, or another person, limited to someone able to help prevent the threat

In addition, the following categories describe other ways that the Plan Sponsor may use and disclose your PHI without your specific authorization. All of the ways the Plan Sponsor is permitted to use and disclose information will fall within one of the categories.

- **Organ and Tissue Donation,** after your death to an organization that handles organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- **Military,** if you are a member of the armed forces, as required by military command authorities. The Plan Sponsor may also release PHI about foreign military personnel to the appropriate foreign military authority.
- **Workers' Compensation** or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.
- **Public Health Risks** for public health activities. These activities generally include the following:
- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading adisease or condition;
- to notify the appropriate government authority if the Plan Sponsor believes that a patient has been the victim oabuse, neglect, or domestic violence. The Plan Sponsor will only make this disclosure if you agree, or when required or authorized by law.
- **Health Oversight Activities** for activities authorized by law. For example, audits, investigations, inspections, and licensure.
- **Lawsuits and Disputes** in response to a court or administrative order, including a response to a lawful subpoena, discovery request, or other process by someone involved in a legal dispute, but only if efforts have been made to tell you about the request or to obtain a court or administrative order protecting the information requested.
- **Law Enforcement** if asked to do so by a law-enforcement official:
- in response to a court order, subpoena, warrant, summons, or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, the Plan Sponsor is unable to obtain thevictim's agreement;
- about a death that the Plan Sponsor believes may be the result of criminal conduct; and
- about criminal conduct.
- **Coroners, Medical Examiners, and Funeral Directors,** for example, to identify a deceased person or determine the cause of death. The Plan Sponsor may also release medical information about patients to funeral directors, as necessary to carry out their duties.
- **National Security and Intelligence Activities** to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Inmates** of a correctional institution or in the custody of a law-enforcement official, to the correctional institution or law-enforcement official if necessary for the institution to provide you with health care; to protect your health and safety or the health and safety of others; or for the safety and security of the correctional institution.

Research, to researchers when the individual identifiers have been removed; or when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The Plan Sponsor is required to disclose your PHI to:

- **Government Audits** to the Security of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.
- **Disclosures to You** on your request, the portion of your PHI that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits.

Other Disclosures

The Plan Sponsor may disclose your PHI to:

- **Personal Representatives** authorized by you, or to an individual designated as your personal representative, or attorney-in-fact. You must provide a written notice/authorization and supporting documents such as a power of attorney. The Plan Sponsor does not have to disclose information to a personal representative if the Plan Sponsor has a reasonable belief that you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; or treating such person as your personal representative could endanger you; or in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.
- **Comply with your Authorization.** Other uses or disclosures of your PHI not described above will only be made with your written authorization. The Plan Sponsor may deny a request to disclose your psychiatric notes. The Plan Sponsor will not use or disclose your PHI for marketing; or sell your PHI, unless you provide written authorization. You may revoke written authorizations at any time, so long as the revocation is in writing. Once the Plan Sponsor receives your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Privacy Rights

- **Right to Inspect and Copy.** You have the right to inspect and copy certain PHI that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, the Plan Sponsor will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, the Plan Sponsor will work with you to come to an agreement on form and format or provide you with a paper copy. To inspect and copy your PHI, you must submit your request in writing to the Privacy Officer identified below. The Plan Sponsor may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. The Plan Sponsor may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to the Privacy Officer identified below.
- **Right to Amend.** If you feel that your PHI is incorrect or incomplete, you may ask the Plan Sponsor to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer identified below. In addition, you must provide a reason that supports your request. the Plan Sponsor may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan Sponsor may deny your request if it:
- is not part of the medical information kept by or for the Plan;
- was not created by the Plan, unless the person or entity that created the information is no longer available tomake the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If your request is denied, you have the right to file a statement of disagreement with the Plan Sponsor and any future disclosures of the disputed information will include your statement.

The information in this communication is confidential and may be used by the authorized recipient only for its intended purpose. Any other use or disclosure is prohibited.

- **Right to an Accounting of Disclosures** You have the right to request an "accounting" of certain disclosures of your PHI.

The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer identified below. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, the Plan Sponsor may charge you for the costs of providing the list. The Plan Sponsor will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions or limitation on your PHI** that the Plan Sponsor uses or discloses for treatment, payment, or health care operations. You also have the right to request a limit on your PHI that is disclosed to someone who is involved in your care or the payment for your care, such as a family member or friend. Except as provided in the next paragraph, the Plan Sponsor is not required to agree to your request. However, the Plan Sponsor will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider involved has been paid in full by you or another person. To request restrictions, you must make your request in writing to the Privacy Officer identified below. In your request, you must state (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply - for example, disclosures to your spouse. If the Plan Sponsor honors the request, it will stay in place until you revoke it or the Plan Sponsor notifies you.
- **Right to Request Confidential Communications** about medical matters in a certain way or at a certain location. For example, you can ask that the Plan Sponsor only contact you at work or by mail. Your request must be made in writing to the Privacy Officer identified below and specify how or where you wish to be contacted. The Plan Sponsor will accommodate all reasonable requests.
- **Right to Be Notified of a Breach** in the event that the Plan Sponsor (or a Business Associate) discover a breach of unsecured PHI.
- **Right to a Paper Copy of This Notice.** You may request a paper copy of this notice at any time from the Privacy Officer identified below, even if you have agreed to receive this notice electronically.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact:

Company: THE WEITZ GROUP, LLC

Title: Privacy Officer

Address: 611 5th Avenue, Ste 300

Des Moines, IA 50309

Phone: 515-697-5992

All complaints must be submitted in writing. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.

The information in this communication is confidential and may be used by the authorized recipient only for its intended purpose. Any other use or disclosure is prohibited.

NOTES

NOTES

NOTES